

Prison mental health: Context is crucial

A sociological exploration of male prisoners' mental health and the provision of mental healthcare in a prison setting

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The degree of civilisation in a society can be judged by entering its prisons.

Fyodor Dostoyevsky (1821–1881)

Abstract

This thesis represents a sociological exploration of Her Majesty's Prison Service, male prisoners' mental health, and the provision of National Health Service mental healthcare in a prison setting. This qualitative social science study is conducted in one prison establishment. The work is characterised as a policy and practice orientated exploratory case study. The study implements an inductive approach to the datum–theory relationship, a constructionist ontological position, and an interpretivist epistemological orientation. Semi-structured interviews are conducted in a male category B prison with healthcare centre staff (*e.g.* registered general nurse, registered mental health nurse, health care assistant, plus varied administration and clinical management staff), the secondary mental health team (psychologist, psychiatrist, community psychiatric nurse), prison governors, prison psychologists, primary-level mental health service users/prisoners, and secondary-level mental health service users/prisoners.

The subject of place is salient when deliberating the mental health of prisoners as a social group. The prison setting can fashion or exacerbate mental illness. In comparison to the general population, the prevalence of mental distress experienced by the prison population is exceedingly high. In order to consider issues that concern the mental health of prisoners (*i.e.* aetiology, prevalence, severity, interventions, and outcomes), the prison setting as a communal and procedural place requires attention. Therefore, this medical sociology study devotes attention to social and institutional arrangements that permeate the prison locale. As examples, these include prisoner–staff relations and prison regimes.

The prison environment is not conducive to good mental health, and is not often a useful catalyst for mental healthcare for myriad reasons. Notably, the custodial treatment setting is important here. The provision of mental healthcare and the pursuit of good mental health in the prison milieu are challenging. Thus, the prison-based exceedingly complex three-way relationship between culture, mental health, and mental healthcare is addressed. As, if one wishes to provide appropriate healthcare in a prison, one also has to understand something about those for whom the healthcare exists. Knowledge of the specific patient group is important. Therefore, prison healthcare ought to be increasingly fashioned (*i.e.* commissioned, provided, managed, and practiced) in accordance with the prison social environment, the institutional set-up, and the specific health requirements of patients/prisoners. The proposition is that *context is crucial* to the provision of wholly apt prison mental healthcare.

Study data are analysed thematically. Resultant themes include: the nature of clinician–patient/prisoner rapport; the working environment of the healthcare setting; the notions of healthcare provision and receipt in a custodial setting; patients’/prisoners’ perspectives regarding prison mental health; aspects concerning prison existence and mental healthcare users’ experiences; prison staff mental health knowledge, roles, and responsibilities; prison service and healthcare services collaborative working.

The penal milieu in relation to an extensive variety of issues impacts mental health and mental healthcare. These range from the overarching ethos of imprisonment right through to individual interactions in the setting. To précis, mental healthcare *provision* and *receipt experiences* and *environments* are important for clinicians and patients/prisoners alike.

Resultant published journal articles:

Jordan, M. (2010) 'Embracing the notion that context is crucial in prison mental health care', *The British Journal of Forensic Practice*, vol. 12, no. 4, pp. 26–35.

This paper received two separate publication awards in 2011 from the School of Sociology and Social Policy, University of Nottingham and the Institute of Mental Health, University of Nottingham and Nottinghamshire Healthcare NHS Trust. Respectively, the awards are entitled: 'Best student publication to arise from PhD work' and 'Best publication flowing from work during doctoral studies or as part of a doctoral dissertation'.

Jordan, M. (2011) 'The prison setting as a place of enforced residence, its mental health effects, and the mental healthcare implications', *Health & Place*, vol. 17, no. 5, pp. 1061–1066.

This paper received a publication award for 'Best student publication to arise from PhD work' in 2012 from the School of Sociology and Social Policy, University of Nottingham.

Resultant journal articles currently under review or construction:

Chapter 4 is currently being utilised to produce a submission for the journal *Psychiatric and Mental Health Nursing*. This paper is entitled: 'Provision of prison mental healthcare and associated team working environment aspects — as narrated by National Health Service prison staff'.

Chapter 5 has been developed to produce two papers that are currently under review at the *Journal of Forensic Psychiatry & Psychology* and the *Mental Health Review Journal*. These papers are entitled: 'Patients'/prisoners' perspectives concerning the National Health Service mental healthcare provided in Her Majesty's Prison Service' and 'Method and methodological reflections concerning the conduct of interviews with Her Majesty's Prison Service-based National Health Service mental healthcare patients/prisoners'.

Chapter 6 is currently being utilised to produce a submission for the journal *Social Theory & Health*. This paper is entitled: 'Prison mental healthcare: Developments and theory'.

Chapter 7 is currently being utilised to produce a submission for the journal *Health Policy*. This paper is entitled: 'The provision of mental healthcare in a prison setting: Context is crucial'.

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Abbreviations

ACCT	Assessment, Care in Custody and Teamwork
APA	American Psychiatric Association
BBC	British Broadcasting Corporation
BMA	British Medical Association
BSA	British Sociological Association
CMH	Centre for Mental Health
CPN	Community Psychiatric Nurse
DH	Department of Health
DNA	Did Not Attend
DSPD	Dangerous and Severe Personality Disorder
EE	Enabling Environments
ESRC	Economic and Social Research Council
GP	General Practitioner
HCC	Healthcare Centre
HMIP	Her Majesty's Inspectorate of Prisons
HMP	Her Majesty's Prison
HMPS	Her Majesty's Prison Service

IAPT	Improving Access to Psychological Therapies
IMH	Institute for Mental Health
IPP	Imprisonment for Public Protection
IRAS	Integrated Research Application System
MoJ	Ministry of Justice
NHS	National Health Service
NIHR	National Institute of Health Research
NIMHE	National Institute for Mental Health in England
NOMS	National Offender Management Service
NSF	National Service Framework
OHRN	Offender Health Research Network
ONS	Office for National Statistics
OSOP	One Sheet of Paper
OTSOG	On The Shoulders Of Giants
PCT	Primary Care Trust
PD	Personality Disorder
PHPI	Prison Health Performance Indicators
PIE	Psychologically Informed Environment
PIPE	Psychologically Informed Planned Environment

PO	Personal Officer
R&D	Research and Development
REC	Research Ethics Committee
RGN	Registered General Nurse
RMN	Registered Mental Nurse
SCMH	Sainsbury Centre for Mental Health
SDO	Service Delivery & Organisation
SEU	Social Exclusion Unit
SHA	Strategic Health Authority
SMHT	Secondary Mental Health Team
SMI	Severe and Enduring Mental Illness
UK	United Kingdom
UoN	University of Nottingham
US	United States
VP	Vulnerable Prisoners
WHO	World Health Organisation

Chapter 1

'It is hard to train for freedom in a cage'

(Morris and Rothman 1995:x).

Introduction

This thesis focuses on the mental health of adult male prisoners and the National Health Service (NHS) mental healthcare provided in Her Majesty's Prison Service (HMPS) in the United Kingdom (UK). Myriad issues regarding prison social environment, prison institutional set-up, and specific mental health requirements of patients/prisoners are addressed.

The penal milieu as a communal and procedural social setting receives attention. Resultant themes include: the nature of clinician–patient/prisoner rapport; the working environment of the healthcare setting; the notions of healthcare provision and receipt in a custodial setting; patients'/prisoners' perspectives regarding prison mental health; aspects concerning prison existence and mental healthcare users' experiences; prison staff mental health knowledge, roles, and responsibilities; prison service and healthcare services collaborative working.

To summarise, this thesis and its data demonstrate the penal milieu in relation to an extensive variety of issues impacts mental health and mental healthcare. These range from the overarching ethos of imprisonment right through to individual interactions in the setting. To précis, mental healthcare *provision* and *receipt experiences* and *environments* are important for clinicians and patients/prisoners alike.

This study's questions are discussed in detail at the beginning of Chapter 3, the Study Design section of the thesis. However, it is useful to include these questions at the outset of the thesis also, as their introduction helps frame the initial two chapters for the reader.

Thus, the overarching study question is:

How could prison mental healthcare be developed?

Therefore, the aim is threefold, to highlight *areas* for improvement, to produce *recommendations* for change, and to note *implications* for future research, practice, and development.

The overall study question is supported by four underlying study questions:

1. In relation to prison mental healthcare and the mental health of male prisoners at the fieldwork site, what are the remaining areas for development according to the involved social actors?
2. Do interviewees desire similar developments to prison mental health services; if not, are the dissimilar suggestions grouped (*e.g.* linked by gender or employment/social role in the setting)?
3. Are there aspects of the prison's social environment that affect mental health or mental healthcare?
4. Are there aspects of institutional existence that affect mental health or mental healthcare?

Research questions require justification and explanation. Thus, an exploration of prison mental healthcare is justified as the contemporary literature demonstrates

problems with current service provision for both staff and patients. Therefore, there is need for additional research and development in this field. Issues surrounding the provision of mental healthcare in the prison setting are debated fully in Chapter 2, the Literature Review section of this thesis.

The four underlying study questions also reflect current quandaries regarding prison mental health, yet are designed to also address gaps in the existent literature and to produce novel study findings.

In order to explain the underlying study questions, it is helpful to clarify key concepts. For this work, aspects of the prison *social environment* and aspects of prison *institutional existence* are salient. These two concepts are included in questions 3 and 4 above. Relevant theory is detailed in Chapter 2, via the sub-headings: The prison population; The incarceration experience; The social world of prison staff; Institutional settings and mental health. However, it is useful to supply examples here also. Therefore, for this study, *social environment* deliberations refer to communication processes, social group labels, rapport building, and relationships between social actors in the penal milieu. Characteristics of *institutional existence* examined in this thesis include the prison timetable, healthcare centre escorts, staff roles and responsibilities, prisoners' time usage, and layout of the NHS setting. To summarise, these *institution existence* explorations have a structural, regime, and practical nature; whereas, the *social environment* discussions relate to social characteristics and population demographics, relations between social groups and individuals, and social actors' personal experiences of the locale.

This initial thesis chapter includes four sub-sections that introduce:

HMPS;

Prison mental health;

Thesis *leitmotif*;

Relevant service evaluation method aspects.

Subsequently, the overall structure of the thesis is outlined.

Her Majesty's Prison Service

The Offender Management Statistics Quarterly, as produced by the Ministry of Justice (MoJ), reports that on the thirty-first of December 2011 public sector prisons in the UK confined 86,598 persons. The existence of imprisonment and the nature of incarceration are — or at least should be — of interest and concern to social scientists, the governing body of the relevant society, and the society's members who reside beyond the prisons' walls. After all, here in the UK, the state-funded prison system will release the vast amount of its prisoners back to wider society. Very few prisoners remain incarcerated for life. This being the case, apt treatment during a prison term and appropriate preparation for discharge (including good mental health) are paramount. However, 'there are so many contentious issues currently blighting the prison system' (Jewkes and Johnston 2006:283); overcrowding, resources, conditions, control of prisoners, and feelings of injustice amongst inmates represent contemporary issues.

It should be noted that imprisonment is not an inexpensive venture, as each prisoner costs UK taxpayers around £35,000 a year (Coyle, 2005). Unfortunately, HMPS has been described as 'teetering on the brink of a potentially devastating crisis' (Cavadino and Dignan 2007:192). Prisons can experience issues

concerning security, problematic staff–prisoner relations, a lack of resources of all types, and the unrest of both staff and prisoners as disparate social groups.

Incarceration in the UK is intended to provide public protection by housing inmates humanely and securely, whilst working towards reducing reoffending and rehabilitation. However, ‘imprisonment spectacularly and persistently fails to achieve one of its primary avowed aims, which is to reduce the level of reoffending by those who have been punished in this way’ (Cavadino and Dignan 2007:192). The Social Exclusion Unit (SEU) (2002) note ‘people who have been in prison account for one in five of all crimes; nearly three in five prisoners are re-convicted within two years of leaving prison; offending by ex-prisoners costs society at least £11 billion a year’ (p. 5).

In June 2011 Kenneth Clarke, Lord Chancellor and Secretary of State for Justice, set out his plan to reduce this cycle of reoffending. A reduction in substance addiction and misuse in prisons represents a central facet of the reforms. Clarke states his two main priorities as public protection and cutting crime; he argues that prison sentences must punish, yet provide demanding programmes of rehabilitation that, therefore, represent value for money for the taxpayer.

However, at present, overcrowding is a critical concern for the UK’s prison system. The prison population in England and Wales has reached a record high. On September the 16th 2011 the prison population figure was only 1,600 below the usable operational capacity of prisons. This small margin is unprecedented. The swift rise and resultant contemporary lack of capacity is, in part, a result of the recent riots across the UK in August 2011 and subsequent sentences for violence and looting. Notwithstanding this bout of social unrest, overcrowding represents a significant current issue for HMPS and is ‘one of the greatest

impediments to care delivery' (Gojkovic 2010:287). In October 2011 eighty-two of the UK's one hundred and thirty public prisons were overcrowded and the Prison Reform Trust (2011) calls for this overcrowding burden to be addressed.

Presently, outcomes of imprisonment are poor (Prison Reform Trust, 2011). It would appear 'the rhetoric of imprisonment and the reality of the cage are often in stark contrast' (Morris and Rothman 1995:xi). HMPS requires alteration in order to provide institutions that achieve their aims (*e.g.* rehabilitation), yet that are also secure, organised, humanitarian, and civilised.

Certainly in the UK, the distinct boundary between exemplar citizen behaviour and legally defined deviant and criminal acts seems set to continue. The existence of our current form of criminality requires publicly overt penalties, often necessitating a removal from free society. Consequently, a physical establishment is required to house these individuals until their liberty is reinstated. Prisoners represent a social group that continues to exist (and is actually proliferating in number). Therefore, it is important to address the nature of incarceration and the social, health, physical, and psychological effects of imprisonment. This is particularly pertinent when it is remembered that very few persons remain incarcerated for life in the UK.

Regrettably, prisoners remain an understudied population (Kupers, 2005). Heretofore, particularly in the UK, sociological analysis of the prison milieu remains nominal. The sociology of prisons and the nature of incarceration, therefore, warrant contemporary study.

It is important to highlight the culture(s), institutional social practices, and social composition of an entire prison system or even an individual prison

establishment are historically-, politically-, socially-, and economically-based. Prisons should not, therefore, be conceived as autonomous institutions devoid of societal context. Arguably, all socially constructed entities (*e.g.* schools, hospitals) should be considered and discussed in relation to the environment where they reside, as cogs in their larger and inescapable machine (*i.e.* their host society at micro-, meso-, and macro-levels). Jones and Fowles (1984) argue ‘talk of total institutions is misleading, because no institution is entirely cut off from the outside world’ (p. 201). This analytical complexity, and the convoluted society–prison connectedness, is crucial.

Prison mental health

The prevalence of mental disorder amongst prisoners is exceedingly high (Brooker and Gojkavic, 2009). The Revolving Doors Agency argues UK’s prisons represent ‘social dustbins’ (2007:1) for people with mental health issues. Once incarcerated, ‘prisoners are a socially excluded and marginalised group whose high level of mental health need is inversely related to their level of service access’ (Sirdifield *et al.*, 2009:78). Currently, HMPS detains a group of people with considerable general healthcare needs. In addition to this, the mental health issues experienced by this population are often severe and complex. ‘There is a high prevalence of mental health problems in prisons and insufficient provision for these problems’ (Nurse *et al.* 2003:484).

Prison healthcare services are in need of development (de Viggiani, 2006). However, the nature of health and healthcare in prison is markedly dissimilar to the nature of health and healthcare in wider society for numerous reasons. Examples include the security dominated access process to services, the complex patient group health and social profile, and the institutionalised treatment setting.

The provision of mental healthcare and the pursuit of good mental health in the prison milieu are challenging. It is this *context* of mental healthcare provision and receipt that is crucial to this thesis.

Reportedly, around ninety per cent of adult prisoners have at least one mental health problem, approximately seventy per cent have two or more mental health problems, around ten per cent have a severe mental illness, and rates of self-harm and attempted suicide in prison are high (Sainsbury Centre for Mental Health (SCMH)¹, 2009). The mental health of prisoners is affected negatively by incidences of overcrowding, bullying, stigma, discrimination, and marginalisation in the prison setting (SCMH, 2009). The poor mental health of prisoners remains ‘under-recognised, not high enough on the public health agenda, and a constant daily nightmare for prison systems’ (Fraser *et al.* 2009:410). Evidently, opportunities for improvements exist.

Conceptually, health is to be viewed holistically in this thesis. The connectedness between health experiences and social and institutional environmental factors is embraced. It is this notion of the importance of the prison social milieu and institutional regime that is central to this thesis.

The mental health of adult male prisoners and the mental healthcare provided in their prisons are ripe for both attention and development.

¹ The SCMH is now the Centre for Mental Health (CMH); however, the SCMH label is utilised often in this thesis, as the literature cited originates from the SCMH and not the newly titled grouping.

The contemporary situation could be surmised in six, albeit summarised, statements:

1. Prisons often receive people from the community with poor mental health;
2. Contemporary prison mental healthcare, although developing well, requires further improvement;
3. Prisoners' views concerning prison mental healthcare should be increasingly considered;
4. Factors associated with imprisonment itself predispose prisoners to mental health problems;
5. Prison culture can affect prisoners' mental health;
6. Mental health determinants in the prison setting require further research.

Thesis *leitmotif*: Context is crucial

The *leitmotif* for this thesis derives from one of the thesis' resultant papers: Jordan (2010). This article appeals for NHS prison based mental healthcare in the UK's HMPS to embrace fully the notion that context is crucial in relation to the provision of wholly apt mental health services in penal settings.

At present, 'the prison milieu is not always conducive to good mental health and is not often a useful catalyst for mental healthcare' (Jordan 2010:26). Therefore, it is argued that an understanding of the prison social environment, the institutional set-up of the establishment, and the specific mental health requirements of the prisoners is fundamental to the appropriate development of prison mental healthcare. Consequently, attention is devoted to social and institutional structures that permeate and affect the prison setting and its

included social actors. ‘The proposition is that situation specific and culturally responsive mental healthcare is a must; context is crucial’ (Jordan 2010:26).

The ethnographic work of Livingston (2008) can be utilised to support this argument that human practice is context bound. Livingston’s (2008) ethnomethodological text, *Ethnographies of Reason*, demonstrates convincingly that reasoning, knowledge, skills, and action are situation specific. Livingston’s (2008) work relates directly to social science methodology. Human reasoning, and therefore resultant action, is portrayed as an inherently social and skilled endeavour that is conducted in direct reference to contextual locale. Livingston (2008) uses intriguing and engaging examples to present his ideas. These include how humans complete origami models, construct jigsaws, and play draughts. The natures of midenic reasoning and midenic practices are explored. Reason and action are considered intrinsically situational social pursuits (*i.e.* ‘part of a living landscape’ (Livingston 2008:57)).

Livingston’s (2008) methodological underpinnings concur with the approach to methodology adopted in this study. This is exemplified via his view on objectivity:

‘unfortunately, we can’t get outside ourselves to see what the world “really” is like. We’re stuck within ourselves, within our immediate situation, within our immediate perceptions of that situation. There’s no Archimedean position from which we can view the world “objectively”’ (Livingston 2008:60, double quotation marks in original).

Livingston (2008) refers to his work as an examination of ‘domain-specific local settings in their idiosyncratic, lived detail’ (p. 187). Congruently, the particular character of the selected fieldwork site is explored in-depth in this study.

Furthermore, the lived experiences of involved social actors, and the perceived details of their social-/institutional-orientated practices in the prison social milieu and institutional environment of the prison establishment are explored. Like Livingston (2008), details regarding social and physical practice in a defined locale (*e.g.* a prison's Healthcare Centre) are of interest for this thesis.

Livingston (2008) highlights the practice of jigsaw puzzle completion cannot be characterised or explained via formal logic or mathematical formulae. Instead, 'the puzzle-relevant features of the puzzle pieces are only discovered through the locally generated, situated search procedures used to find them' (Livingston 2008:190). This reiterates the notion that context is crucial to a sociological study such as this that explores the nature of a social practice in a social sphere that is heretofore unknown to the social scientist. For this thesis, the social practice is the provision and receipt of mental healthcare by clinicians and patients and the social sphere is the prison establishment.

The sociologist should frequent the social setting often, and ought to do so with a desire to explore situation specific features, such as: shared tacit knowledge; learnt group behaviour patterns; collective opinions not expressed in formal guidelines/rules; communally constructed acceptable and deviant social norms and values. These data can then be utilised to aid the construction of analysis sections, final conclusions, and implications for policy and practice. Poignantly, experiential knowledge from the fieldwork site is of great worth for social science theses such as this.

To summarise, Livingston (2008) presents reasoning as 'being bound up with the material world and situated embodied action' (p. 199) where social actors

work together locally to produce and sustain functioning social environments. This approach helps to support and develop the *leitmotif* of this study.

Merton's (1965) seminal text *On The Shoulders Of Giants*, commonly referred to by its acronym OTSOG, explores the historical origin of Newton's famous aphorism: *If I have seen further, it is by standing on the shoulders of giants*. This thorough and scholarly (yet sharp and witty) investigation debates numerous issues pertinent to social science, including the natures of creativity, plagiarism, originality, tradition, progress, and the transmission of knowledge. The Roman grammarian Priscianus and Bernard of Chartres (*circa* twelfth century) are noted for their contributions.

Numerous forms of the renowned aphorism are presented, including *Pigmies placed on the shoulders of giants see more than the giants themselves* and *A dwarf standing on the shoulders of a giant may see farther than a giant himself*. The meaning of the aphorism is pertinent to this study, as it recognised that a sociological thesis that prioritises the social and institutional aspects of a particular social setting is not a novel pursuit *per se*. The thesis *leitmotif* draws on the prior work of preceding sociologists. This literature is demonstrated via the literature review that follows this chapter.

OTSOG's *Afterword* reiterates the notion that the esteemed property of science is originality; however, this is linked with the concept of humility, whereby a scientist professes how greatly she/he stands in debt to her/his precursors. Therefore, it is with humbleness and appreciation that this thesis utilises the ideas of foregoing social scientists to broaden and deepen the importance of context in a historically rooted — yet fresh — manner.

Service evaluation

As explained in Chapter 3 of the thesis, this work is labelled a service evaluation via the NHS Research Ethics Committee (REC) and the NHS Research & Development (R&D) grouping. Consequently, the celebrated work of Pawson and Tilley (1997) on realistic evaluation is worthy of consideration.

Pawson and Tilley's (1997) formal realistic evaluation method is not utilised for this study; instead, it is just several aspects of this evaluation process that are relevant. Their work explores the aforementioned concept of context. Therefore, it is suitable for discussion at this point in the thesis. Pawson and Tilley (1997) use the realist formula *mechanism + context = outcome* and then this formula is used to examine social world causation. This thesis does not explore explicitly social world causation or adopt a realist position. However, the authors' focus on *context* is useful.

For Pawson and Tilly (1997), *context* implies 'why a program works for whom and in what *circumstances*' (p. *xvi*). Accordingly, for this study, it is the *contextual circumstances* of prison mental healthcare provision that are important. This occurs alongside a consideration of all those involved with the healthcare and their views regarding these services. This approach fulfils the aforementioned 'Why?', 'For whom?', and 'In what circumstances?' questions raised by Pawson and Tilley (1997).

Furthermore, Pawson and Tilley (1997) highlight social policies or initiatives under investigation include different groups of subjects with dissimilar experiences. These bodies of experiential knowledge 'play quite different roles in the routine performance of the program' (p. *xvi*). Moreover, 'knowledge of

how the program works will thus differ from participant to participant and indeed between researcher and subjects' (p. *xvi*). This knowledge differentiation facet of evaluation method is relevant to this study, as provision/receipt experiences of prison mental healthcare are discussed in relation to participants' social roles and responsibilities in the prison setting.

Importantly, Pawson and Tilley (1997) argue:

'all social programs involve the interplay of individual and institution ... All social interaction creates interdependencies and these interdependencies develop into real-world customs and practices ... [Therefore] always begin with an attempt to come to a *sociological* understanding of the balance of resources and choices available to all participants involved in the program' (p. *xiii*, italics in original, ellipses denote removed sections, square brackets added).

This analysis of social institutions stresses the influences of both culture and the individual–institution relationship. Congruently, these two routes of reflection play roles in this thesis. Finally, Pawson and Tilley (1997) profess evaluations are conducted in order to inform the thinking of program participants, policy makers, practitioners, and the public. This study echoes this objective.

Thesis structure overview

The thesis contains seven chapters; the arrangement of these adheres to an orthodox order. Therefore, Chapter 1 acts as a preface to the thesis, thus introducing four fundamental foci: HMPS; prison mental health; thesis *leitmotif*; essential elements of study design. Chapter 2 then addresses relevant literature for the thesis including: prison history; current HMPS status; prisoner population

characteristics; mental healthcare policy and practice; prison culture; institutional settings and healthcare. To summarise, this review explores both social and structural aspects of the penal setting, particularly in relation to mental health. Chapter 3 represents the method and methodology section of the thesis. This design segment debates: study questions; ontology; epistemology; reflexive practice; social science interview method; analysis processes; ethical considerations and processes.

The subsequent three chapters represent analysis sections. Chapter 4 explores the NHS staff interviews and examines the nature of collegiate team health at the Healthcare Centre in the prison. NHS staff workplace relationships with both colleagues and patients/prisoners are addressed alongside issues associated with clinical practice in the custodial setting. Chapter 5 analyses prisoners' perspectives regarding mental health in the penal milieu; topics narrated by prisoners include rapport and relationship aspects with clinicians, wing staff, and inmates. This chapter also incorporates specific method and methodology commentary. Chapter 6 could be typified the development-orientated section of the thesis, as it debates potential alterations to HMPS and NHS services — both social and institutional facets are integrated. Chapter 7 concludes the thesis with multiple reflections concerning study questions, content, method, and implications.

Chapter 2

‘While public protection remains the priority, there is a growing consensus that prison may not always be an appropriate environment for those with severe mental illness and that custody can exacerbate mental ill health, heighten vulnerability and increase the risk of self-harm and suicide’

(Department of Health 2009:7).

Overview of prison mental health

This literature review commences by addressing the history of the prison and outlining the status of the current prison system in the UK. Attention is then devoted to the prison population, the nature of mental illness, UK mental health policy and practice, and the mental healthcare provided in the prison setting. Prison culture literature is then utilised for debate. Institutional settings and mental health are explored subsequently. A critical consideration of therapeutic environments and the Enabling Environments initiative follows. The prison-based exceedingly complex three-way relationship between culture, mental health, and mental healthcare is addressed.

After all, ‘nothing touches the lives of mentally ill and mentally handicapped people more than the setting within which they are cared for and treated’ (Gostin 1986:9). An understanding of a setting’s social and cultural conditions can enhance healthcare providers’ understandings of the health problems and the care required, as social and cultural surroundings impact the health of a society’s members (Winkelman, 2009).

As an aside, this study is based on the assumptions that imprisonment and mental health treatment are legitimate practices. It is recognised that both are questionable ventures that are debated at length elsewhere. However, for the purposes of this thesis, the existence of prisons and psychiatry as a medical discipline are accepted.

Furthermore, it is recognised at the outset that numerous aspects of the UK's criminal justice system are not addressed specifically in this thesis. Examples include private UK prisons, female prisoners, minority ethnic prisoners, foreign national prisoners, young offenders, and the probation service. Absences are reflected on in the concluding chapter of this thesis.

Additionally, it is worth noting early in the thesis reasons for selecting prison mental health as the topic for doctoral study. The explanation is three-fold. Firstly, an exploration of the UK's prison service with its divergent and disputed roles, responsibilities, and influences is apposite for a social scientist, as prison establishments forcefully contain, manage, and powerfully affect a specific subjugated social group. Secondly, to focus on a particular healthcare setting, a set of healthcare services, and the experiences of involved social actors is also apt for a budding medical sociologist. Thirdly, the decision to concentrate on mental health as the field of medicine for attention was somewhat directed by the Economic and Social Research Council (ESRC) funding call at the time of application, as mental health was listed as a current theme for research and development. Notwithstanding this stimulus from the funding body, mental health and mental healthcare represent an ongoing area of personal academic interest. Therefore, the choice to conduct study in the field of prison mental health seemed fitting, worthy, and inspiring.

To begin this literature review formally, the evolution of the prison is now outlined.

History of the prison

‘Prisons not only have a history, but a rich history’ (Morris and Rothman 1995:*vii*). A ‘deep cultural attachment to the prison’ (Jewkes and Johnston 2006:284) exists in the UK, nevertheless it is important to recognise that prisons — as we understand them today — have not always been at the core of the criminal justice system. ‘In the popular imagination, institutions of incarceration appear so monumental in design and so intrinsic to the criminal justice system that it is tempting to think of them as permanent and fixed features of Western societies’ (Morris and Rothman 1995:*vii*). However, ‘the English prisons of 1790 ... had little in common with the prisons of 1990 ... regardless of whether the yardstick is the daily routine, the amount of time served, or ... the public’s understanding of the purposes of confinement’ (Morris and Rothman 1995:*vii*, ellipses to denote removed sections). The historical development of the prison system did not, and does not today, occur impervious to wider societal contexts (*e.g.* economic, political, social).

Incarceration represents ‘the public imposition of involuntary physical confinement’ (Peters 1995:3). Such sanctions have existed since the ancient and medieval epochs. For example, the pharaohs of Middle Kingdom Egypt (2050–1786 BC) condoned human confinement, Greek myths tell tales of imprisonment, Plato (427–348 BC) discussed the prisons of ancient Athens, the Bible’s Book of Genesis reports the prisons of the ancient Hebrews, and the Romans constructed underground prisons to house debtors and persons awaiting execution.

Detention of persons awaiting sentencing, public punishment, and execution was the intention originally. *Punishment* via incarceration represents a later development.

Prior to being held in prisons as they are understood in the UK's society today, offenders were often transported, subjected to public punishment and execution, or housed temporarily in bridewells (houses of correction) and gaols. 'Before the eighteenth century the prison was only one part, and by no means the most essential part, of the system of punishment' (Morris and Rothman 1995:vii).

Imprisonment became the predominant form of punishment between the end of the eighteenth century and the mid-nineteenth century. It was necessary to 'mete out punishment away from the public gaze and to find alternatives to the gallows' (Morris and Rothman 1995:viii), as public executions were beginning to provoke widespread revulsion. Foucault (1977) reports the 'new age for penal justice' (p. 7) across Europe and the United States (US) between 1770 and 1810 as encompassing many alterations in penal style, including 'the disappearance of torture as a public spectacle' (p. 7). Punishment steadily ceased to be an exhibition, as 'the body as the major target of penal repression disappeared' (Foucault 1977:8).

Overt punishment became 'the most hidden part of the penal process' (Foucault 1977:9). Instead, the covert regulation of offenders' minds is debated in the literature. For example, Bentham's Panopticon prison design (1785) consists of a central circular watchtower for the guards, surrounded by an outer circular structure comprised of prisoners' cells. Continual supervision is the aim; one watcher can observe numerous inmates. Importantly, prisoners cannot know whether, or not, they are being watched. The cells are likened to 'many small

theatres, in which each actor is alone, perfectly individualised and constantly visible' (Foucault 1975:200). Foucault (1975) claims the Panopticon prison may 'induce in the inmates a state of conscious and permanent visibility that assures the automatic functioning of power' (p. 201). Bentham's prison design aims for significant mastery over the minds of prisoners (Evans, 1971). Arguably, the ethos of imprisonment has evolved to prioritise overt and unrelenting control and authority over inmates. Punishment for public spectacle and bodily chastisement — historical intentions — have ceased.

'Disorder and neglect were the dominant features of the eighteenth century prisons' (McGowen 1995:79). Authority of the staff was reportedly near non-existent and the lives of the jail inhabitants ranged from utter squalor to relative luxury, dependent on economic status. In contrast, the nineteenth century 'quiet and orderly' (McGowen 1995:79) prison system aimed for 'the imposition of deterrent and retributive justice' (Cavadino and Dignan 2007:193). The institutions were 'constructed around the belief that, through hard work, religion and solitude, the prisoner could be transformed into a law-abiding citizen' (Jewkes and Johnston 2006:13). The two principles of regularity and order underpinned prisons in the early- to mid-nineteenth century.

Victorian prisons often 'isolated each prisoner in a cell and enforced rules of total silence' (Morris and Rothman 1995:vii). Punishment was now a central characteristic of incarceration. McConville (1995) termed the Victorian era: 'hard labour, hard board, and hard fare' (p. 145). Physical suffering was imposed. The penal diet was exceedingly meager and strenuous physical exertion was enforced.

Such overt bodily hardships are no longer imposed on the incarcerated². Instead, it is the mental disturbances of imprisonment that now receive attention, as ‘attacks on the psychological level are less easily seen than a sadistic beating, a pair of shackles in the floor, or the caged man on a treadmill, but the destruction of the psyche is no less fearful than bodily affliction’ (Sykes 1958:64).

Responses to the question “Why the prison?” usually detail desires: to deter crime; to express society’s urge for retribution; to reform the deviant; to incapacitate dangerous criminals (adapted from Morris and Rothman 1995:ix). However, it is ‘likely the prison deters some citizens and some prisoners from crime, but equally likely, it confirms other prisoners in their criminality’ (Morris and Rothman 1995:x). A rift exists between the intentions of prisons and their outcomes. This situation is explored further in the following sub-sections.

Her Majesty’s Prison Service — its *raison d’être*

The aims of imprisonment in the UK could be typified as punishment, deterrence, reform, and public protection (Coyle, 2005). HMPS ‘serves the public by keeping in custody those committed by the courts ... to look after them [the prisoners] with humanity and help them lead law-abiding and useful lives in custody and after release’ (www.justice.gov.uk, last accessed Aug. 31st 2011, square brackets not in original, ellipsis to denote removed section).

² Whilst this remains the case in the UK, an American criminologist, Moskos (2011), has published recently a book in the US entitled *In Defense of Flogging* that debates the re-introduction of corporal punishment as a viable alternative to prisons — that are presented as failed institutions in relation to their goals.

The objectives of HMPS are ‘to protect the public and provide what commissioners want to purchase by:

Holding prisoners securely;

Reducing the risk of prisoners re-offending;

Providing safe and well-ordered establishments in which we treat prisoners humanely, decently, and lawfully’

(www.justice.gov.uk, last accessed Aug. 31st 2011).

The 2007–08 Annual Report from Her Majesty’s Chief Inspector of Prisons for England and Wales (2009) states ‘prisons are, in general, undoubtedly better-run, more effective and more humane places than they used to be’ (p. 7), yet branded the system ‘pressured ... with record numbers in prison’ (p. 5, ellipsis to denote removed section) and notes lessons ‘need to be learnt if prisons are to be safe and effective’ (p. 5). In the same report Dame Anne Owers, Chief Inspector of Prisons (*emerita*), argues ‘no one should be in any doubt that this is still a system under sustained and chronic pressure’ (p. 5), as the prison population is set to continue to rise, resource cuts are considered likely, safety is an ongoing concern, accommodation remains unsuitable in many local prisons, activity levels are still too low, and alcohol services remain inadequate.

Overcrowding is a pertinent issue. Between 1992 and 2005 there has been over a sixty per cent increase in the number of persons incarcerated (Coyle, 2005). The prison population in England and Wales is higher than in any other European country and is continuing to rise (Harris *et al.*, 2006). ‘The Government has forecast that the prison population could reach more than 100,000 by 2014’ (SCMH 2008:13). In relation to mental health, ‘the current trend of increasing prisoner numbers can do nothing but worsen the environment within prisons with the resultant consequences on mental health’ (Nurse *et al.* 2003:484).

Overcrowding has been linked to increased inmate–inmate bullying, self-harm, amplified mental distress, and self-inflicted deaths.

Nevertheless, it should be recognised that it is not the case that HMPS is set an easy task that it fails to complete. Rather, HMPS is set an exceedingly difficult task, as its aims are often conflicting, its population is exceptionally needy, resources are tight, and political and public opinion is volatile. The contemporary problems of containment are colossal:

‘it is very difficult indeed to run prisons which are more or less escape proof, orderly and safe, which provide programmes aimed at changing offending behaviour and offering prospects of rehabilitation, and which respect the human rights of staff and prisoners’ (King 2007:329).

The 2010 MoJ Green Paper *Breaking the Cycle: Effective Punishment, Rehabilitation and Sentencing of Offenders* prioritises the need for the UK to address its cycle of crime issue via the provision of effective rehabilitation in prison, resulting in a reduction in reoffending. As, ‘despite record spending and the highest ever prison population we are not delivering what really matters: improved public safety through more effective punishments that reduce the prospect of criminals reoffending time and time again’ (p. 5). HMPS is considered in need of transformation, and plans for fundamental changes are proposed. A future firm focus on reform and rehabilitation is suggested. ‘The criminal justice system cannot remain an expensive way of giving the public a break from offenders, before they return to commit more crimes’ (p. 1). This Green Paper’s spotlight on rehabilitation, that includes inherently good mental health, is welcome.

The most recent national inquiry published by Make Justice Work (2011) *Community or custody: Which works best?* explores whether rigorous community sentences are more effective than short prison sentences in relation to preventing persistent low-level offending. The arguments are made in reference to the contemporary backdrop of increasing criminal justice system costs and escalating reoffending rates. In conclusion, robust community sentences are posited as the preferable alternative to custody for repetitive low-level offenders. In addition, these sentences are claimed to be cheaper, more effective, and tougher. Furthermore, these exacting community sentences are contended to ‘identify the underlying causes of offending behaviour and work to ensure the offences won’t be repeated and there will be fewer victims in future’ (p. 24). Community sentences are gaining support. This is occurring alongside the current intention to divert those offenders, for whom prison is not a suitable environment, away from incarceration in HMPS establishments.

However, Brooker *et al.* (2011) investigate offenders under probation supervision and conclude the prevalence of mental health disorder, comorbidity, dual diagnosis, and substance misuse in this population to be very high in relation to the general population. Brooker *et al.* (2011) argue ‘there is need for the mental health and substance misuse needs of offenders to be given a higher priority in terms of service delivery, education and research’ (p. 10). Therefore, offenders experience unmet mental health need across the criminal justice system (*i.e.* not just in the prison setting) and community sentences/diversion tactics alone are unlikely to address offender mental health requirements fully.

The prison population

Adshead (2010) highlights:

‘from a sociological perspective, prisons function as containers for social disturbance that place an emphasis on individual deviance, rather than social and political disorganisation’ (p. 253).

Therefore, prisoners’ pre-institutionalisation social exclusion issues and the political and social arenas of UK society are relevant for consideration.

‘The idea that prison is a microcosm of society is well established’ (Bandyopadhyay 2006:187). However, prisons as isolated institutions are also inextricably linked to the outside social world, as a prison’s intake arrives from wider society, and then the vast majority of prisoners are returned to the general population. Therefore, the social situations of prisoners prior to offences are ripe for consideration. An awareness of the social and health profile of prisoners is decisive to the positive development of prison mental healthcare, as services should be fashioned in accordance with the needs of their patients/prisoners.

Coyle (2005) states a country’s marginalised groups can be predicted via an examination of its prison population and refers to prisoners as ‘those at the edges of society’ (p. 60); congruently, the UK’s prisoners are ‘probably the most socially excluded group in our society’ (Rutherford *et al.* 2008:262). Preceding imprisonment mental health problems, unemployment, substance misuse, poverty, homelessness, poor education, lack of qualifications, and a history of suffering abuse are issues commonly experienced by prisoners (SEU, 2002).

HMPS confines ‘a highly vulnerable population’ (Harris *et al.* 2006:56), that currently experiences high levels of HIV positivity and AIDS, severe alcohol/drug abuse and addiction, a current increase in geriatric disorders and terminally ill prisoners, and an ongoing influx of persons with mental health issues. ‘Within the sometimes overwhelming burden of need for care within prisons today lies the ongoing problem of people with ... very low mental health resilience, low self-belief and little possibility of recovery without skilled help’ (Fraser *et al.* 2009:410, ellipsis to denote removed section). Ramsbotham (2003) states if all prisoners were separated into three groups (*i.e.* the bad, the mad, and the sad), the sad and mad prisoners would far outnumber the bad.

The prison population, as a whole, does not experience good mental health. ‘Psychotic disorders reportedly affect 7% of sentenced male prisoners in comparison to 0.5% of men societal wide’ (Jewkes and Johnston 2006:229). Comorbidity is prevalent (SCMH, 2008a); many prisoners have a complex mix of several mental health issues or other health issues, including substance and alcohol misuse. Suicide rates in prisons are six times higher than in the general population (Nurse *et al.*, 2003). Our prisons ‘carry a great burden of mental disability from major conditions ... to lesser forms’ (Fraser *et al.* 2009:410, ellipsis to denote removed section). HMPS detains a group of people with considerable and complex mental health needs.

Mental health and illness

It is critical to remember that single definitions for mental health and mental illness do not exist, as ‘a lawyer will have one definition, a psychiatrist another, a service user another still’ (Lester and Glasby 2006:2). Dissimilar interest groups often possess ‘markedly differing ways of speaking about mental health

normality and abnormality' (Rogers and Pilgrim 2005:1). Numerous frameworks exist to conceptualise mental health and illness: psychiatry, psychology, social causation, social constructivism, bio-determinism, psychological determinism, and social determinism. Definitions concerning mental health and mental illness often disagree over the extent to which mental health problems are psychological or biological entities. It is the aetiology of mental illness that is often the site of definition divergence (Pilgrim, 2005).

Formal systems of medical diagnosis commenced in the nineteenth century alongside the development of psychiatry as a branch of specialised medicine. 'Today, assumptions about the biological origins of serious mental illness remain in a dominant position in psychiatry' (Pilgrim 2005:7). The medical profession's biomedical definition is, on the whole, the accepted approach and is currently supported by Government and reinforced by Department of Health (DH) policy and practice guidance. The World Health Organisation's (WHO) *International Classification of Diseases* and the American Psychiatric Association's (APA) *Diagnostic and Statistical Manual of Mental Disorders* are the currently utilised systems of classification. Numerous forms of classified mental disorder exist, including: personality disorder (PD), post-traumatic stress disorder, schizophrenia, bi-polar disorder.

Severe mental illness, in the NHS prison context, refers to: schizophrenia, schizophrenic disorder, psychosis, mood disorder, *etc.* Other mental health issues present in the prison setting include, yet are not limited to: anxiety issues, adjustment problems, dual diagnosis, multiple forms of PD, and depression.

Notably, 'while madness, sadness and fear have always existed, as part of the human condition, "mental illness", or "mental disorder" only exist as by-

products of activity by the psychiatric profession' (Pilgrim 2005:11, double quotation marks in original). The conceptualisation of mental illness as a biomedical entity has been challenged.

To characterise several influential academics, the dissident psychiatrist Szasz (1974) challenges the medical definition via claiming mental illness is not a disease, yet is instead a myth fabricated by psychiatrists for reasons regarding professional advancement. Foucault (1961) considers mental illness to be a cultural construct sustained by medico-psychiatric practices. Zola (1972) deems medicine a system of social control ever increasing its power by intentionally broadening its definitions to include more aspects of human existence in its literature and practice. Kirsch (2009) examines the pharmaceutical industry concerning the nature of depression and its developed antidepressant drugs; issues regarding greed and medical myth arise.

This anti-psychiatry movement, that overtly criticises orthodox psychiatry, raises issues pertaining to psychiatry's coerciveness, stigmatisation, exclusion, and treatments (Pilgrim, 2005). Despite the anti-psychiatry movement, biological understandings currently hold a position of dominance. Poignantly, the patient perspective and lay view of mental health and illness often continue to differ from this medical model (Fawcett and Karban, 2005). For a detailed account of the history of psychiatry, see Shorter (1997).

In a study somewhat similar to this, Nurse *et al.* (2003) utilise a social context orientated and holistic definition of mental health. This is useful for this work, as it considers mental health and mental illness to be affected by social environment, and connects both individual and group understandings. Mental health is considered to be 'how people, communities and organisations think and

feel about themselves and their experience of mental well-being' (Nurse *et al.* 2003:480). Arguably, 'madness is sustained unintelligible conduct. The mad person inhabits an idiosyncratic world, which does not make immediate sense to others' (Pilgrim 2005:18). This renders understandings of mental illness context bound. The dividing line between mentally healthy and mentally ill is evidently affected by 'prevailing ideologies, social and cultural practices and belief systems' (Fawcett and Karban 2005:1).

To further develop these debates that concern the nature of mental health definitions, Radley and Billig (1996) question what individuals are actually doing when speaking about their state of health and argue 'health talk' (p. 220) defines 'social fitness' (p. 220) and 'everyday notions of health and illness' (p. 222) actually 'reflect ideological values' (p. 222). Individuals are argued to 'construct their state of health as part of their ongoing identity in relation to others, as something vital to the conduct of everyday life' (p. 221). Therefore, 'health beliefs are ideological in that they are sustained within a wider social discourse that shapes not just how individuals think, but how they feel they ought to think' (p. 227). This proposal, that health accounts are socially negotiated and setting specific, further supports the central assertion of this thesis. Context is crucial to the provision of wholly apt healthcare.

This study accepts:

'knowledge is subjective, constructed and based on the shared signs and symbols that are recognized by members of a culture. Multiple realities are presumed, with different people experiencing these differently' (Grbich 2007:8).

Appropriately, therefore, mental health and mental illness are investigated in accordance with individuals' socially constructed understandings. Similarly, Morgan *et al.* (2007) study mental health service seeking behaviour in a prison context; service seeking behaviour is reportedly affected by inmates' understandings of their own mental health. Gately *et al.*, (2006) research prisoners' perspectives on managing their own healthcare and conclude divergences between the healthcare professionals' and the patients' healthcare desires are worthy of renewed research attention. Denzin and Lincoln (2005) state 'the province of qualitative research ... is the world of lived experience, for this is where individual belief and action intersect with culture' (p. 8, ellipsis to denote removed section). Therefore, this study combines explorations of both *individual* social actors' understandings and social/professional *group* understandings of mental health in the prison environment. Relations between social group culture and individual belief are important for consideration.

Winkelman (2009) debates transcultural psychiatry issues and highlights the complexities of the cultural concepts normalcy and abnormalcy in a mental health sense, yet also in relation to both acceptable behaviours and tolerable deviations in differing social contexts. Winkelman (2009) demonstrates that relevance, impact, and affect of symptoms are culture based. Winkelman (2009) argues:

'mental illness is a major area in which cultural perspectives contribute to an understanding of health maladies and illustrate the limitations of the biomedical perspectives as a universally valid system for diagnoses and classification' (p. 244).

An understanding of a society's culture is of central importance to a health orientated consideration of a patient's personality, self, and identity, and

therefore their cultural approach to the notions of health and illness. A transcultural critique of the mental health policy/practice framework, as utilised by the NHS at present, does not feature in this thesis; however, it is recognised that the UK's current system, often labelled Western- and biomedical-focussed, is questionable in relation to alternative approaches. Although Winkelman's (2009) transcultural psychiatry debates are not elaborated here, the preceding overview of Winkelman's (2009) argument does serve to stress the importance of the social context of the prison for this study, in reference to both prisoner and staff cultures. However mental illness is defined, it is important to remember that mental health 'varies not only across groups and persons but for each person over time' (Toch 1975:1). An individual's mental health is not a static status. It is paramount that research exploring mental health recognises the fluidity and nuances of mental illness. Mental health is an exceedingly convoluted area of both clinical medical practice and theoretical medical sociology.

UK mental health policy and practice

'Mental health policy needs to be identified as confusing, ambiguous and contradictory territory' (Fawcett and Karban 2005:25). Mental health policy 'is partly about the control of mad behaviour, partly about promoting well-being, partly about ameliorating distress and partly about responding to dysfunction' (Rogers and Pilgrim 2001:226). The historical development and current condition of UK mental health policy is convoluted and troubled by multifarious discrepancies of opinion. The UK's extensive asylum system emerged in the nineteenth century³.

³ Prior to this, madness, as it was then termed, was viewed as a 'domestic responsibility' (Lester and Glasby 2006:24) and managed by individual families.

‘Asylums became warehouses for the unwanted’ (Lester and Glasby 2006:25). Asylums were reportedly stigmatising, regimented, and custodial institutions seemingly failing to deliver the cures that the medical approach to insanity had promised. This era of UK mental healthcare has since been labelled overly segregative and coercive.

It should be noted that ‘the notion of mental health policy is relatively recent’ (Pilgrim 2005:113), as lunacy policy was not superseded by mental illness policy until the twentieth century. At the conclusion of the Second World War asylum provision began to decline precipitously; the decarceration of those with mental illnesses began. Five main factors influenced the closure of asylums: developed drug treatments; mental hospital scandals; reductions in public expenditure; concept of normalisation; civil liberty campaigns (Jones, 2004).

A shift from hospital based to community based sites of mental healthcare delivery occurred gradually throughout the second half of the twentieth century. In direct relevance to this study, Pilgrim (2005) reports that trans-institutionalisation is currently taking place⁴. This concept implies that mentally disordered persons who would previously have been housed in asylums are now residing in prisons.

Mental health policy debates are underpinned by a ‘dynamic and rapidly changing kaleidoscope of concepts and ideas’ (Fawcett and Karban 2005:123). In addition, all alterations are occurring ‘in a highly politicised climate’ (Bartlett and Sandland 2007:71). UK mental health policy is a contested field rife with disagreement and conflict. For example, Crossley (2006) details how a diverse

⁴ For a balanced debate concerning this trans-institutionalisation phenomenon, see Prins (2011).

mixture of UK based complex social movements have overtly questioned and resisted the power and control of traditional psychiatry since the 1950s and publicly highlighted the contentious issues associated with orthodox psychiatric practice. Contemporary mental health policy debates deliberate: issues of exclusion; levels of acceptable control; extent of citizenship involvement; value of professional opinion; user involvement; definition of mental illness; quality of life; adequacy of resources; community safety; territorial disputes between healthcare professionals.

Prison specific mental healthcare is now introduced.

HMPS mental health policy and practice

The SEU (2002) demonstrate, preceding imprisonment, 47% of male prisoners ran away from home as a child, compared to 11% of the general population; 52% of male prisoners have no qualifications, compared to 15% of the general population; 32% of male prisoners were homeless prior to imprisonment, compared to 0.09% of the general population.

In contrast to the general public, prisoners are: thirteen times as likely to have been in care as a child; thirteen times as likely to be unemployed; twenty times more likely to have been excluded from school; two-thirds of prisoners were using drugs before imprisonment (yet 80% have never had any contact with drug treatment services); half of prisoners had no General Practitioner before they came into custody; four in five have the writing skills, two-thirds the numeracy skills, and half the reading skills at or below the level of an 11-year-old (SEU, 2002).

The social exclusion issues faced by this social group are overwhelming. Moreover, psychiatric morbidity is prevalent amongst the incarcerated (Singleton *et al.*, 1998). Over 90% of prisoners have a mental disorder (Birmingham, 2003). Furthermore, numerous prisoners experience multiple mental health diagnoses, sometimes alongside complex substance misuse issues. Additionally, whilst incarcerated, one-third of inmates lose their home, two-thirds lose their previous employment placements, over a fifth develop further financial problems, and over two-fifths lose contact with their family (SCMH, 2008a).

HMPS has under its care one of the most vulnerable and mentally unhealthy populations in the UK. This presents a huge challenge for the system which cannot, like other services outside, refuse to admit on the grounds that there are no available beds, insufficient trained staff, inadequate facilities, or because diagnosis does not warrant admission. ‘The delivery of mental health care within the prison system is a complex process’ (Brooker and Birmingham 2009:1).

As prison life is associated with discipline and control, the environment alone could be considered anti-therapeutic (Hughes, 2000). The prison nursing staff in Powell *et al.*’s (2010) study ‘acknowledge the conflict between the custody regime and healthcare delivery’ (p. 1257) and reportedly experience this tension acutely. Sifunda *et al.* (2006) also document the divergence between health needs of prisoners and safety protocols in the prison.

In accordance with DH and HMPS (1999) *The Future Organisation of Prison Healthcare* since the 1st of April 2003 the NHS has had responsibility for prison-based healthcare. Frontline responsibility for prison health was transferred to NHS Primary Care Trusts (PCTs) in April 2006. DH and HMPS (2001)

Changing the Outlook: A Strategy for Modernising Mental Health Services in Prisons officially introduces the principle of equivalence to prison mental healthcare. The equivalence strategy calls for prison mental health services and treatments to be in-line with the range of community based mental healthcare available beyond the prison setting. It is worth noting at this juncture that it is widely stated that equivalence has not been fully achieved and continues to pose an ‘enormous challenge’ (SCMH 2007:2). To highlight the continuing dominance of the equivalence aim, the DH (2005) *Offender Mental Healthcare Pathway* commences by reiterating the principle and pledging continued allegiance to the ideal.

Wilson (2004) argues the principle of equivalence is unsuitable conceptually for prison, as similar environments do not exist in the community model of mental healthcare. Arguably, the direct application of community mental health services to the prison population is mistaken, as issues of criminality complicate the situation (Steel *et al.*, 2007). Birmingham *et al.* (2006) appeal for recognition that ‘being a prisoner is not the same as being an ordinary citizen’ (p. 4). This distinction concurs with the work of Cote *et al.* (1997) who claim ‘clinical specificity of prison inmates’ (p. 571). Niveau (2007) states ‘from a clinical point of view, the principle of equivalence is often insufficient to take account of the adaptations necessary for the organisation of care in a correctional setting’ (p. 610).

Prison In-reach teams⁵ are intended to provide the specialist mental health services to persons in prison that are provided by community based mental

⁵ In-reach teams are now often termed Secondary Mental Health Teams; however, the label In-reach occurs often in this thesis, as the literature and participants relevant to this study utilise this term.

health teams to the wider population. However, In-reach teams have been affected negatively by limited resources, constraints imposed by the prison environment, difficulties in ensuring continuity of care, and wide variations in practice (SCMH, 2008a). Misconceptions exist concerning the official remit of In-reach teams (Armitage *et al.*, 2003).

In addition, In-reach team staffing issues are also prohibiting equivalence with community based care (Brooker and Birmingham, 2009). £20.8 million was spent on In-reach teams in the year 2006–2007 (SCMH, 2008); however, Brooker and Birmingham (2009) consider In-reach teams to possess only ‘meagre resources’ (p. 2) and Brooker and Gojkovic (2009) appeal for increased funding. Service improvement is required before the complex needs of prisoners with mental health problems can be addressed fully.

In March 2011 the Offender Health Research Network (OHRN) submitted their 2009 evaluation report concerning the nation’s In-reach services to the National Institute of Health Research (NIHR). The three-part study includes a survey of In-reach teams, case studies of In-reach teams, and case studies of prisoners with a severe and enduring mental illness (SMI). The majority of In-reach team leaders state their teams are too small in size/staffing levels to ‘meet the needs of prisoners’ (p. 7). The bureaucracy in the prison system is highlighted as an ongoing barrier, and working with HMPS in terms of suicide/self-harm prevention and management (Assessment, Care in Custody and Teamwork (ACCT)) is variable, and involvement and responsibilities are confused. Overall, however, In-reach team leaders highly value the service, and consider the concept of In-reach in the prison environment to be ‘an excellent idea’ (p. 8). In support of the notion that ‘context is crucial’ (Jordan 2010:26) in prison mental healthcare, In-reach teams report ‘the impact of historical, organisation, and

physical factors upon the everyday delivery of care' (OHRN 2011:8) in 'an institutional setting with well established procedures, relationships and cultural norms' (OHRN 2011:8). The provision of healthcare is here linked to the social and institutional nature of place.

The aforementioned report (OHRN, 2011) provides updated mental health prevalence statistics: SMI is present in 23% of the prison population; major depression is present in 19% of the prison population; psychosis is present in 4% of the prison population; dual diagnosis is present in 18% of the prison population; substance misuse is present in 66% of the prison population. Overall, 71% of the prison population has a SMI, substance misuse problem, or both. The OHRN (2011) recommends: mental health in the UK's prisons should be an issue for the entire HMPS; increased resources are required to meet clinical needs; PD and dual diagnosis clinical skills and services require development; continued research and investment in prison mental healthcare is necessitated.

Lord Bradley's (2009) *DH Review of People with Mental Health Problems or Learning Disabilities in the Criminal Justice System* firstly argues that the implementation of diversion approaches to policy and practice that aim to divert those with a severe mental illness or learning disabilities away from the prison custodial environment have been inconsistent across the nation. Secondly, the review appeals for a renewed focus on these ideals. Lord Bradley's (2009) document stresses prison may not always be the correct environment for those with a SMI. In addition, the nature of existence in prison custody is noted to exacerbate mental illness and heighten the risk of self-harm or suicide for some prisoners. Evidently, improvement is required for the complex needs of prisoners with mental health problems to be addressed fully in the UK's prisons.

The quality of NHS healthcare in prisons is measured by Prison Health Performance Indicators (PHPI). This is a traffic light performance rating system submitted to the Strategic Health Authority (SHA). DH (2008) *Guidance Notes: Prison Health Performance and Quality Indicators* details forty-three distinct areas for assessment (e.g. *Suicide Prevention, Primary Care Mental Health*). These multiple measurements assess numerous aspects of prison healthcare, not just the mental health services. The DH and MoJ East Midlands SHA PHPI Performance Report (2009) details the traffic light quality indicators for seventeen of the UK's HMPS prisons. The *Healthcare Environment* section receives two red lights and five amber lights, with the remaining ten lights showing green. Furthermore, the *Access To Specialist Mental Health Services* section receives one red, nine amber, and seven green lights.

The 2008–09 Annual Report from Her Majesty's Chief Inspector of Prisons for England and Wales (2010) argues 'the prison system is struggling with the twin pressures of increased population and decreasing resources' (pp. 5–6). Overcrowding and its related issues appear frequently throughout the report. 'Primary mental health services in particular remain stretched ... equally troubling, are the links between violence, self-harm and mental illness in men's prisons – where violence reduction strategies are in general underdeveloped and inadequately implemented' (p. 6, ellipsis to denote removed section). The report highlights repeatedly the vulnerability of the prison population. Sixty-four self-inflicted deaths occurred in prison custody in the Inspectorate's reporting year; importantly, 'most local prisons were not monitoring near-fatal incidents in order to learn lessons' (p. 22). In addition, prisoners in receipt of self-harm or suicide monitoring services are still, sometimes, 'placed on the basic regime, without consideration of its effect on their care arrangements' (p. 22). In some of the UK's prisons 'time out of cell was minimal and patients complained they had

nothing to do' (p. 28). The report appeals for increased day-care facilities for those prisoners less able to cope on the wings due to mental distress. In-reach teams (*i.e.* the secondary-level mental health service providers) are reportedly 'often under-resourced, with staff carrying a heavy caseload' (pp. 29–30).

The WHO highlight their healthy prison concept to be a recognition that the health of prisoners is not the responsibility of healthcare clinicians alone, yet is instead also dependent on the ethos and regime created in the penal setting. The WHO's *Health in Prisons Project* and report *Health in Prisons: A WHO Guide to the Essentials in Prison Health* (2007) acknowledge that prisoners' individual healthcare needs are essential; however, the promotion of a whole-prison approach to health is considered vital for apt development of healthy prisons that provide appropriate care for those in custody. Thus, in the UK setting, this implies HMPS and the NHS working together.

However, 'it is clear that, in many ways, mental health service provision and the criminal justice system exist in parallel universes' (Brooker and Birmingham 2009:3); this is both unhelpful and inappropriate. Arguably, the convergence of these public services ought to be sought for the benefit of those persons affected by them (*i.e.* prisoners, NHS and HMPS employees, and wider society). Brooker *et al.* (2009) report 'prisoners may well benefit from one integrated system with a shared philosophical basis and culture' (p. 107). This appeal for a unified culture between the two services supports the notion that context is crucial to HMPS developments, as positive developments are foreseen as a direct result of alterations to prison culture and institutional ethos. A future union here is arguably paramount to the success of both of these two important public services.

Both prisoner culture and staff culture are now considered in turn, as the link between social environment, mental health, and the provision of mental healthcare is vital.

The incarceration experience: Prison culture

*Vile deeds like poison weeds bloom well in prison air,
it is only what is good in man,
that wastes and withers there.
(Oscar Wilde, 1854–1900)*

At this juncture, is it imperative to note that a large proportion of the prison culture literature originates from the US. Admittedly, US and UK prisons are innately dissimilar; however, so are individual prisons and individual inmates' subjective experiences of incarceration. Therefore, the body of US origin knowledge is suitable for inclusion in a UK based discussion, providing its source is recognised and it is utilised appropriately.

Clemmer (1940) notes prison culture includes the prisoner–staff–surroundings relationship in tandem with the traditions, habits, rules, attitudes, customs, and codes that govern the social organisation of the prison. However, 'for most people the prison is a closed world, with little known about what goes on behind its high walls' (Coyle 2005:xi).

To summarise, 'imprisonment is in essence a negative experience' (Coyle 2005:6). Imprisonment deprives individuals of rights and possessions including

liberty, heterosexual relationships, goods and services, and security and autonomy⁶.

Prisons are single-sex institutions that operate repetitive and exceedingly disciplined daily routines. Coyle (2005) highlights that these two prevailing characteristics of prisons can be problematic for its population, since the bulk of prisoners are young men who are unused to a lifestyle dictated by daily schedules and authority. These inmates are then held in conditions of close confinement with very little private space. Cells intended for single occupancy often hold two or three inmates (Coyle, 2005). The potentiality for social tension and disagreements is, understandably, great.

Clemmer's (1940) American based penitentiary study, *The Prison Community*, aims to describe the culture of the prison: its 'penal milieu' (p. 294). Language is cited as an important vehicle for the expression of culture. Clemmer (1940) develops a document, similar to a dictionary, of prison language; sixty per cent refers to crime and aspects of the prison environment. It is suggested — that due to the relatively restricted vocabularies of inmates — profanities and slang are enacted as substitutes.

Clemmer (1940) highlights three fluid subgroups in his studied prison population; social classes are argued to exist. The élite class consists of the most intelligent, sophisticated, and urbanised offenders who choose to overtly set themselves apart from the masses.

⁶ Whilst prisons are narrated often as undesirable locales and imprisonment as a disagreeable experience, it is conversely that case that, for a small minority of, often homeless, low-level repeat offenders, local prisons can represent desired sanctuary — a relatively safe place of warm residence with daily food and drink. This issue is addressed in chapter six of the thesis.

The middle class is occupied by the vast majority of inmates, and it is typified by its lack of unorthodox individuals and dislike for the third class, 'the hoosiers' (p. 108). The hoosiers are labelled so by the members of the other two social groups. This lowest class includes sexual offenders, 'the feeble-minded' (p. 108), those who lack physical courage, and 'the backward' (p. 108). The relationship between mental health and culture is evidenced here, as those with overt mental health issues are labelled negatively and placed at a cultural disadvantage in the social setting.

In 1958 Sykes reported the utilisation of the labels below by prisoners in order to brand one another (pp. 84–108):

Merchant (a prisoner who sells what he should merely give),

Punk (a prisoner who submits to aggressive homosexuals),

Gorilla (a prisoner who takes what he wants from others by force),

Rat (a prisoner who voluntarily communicates with the guards),

Fish (a prisoner who is newly arrived),

Fag (a prisoner classed as a passive, stereotypical homosexual),

Ball Buster (a prisoner who perpetually defies the guards),

Wolf (a prisoner considered to be a dominant, forceful homosexual),

Tough (a prisoner labelled as aggressive and touchy),

Real Man (a prisoner who endures the rigours of imprisonment with dignity).

Ireland and Qualter (2008) detail how contemporary forms of intragroup prison bullying via psychological/verbal victimisation often result in social or emotional loneliness. Prison culture is linked to prisoners' wellbeing. This highlights the relationship between social place and resultant health orientated experiences.

Sim (2006) claims daily experiences of male prisoners are mediated by their relationships with, and expectations of, the other prisoners and their guards as men. Sim (2006) believes a culture of masculinity permeates prisons, often generating a hostile environment. De Viggiani's (2003) UK based prison ethnography reports that masculine ideology dominates a prison's culture. Newton (1994) explains how theories of masculinity can be utilised effectively to study men in prison: it is the unwritten codes in the male hierarchy and the power relations of hegemonic masculinity that are particularly pertinent in prison culture.

Bandyopadhyay's (2006) India based prison ethnography focuses on what happens to maleness and masculinities in 'the chaotic, violent atmosphere' (p. 195) during periods of incarceration; inmates' struggles to reclaim agency and to assert a sense of self in the prison as an 'overwhelmingly male space' (p. 186) are explored. 'The ideas of weak men, strong men, hardened men, and soft men are implicit in the hierarchies that prisoners construct' (p. 190). Aggressive, violent men usually occupy highest rungs of the prison hierarchy. Status is also dependent on money, political connections, length of sentence, relations with influential staff members, personal appearance, and crime committed. For example, inmates who conducted crimes regarded as intelligent were honoured; whereas, 'rapists were universally hated' (p. 190). Acts of violence and threats of violence are often utilised in an attempt to maintain and control the social structure. Prisoners' presentation of self is characterised as 'a performance of a certain image' (p. 196) where speech, body language, and dress style have cultural ramifications.

Bandyopadhyay (2006) labours the point: ‘the idea of a changing persona is significant in understanding the issue of competing masculinities in prison’ (p. 197). It is important to remember ‘hardness and softness are not fixed attributes inscribed onto maleness, but notions that circulate in prison and vary with circumstances’ (p. 191). The prison environment is significantly complex and inmates’ construction of self in the institution, and place in the prison hierarchy, are fluid. An inmate’s personality is not a static construct throughout their period of imprisonment. Prison mental health services need to reflect appropriately the exceedingly convoluted nature of inmates’ experiences of incarceration and consider whether the nature of health provision is compatible with the prison social environment. In relation to health behaviour, as a result of hypermasculinity, male prisoners tend to under-report emotional difficulties and often help is sought only when the condition has deteriorated severely (Kupers, 2005).

Positive social interaction can improve mental health by fulfilling both emotional and material human needs. However, ‘social integration may play a different role for persons incarcerated in total institutions than among the general population due to unique prison conditions’ (Lindquist 2000:431). Schmid and Jones (1993) found inmates’ ‘prison careers’ (p. 439) are creative processes ‘through which inmates must invent or learn a repertoire of adaptation tactics’ (p. 439). ‘A person who is incarcerated for the first time becomes a “prisoner” but does not automatically acquire a meaningful status within the prison world’ (p. 439, double quotation marks in original); this suggests individuals move from free society with its (either prescribed or imagined) status to the prison setting with its absence of meaningful ascribed status. Incarceration experiences are, therefore, subjective and fashioned by individual inmates. It is reported the inmate population share ‘the experience of being pulled in psychologically

different directions' (p. 443). Evidently, mental wellbeing issues are associated with assimilation into the prison social environment.

Prisons 'represent unique conditions that have the potential to alter the traditional relationship between social ties and mental health' (Lindquist 2000:431). SCMH (2008a) campaign 'being in prison may in itself damage mental health' (p. 7), as the separation from family, the existence of prison bullying, and absence of trust in the social setting are detrimental to prisoners' mental health. Seemingly, 'prison can be a dangerous environment for those with mental health disorders' (Brooker and Birmingham 2009:3). 'Living inside prison is very, very different from living in free society ... in almost all ways it is a much worse experience to live in prison than outside' (Tewksbury 2006:vi, ellipsis to denote removed section).

Lipsky (1980), in his seminal text *Street-Level Bureaucracy*, states 'order in a prison is a function of adjustments made by guards in exchange for prisoners' general compliance with regulation. So it is with most social organization' (p. 57). Social compliance (that is central to a well functioning prison as we understand them in UK society today) according to Lipsky (1980) is a result of the 'milieu' (p. 57), 'which comprehensively cues clients concerning behavioral expectations ... because they have a diffuse appreciation of "proper" modes of behavior and a diffuse awareness that deviance from these norms may be punished' (pp. 57–58, double quotation marks in original, ellipsis to denote removed section). Congruently, the prisoner social system, as described by Sykes and Messinger (1960), represents a value system with explicit codes that guide prisoners' behaviour and 'violations call forth a diversity of sanctions ranging from ostracism to physical violence' (p. 5).

‘Aggressive and violent behaviour in prisons is a significant problem for penal systems’ (Lawrence and Andrews 2004:273). Carceral (2005) refers to the life-altering violence in prisons as ‘guerrilla warfare’ (p. 33). ‘The sound of fists hitting flesh, knuckles hitting a skull, is sickening. It carries a very distinct sound that one never forgets. It’s not like the movies, especially when one human being is being pulverised by another. The sound that the body makes is unforgettable. When one hears it over and over again, it changes a man’ (Carceral 2005:40). It would appear, occasionally, ‘terrible things go on inside men’s prisons’ (Kupers 2005:718).

The prison diary kept by Ervin James (2003) demonstrates the ‘fragile equilibrium, the complex relationships, the simmering tensions and the paranoia that lie behind Britain’s prison walls’ (p. *vii*). Kupers (2005) observes human-to-human interactions in the prison setting are habitually hypercompetitive. Aspects of bartering appear to penetrate social interaction; ‘inmates’ relationships with one another are often built on some type of exchange ... Among prison inmates, it is common for exchange relationships to have some degree of coercion and exploitation built into them’ (Tewksbury 2006:73, ellipsis to denote removed section). Clemmer (1940) characterises the prison setting as permeated by a culture where ‘trickery and dishonesty overshadow sympathy and cooperation’ (p. 297).

Despite Oscar Wilde’s gloomy introduction to prison culture that heralds the environment as destructive to even the positive aspects of inmates’ personalities, there is scope for constructive progress. After all, common to all cultures is the characteristic of flux. A society’s culture, or more often its array of cultures, is continually changing. Culture is not a static social construct. The promotion of a new cultural model is perhaps a possible project for HMPS. It is theoretically

feasible to alter the social dynamics in prisons. Arguably, an ideological shift towards viewing incarceration *primarily* as a period of time to develop inmates' preparation for release (via addressing social exclusion issues, literacy and numeracy skills, and the promotion good mental health, as examples) is worthy of consideration. The creation of prison establishments where containment is considered *secondary* to the positive development of prisoners is a valuable suggestion. Arguably, if prisoners perceive, and experience, their prison stays as opportunities for beneficial personal development, a more positive psychological and physical approach to imprisonment may be fashioned.

The literature indicates the social setting in a prison has ramifications on both individuals' mental health and mental health services; prison social life is a health determinant (de Viggiani, 2006). As a consequence, the prison's social environment warrants inclusion in this study; in addition, the area is worthy of contemporary attention, as many UK-based prison ethnographies that explore prison culture are now dated (*e.g.* Clemmer, 1940; Morris and Morris, 1963; Parker, 1970).

The social world of prison staff

'In order to understand how prisons function, it is essential to know something about the kind of people who work in prisons and what they do' (Coyle 2005:83). It should be remembered that many members of prison staff spend more time in prison during their lives than the majority of prisoners.

Crawley and Crawley (2008) report:

‘prison officers see themselves as part of an unvalued, unappreciated occupational group. Their understanding is that they are regarded by the public as unintelligent, insensitive and sometimes brutal, and that their work is perceived as entailing no more than the containment of society’s deviants and misfits’ (p. 134).

Therefore, resultant occupational norms and values are important. Cynicism, suspiciousness, group solidarity, conservatism, and machismo are characteristics often attributed to prison officer culture. Feelings of social isolation and an emphasis on physical courage often typify prison officer culture (Crawley and Crawley, 2008); interestingly, this also characterises some inmate cultures. Additionally, pressure to conform to occupational culture is reportedly strong, bullying behavior exists, and experiences of the environment are often branded stressful (Crawley and Crawley, 2008); this also echoes prisoners’ experiences of the social environment of the prison setting. A prison staff ‘circle of stress’ (Nurse *et al.* 2003:480) as a result of high levels of staff sickness and absence, and poor job satisfaction seems to subsist. Congruently, MacDonald and Fallon (2008) report that it is these two aspects that prison healthcare staff also cite as their main workplace issues.

Therefore, it would appear that some of the problematic aspects of the prison environment are shared between its members, both staff (with differing roles) and prisoners. These apparent similarities arguably suggest that future improvements are somewhat simpler than if disparate issues affected dissimilar social groups in the setting.

Tait (2008) argues a radical reassessment of the role of the prison officer is currently required. The idea of prison officers as ‘turnkeys’ (p. 3) must be supplanted; instead, ‘the care *of* and contact *with* the inmates in his or her charge’ (p. 3, italics not in original) should be the primary occupation of prison officers. Care and contact are essential. Tait (2008) argues developing caring inmate–officer relationships often helps inmates manage their period of imprisonment, increases prison officer job satisfaction, and develops prison officer career aspirations. Such relationships require prison officers to listen, understand, and respond to inmates’ needs.

Imprisonment is traditionally associated with punishment, security, and control. Therefore, the concept of care is questionable. The convoluted and ongoing patient versus prisoner debate, in relation to prison healthcare, is pertinent. It is argued ‘prison environments have a culture characterized by order, control, and discipline, and this overrides the healthcare needs of prisoners’ (Powell *et al.* 2010:1264). Tait’s (2008) caring interactions are ‘founded on relationships characterised by respect, fairness and sociability’ (p. 5); arguably these characteristics of human interaction are both feasible and desirable in the prison social setting, irrespective of the overarching aim of HMPS. Wheatley (2007) has perhaps hit-the-nail-on-the-head with his appeal to embark on ‘staff training, promoting a supportive, helpful culture that aims for fairness and respect’ (p. 415), as fairness and respect are issues frequently raised by prisoners in their prison narratives.

Institutional settings and mental health

The prison is not conducive to good mental health and can exacerbate mental illness. Aspects of the prison regime and the nature of institutionalised existence are, therefore, explored.

According to Goffman (1961), on entrance to total institutions (prisons, asylums, monasteries, and army camps) inmates begin ‘a series of abasements, degradations, humiliations, and profanations of self’ (p. 24). Inmates’ conception of self ‘is systematically, if often unintentionally, mortified’ (p. 24). The processes of admission to an institution mark ‘a leaving off’ (p. 27) from the ‘conception of himself made possible by certain stable social arrangements in his home world’ (p. 24) and ‘a taking on’ (p. 27) of ‘activity whose symbolic implications are incompatible with his conceptions of self’ (p. 31). Factors associated with the nature of imprisonment itself arguably predispose prisoners to mental health problems. Renewed attention to the total institution work of Goffman (1961) is apt, as the recent prison-based mental healthcare study conducted by van Marle (2007) argues Goffman’s (1961) work is still remarkably relevant to contemporary prison life.

Institutions are often characterised by their exceedingly rigid authoritarian organisation and highly ritualised daily schedule. Institutionalised existence is very dissimilar to subsistence in wider society). ‘Everyday prison rituals confirm prisoners’ sense of powerlessness’ (Pratt 2002:113). The process of incarceration ostensibly causes demoralisation and the destruction of prisoner self-respect (Pratt, 2002). Morris and Morris (1963) use the term ‘prisonization’ (p. 169) to refer to the ‘continuous and systematic destruction of the psyche in consequence of the experience of imprisonment’ (p. 169).

Barton's (1976) mental hospital based study reports the fabrication of a disease, entitled Institutional Neurosis, as a direct result of institutionalised life. It is the aetiology of the disease which is of relevance here. The probable aetiology of Institutional Neurosis is related to the psychiatric institution's environment. Arguably, all eight factors cited are relevant to the prison setting:

1. Loss of contact with the outside world;
2. Enforced idleness and loss of responsibility;
3. Brutality, browbeating and teasing;
4. Bossiness of professional staff;
5. Loss of personal friends, possessions and personal events;
6. Drugs;
7. Ward atmosphere;
8. Loss of prospects outside the institution (Barton 1976:77).

Barton (1976) specifically suggests that Institutional Neurosis may occur in prisons and notes that it is 'the all-enveloping tissues of constraints and lack of privacy' (p. 74) that typify those institutions at risk. Accordingly, the HMPS setting is riddled with overt constraints and an inherent absence of personal privacy.

The institutionalised life of prisoners is characterised by long periods of inactivity interspersed with short stints of intense activity. Nurse *et al.* (2003) reveal prisoners consider a lack of mental stimulus and physical isolation to have a negative impact on their mental health, via resultant feelings of anger, frustration, and anxiety. 'For those with mental health problems, a lack of meaningful daytime activity and limited opportunities for exercise are major concerns' (SCMH 2008a:7). The SCMH (2008a) research — that explores prisoners' experiences of the mental health services — reports prisoners desire

‘something to do’ (p. 7) and ‘someone to talk to’ (p. 7) with the belief that it would help alleviate experienced mental distress. Interestingly, it is not the mental healthcare itself that is criticised by the prisoners; instead, it is aspects of the prison regime and institutionalised existence. Therefore, it can be argued that institutionalisation theory remains relevant to the future development of prison mental healthcare.

The SCMH (2008) document *In The Dark* discusses the mental health implications of Imprisonment for Public Protection (IPP) sentences. The controversial IPP sentences, implemented in 2005, are of indeterminate length; IPP prisoners are provided with no release date. Departure from prison is dependent on the Parole Board’s assessment of the risk posed to wider society by the individual. The lack of release date causes many IPP prisoners additional mental distress. IPP inmates purportedly suffer higher levels of mental illness compared to the general prison population.

In relation to IPP sentencing and the prison environment:

‘there are serious and volatile tensions on prison landings because of IPP. It is hard for IPP prisoners to live alongside prisoners with fixed sentences who know when they are getting out of prison regardless of how they behave. Life prisoners, who are also being held in long queues for programmes, blame IPP prisoners for the perceived delays to their sentence progression’ (p. 7).

In addition, IPP prisoners reportedly fear treatment via mental health services in case it prevents their release at the Parole Board hearing. The existence of inmates with indeterminate sentences in the prison setting is clearly problematic. The report concludes ‘IPP prisoners have multiple and complex needs, often

combining alcohol and drug additions with myriad mental health problems. The criminal justice system and prison health services are struggling to cope with these needs' (p. 6).

Regrettably, 'there are real dangers that prison will cause a person's mental and physical health to deteriorate further, that life and thinking skills will be eroded, and that prisoners will be introduced, or have greater access, to drugs' (SCMH 2008:14). Prisoners misuse drugs for psychiatric, psychological, biological, pharmacological, and socioeconomic reasons (Wheatley, 2007). Nurse *et al.* (2003) record inmates often resort to drug misuse to relieve the tedium of incarceration, the feelings of isolation, and the lack of mental stimulus. Accordingly, Sifunda *et al.* (2006) report the 'monotony of prison life' (p. 2307).

Moreover, 'prescription drug dealing is common in prisons' (Feron *et al.* 2008:151), presenting problems for prison mental health services in relation to prisoners' possession of prescription medication. Smith (2010) states 'where possible, prisoners are encouraged to manage their own medication, except for drugs such as opiates and benzodiazepine, which are very sought after among the prison population. Prisoners often trade medication, even after it has been concealed in their mouth' (p. 34). Once again, this highlights the interrelated nature of healthcare (*i.e.* prescribed drug treatment) and place (*i.e.* the prison wing).

Strauss *et al.* (1963) formulate a concept to explore the hospital as an organisation that can be utilised to consider healthcare staff in a prison. Strauss *et al.*'s (1963) negotiated order model is utilised to analyse the interactional features between members of hospital staff.

The hospital, as an institution, is typified as:

‘a locale where personnel, mostly but not exclusively professionals, are enmeshed in a complex negotiative process in order both to accomplish their individual purposes and to work — in an established division of labour — toward clearly as well as vaguely phrased institutional objectives’ (Strauss *et al.* 1963:167, em dashes in original).

Poignantly, the negotiation of institutional objectives is markedly relevant to this prison mental healthcare thesis, as mental healthcare professionals must practice in an environment concerned primarily with security, not healthcare.

Jones and Fowles (1984) study the nature of institutions at length via the work of Foucault, Goffman, Szasz, Townsend, Rothman, and Kittrie and conclude their analyses with the fundamental question:

‘whether the material we have presented has any unity of approach other than the unity we have imposed on it. It is certainly a heterogeneous collection. Are we right in thinking that it is possible to study ‘institutions’ as a generic category, or are the similarities merely superficial?’ (p. 194, apostrophes in original).

This question is then answered by the authors with the following summary of regularities located across the institutions based literature:

‘we have come to the conclusion that there is a basic theme to these very disparate works. It has five aspects:

- (i) loss of liberty
- (ii) social stigma
- (iii) loss of autonomy

- (iv) depersonalisation
- (v) low material standards' (Jones and Fowles 1984:200).

The work of Jones and Fowles (1984) is utilised here to conclude this subsection on the nature of institutions to highlight the complexity of these social settings, yet to also state the common attributes ascribed. These aforementioned five characteristics, as recorded by Jones and Fowles (1984), represent facets of institutionalised existence for prisoners in the UK's contemporary HMPS.

Therapeutic environments

'In too many places [mental health] in-patient services have been relatively exempt from socially inclusive thinking and continue to overemphasise containment and segregation, unwittingly colluding with and reinforcing the public's negative stereotypes about mental illness' (Sheehan 2004:*xiii*, square brackets not in original). Congruently, it has become too easy to see mental health in-patient and residential settings as detrimental; this requires amendment, as the environments themselves can, instead, enhance therapeutic potential (Campling *et al.*, 2004).

In relation to therapeutic environments, Collins and Munroe (2004) state 'the environment can be thought of as the interplay of four main factors, each of which has varying degrees of influence: the patients; the staff; the care context...; external constraints and influence' (p. 132, ellipsis to denote removed section).

Therapeutic communities are considered to be psychologically informed and planned environments. They are places where the social relationships and structure of the day are designed to aid health and wellbeing. Treatment

environments are influenced by an array of factors including institutional aims, physical set-up of the care centre, organisational factors (*e.g.* management set-up, level of patient involvement), and ‘suprapersonal factors’ (Timko and Moos 2004:144). Suprapersonal factors refers to the sum of involved social actors’ characteristics, for example the gender split, average age, social role mix, and faith variance. To typify, the therapeutic community ideal aims for a personalised health service that embraces approaches beyond the biomedical model.

Therapeutic community principles are ‘based on the premise that just as a disordered personality may be produced by a pathological social environment, so a beneficial environment may remove such disorder’ (Manning 1979:303). These ideals were developed in the UK throughout the Second World War and were embraced by the social psychiatry movement in the 1950s (Manning, 1979a). Therapeutic communities are psychological treatment environments based on the ideas of emotional attachment, collective responsibility, and citizenship empowerment that utilise many therapeutic principles including analytic, behavioural, cognitive, systemic, creative, educational, and humanistic (www.therapeuticcommunities.org, last accessed Aug. 31st 2011).

In 1962 Her Majesty’s Prison (HMP) Grendon opened as the first ‘Psychiatric Prison’ (Parker 1970:*xi*). Psychiatric prisons imply ‘the total organisation in which the patient is involved forms part of the therapeutic regime’ (Parker 1970:*xi*) where ‘the aim is to produce a supportive and permissive environment in which the inmate is encouraged to express his inner feelings, his doubts and difficulties, without fear of retaliation from others’ (Parker 1970:*xii*). In 1970 Parker predicted ‘Grendon’s greatest contribution will most certainly be the example it sets as a very human, and humane, institution’ (p. *xiii*).

Accordingly, Genders and Player's (1995) study of HMP Grendon that explores factors shaping the structure and culture of the prison, recorded ninety-four per cent of the interviewed men understood themselves to be benefiting from the therapeutic regime (p. 113). At HMP Grendon, rules and regulations are kept to a minimum, democracy and group-based decision-making is promoted, and communalism are idealised (Genders and Player 1995:83). Genders and Player (1995) argue the existence of mutually supportive relationships between inmates, and between inmates and staff, are key to the therapeutic environment, and the conventional prison culture and prisoner code of conduct is dismantled at HMP Grendon with positive ramifications.

Campling *et al.* (2004) argue we are all constructions of our environment and of each other, developing our identities, learning patterns of communicating, and our social responses in the context of our social environment. 'The quality of our physical environment can be health giving or health destroying' (Howard 2004:69). Collins and Munroe (2004) list components of a therapeutic environment including: apt personal space and privacy; access to diversional activities; shared philosophy of care. Problematically, UK prisons are currently renowned for overcrowding, a lack of mental/physical stimulation, and trouble balancing their patient care versus prisoner containment attitudes and responsibilities. Evidently, the UK's mainstream public sector prisons have a long way to go before they could be considered therapeutic environments (should they wish to aspire to these principles). However, perhaps the mental health of prisoners could be positively developed via a conscious effort on the part of prisons to fabricate some form of a more therapeutic social milieu.

The Enabling Environments project

Johnson and Haigh (2011) review the Royal College of Psychiatrists's latest initiative, the Enabling Environments (EE) project. This novel 21st century approach can be considered a development of the preceding therapeutic environment treatment methodology and the therapeutic community movement; the principles of EE represent an adaptation of these values and standards in reference to contemporary society and the current nature of mental health (Johnson and Haigh, 2011).

The EE system intentionally identifies features in any given setting that foster a sense of connected belonging for the involved social actors 'and suggests a process by which these principles can then be customised for specific settings' (Johnson and Haigh 2011:17). Two new concepts from the EE initiative are noteworthy here: the Psychologically Informed Environment (PIE) and the Psychologically Informed Planned Environment (PIPE). To summarise, both of these approaches strive for greater psychological awareness of a setting, humane and enlightened treatment, enhanced wellbeing for all involved, plus reflective practice and shared action learning in the staff team (Johnson and Haigh, 2011). The PIPE scheme is designed for high security or high risk settings (*e.g.* HMPS).

It is argued, by Johnson and Haigh (2011), that the EE initiative signals a new approach to social psychiatry and has implications for both public mental health and social policy in the UK: 'the enabling environment approach is as broad as it is ambitious' (p. 22). Johnson and Haigh (2011) detail nine core elements to the provision of EE; four of these are important in relation to the prison setting: 'a positively enabling environment would be one in which the nature and the quality of relationships between participants or members would be recognised

and highly valued ... where engagement and purposeful activity is encouraged ... where power or authority is clearly accountable and open to discussion ... where behaviour, even when potentially disruptive, is seen as meaningful, as a communication to be understood' (pp. 19–20, ellipses denote removed sections).

These four ideals are poignant as a) the importance of quality relationships between those with differing social roles in the prison setting is not always considered critically, b) the quantity of worthwhile activities provided for prisoners is diminutive, c) the power relations in a prison (*e.g.* between wing staff and prisoners) are not often debateable, and d) disruptive behaviour often results in sanctions in the prison environment and perhaps insufficient attention is devoted to understanding underlying causes of socially deviant actions in the setting.

The EE vocabulary of shared values is the basis for the practical application of the approach; this is problematic in the prison setting, as the underlying goals of the NHS and HMPS are dissimilar (*i.e.* care versus containment). The EE initiative serves to highlight the prisoner versus patient issue in prison establishments.

Literature review critical reflection

Of most relevance to this study, prison health research to date indicates:

1. Prison healthcare continues to require development (de Viggiani, 2006);
2. Prison is not conducive to good health (Earthrowl *et al.*, 2003);
3. Imprisonment can create or exacerbate mental illness (Mills, 2002);
4. Comorbid mental health problems are prevalent (Steel *et al.*, 2007);

5. Ineffective health services are not a new phenomenon (Steel *et al.*, 2007);
6. Mental health determinants warrant investigation (de Viggiani, 2006).

Congruently, this thesis addresses these six matters. To summarise, the first four are somewhat supported by the data of this study and are addressed overtly in the analytical sections of the thesis. Although no. 5 is arguably worthy and relevant to healthcare service debates across the prison service as a whole, the ineffectiveness of mental health services does not feature in this study. Participants do not depict the mental healthcare itself as deficient or unsuccessful. This is demonstrated via the ensuing chapters. However, the sentiment of no. 6 (*i.e.* that research exploring factors impacting prisoners' mental health should be supported) is here encouraged. To validate this call for ongoing research and development regarding prison mental health, the following few paragraphs summarise the literature review. Aspects of study design are then addressed in the subsequent chapter.

To recap, at present, HMPS arguably prioritises the secure containment of offenders above apt preparation for release. However, rehabilitation and reducing reoffending services and interventions ought to be extended. The SEU (2002) argue efforts to effectively rehabilitate prisoners to wider society require drastic improvement and expansion. Good mental health, or the effective management of an enduring mental illness, is arguably a prerequisite for apt reform and positive integration into, and involvement in, society post-release. Further prison based mental healthcare research and service improvement is consequently both necessary and fitting. Currently, there is a paucity of prison based mental healthcare studies that assess policy implementation, policy effectiveness, the role of NHS commissioning, and the effectiveness of the provision in the prison context (Brooker *et al.*, 2009). An understanding of the

nature of the prison environment is fundamental to the constructive improvement of prison mental healthcare.

Brooker *et al.* (2009) note research that focuses on the mental health of prisoners usually falls into three categories: prevalence and epidemiology; interventions; service delivery and organisation. The notion that context is crucial transcends yet encompasses all three of the aforementioned categories of prison mental healthcare debate. This thesis calls for an increased focus on, and a developed adherence to, the idea that the prison milieu is central to the positive development of prison mental health. ‘The impact of imprisonment on the mental health of all prisoners should be better understood’ (Fraser *et al.* 2009:410). At present, ‘there is no research that directly assesses the effects of the prison environment upon mental health’ (Brooker *et al.* 2009:106). Brooker *et al.* (2009) argue ‘significantly more research is needed into what works for whom in the prison context’ (p. 118) and this thesis reiterates the appeal. Context specific and culturally responsive care is required; context is crucial.

However, frequent reminders of the complexity of the prison setting are apt; solutions to problems may not be simple. Simplistic research conclusions and undemanding policy responses arguably miscalculate and undervalue the complexity of human social life. As Kupers (2005) points out, ‘every generalization has many exceptions’ (p. 714); therefore, it must be remembered ‘it is not at all the case that all prisoners fit a mould’ (p. 714). ‘Every prison is different in population, culture, organisation, and practice and the availability of appropriate NHS beds/services varies between regions’ (Brooker *et al.* 2009:110). Moreover, an assumption that the context of study is a stable fieldwork site in numerous respects arguably underestimates the inherent fluidity and infinite complexity of social settings. It is fundamental to recognise

‘all prisons differ, and what works in one prison may not be effective — or even feasible — in another’ (Brooker *et al.* 2009:117).

Evidently, ‘prison settings are a challenging environment in which to manage and deliver healthcare’ (Powell 2010:1263). Despite this, Sifunda *et al.* (2006) ‘found strong evidence of prison being a strategic point to increase access to health services for offenders’ (p. 2301). A prison stay represents a useful point of access to address this social population’s many health issues. Arguably, a prison sentence could be regarded a temporal entity permitting the devotion of time and attention to appropriate preparation for release (including good mental health). The prison based exceedingly complex three-way relationship between culture, mental health, and mental healthcare requires further attention and thought, as positive developments in the prison system may benefit prisoners’ mental health and the provision/receipt experiences of prison mental healthcare. This thesis addresses these issues.

Chapter 3

Study design

Bryman (2004) lists five main preoccupations of qualitative researchers (pp. 279–284):

1. Seeing through the eyes of the people being studied;
2. Description and the importance of context;
3. Emphasis on process;
4. Flexibility and limited structure;
5. Concepts and theory grounded in data.

These preoccupations are suitably central to this study. For example, the emphasis on prison context is important. For this work, prison context refers to the prison social environment, the institutional set-up of the prison, and the social actors involved in the prison establishment. In addition, the subjective experiences of prisoners and staff are examined. Moreover, the fieldwork adopts an exploratory and consequently relatively unstructured approach. As a final example, an inductive approach to the construction of theoretical and analytical discussions is adopted.

Overarching study question

How could prison mental healthcare be developed?

The general focus of this overarching study question — prison mental healthcare — has remained consistent since application for ESRC 1+3/MA+PhD funding in 2007. It is evident that prison mental healthcare and the mental health of

prisoners require development. It is this situation that underpins the overarching question.

The aim of this work is threefold:

To highlight *areas* for improvement;

To produce *recommendations* for change;

To note *implications* for future research, practice, and development.

This field of research, knowledge, policy, and practice is exceedingly broad. Therefore, it is worth noting here that this study began as an exploration of *barriers* to successful prison mental healthcare, with the original thesis title: *An exploration of remaining barriers to wholly effective prison mental healthcare*. However, the idea of single-entity non-connected *barriers* existing that merely require removal in order to result in a perfect health service is now considered too simplistic. Such an approach underestimates the convoluted and multi-faceted nature of problems in healthcare settings. Therefore, the *barrier* concept is disregarded and the study is more exploratory in nature.

Moreover, a second modification in direction arose during the fieldwork phase, as it became apparent any intention to investigate only the *supplied* mental healthcare *services* was not salient with the participants of this study. It was evident that the supplied services themselves were praised and no issues regarding healthcare services *per se* were narrated by interviewees. Both the clinicians and the patients supported the care available. Instead, aspects regarding the *provision* and *receipt environments* and *experiences* of mental healthcare arose for debate. These environment and experience issues are discussed in the subsequent analysis chapters.

It is the analyses of the four subsequent underlying questions that, when combined, considered, and evaluated together, enable the overarching question to be addressed. This overarching question is appropriate to the aim of this study, as the objective is to formulate policy and practice suggestions to beneficially develop prison mental health services.

Underlying study questions

1. In relation to prison mental healthcare and the mental health of male prisoners at the fieldwork site, what are the remaining areas for development according to the involved social actors?
2. Do interviewees desire similar developments to prison mental health services; if not, are the dissimilar suggestions grouped (*e.g.* linked by gender or employment/social role in the setting)?
3. Are there aspects of the prison's social environment that affect mental health or mental healthcare?
4. Are there aspects of institutional existence that affect mental health or mental healthcare?

As noted in questions 3 and 4, aspects of the prison *social environment* and aspects of prison *institutional existence* are salient.

For this study, *social environment* deliberations refer to communication processes, social group labels, rapport building, and relationships between social actors in the penal milieu. Characteristics of *institutional existence* examined in this thesis include the prison timetable, healthcare centre escorts, staff roles and responsibilities, prisoners' time usage, and layout of the NHS setting.

To summarise, these *institution existence* explorations have a structural, regime, and practical nature; whereas, the *social environment* discussions relate to social characteristics and population demographics, relations between social groups and individuals, and social actors' personal experiences of the locale.

Study methodology overview

This study explores how prison mental healthcare could be developed. Attention is devoted social and institutional structures that permeate the prison setting. This qualitative social science study is conducted in one prison establishment. The work is characterised as a policy and practice orientated exploratory case study. The study implements an inductive approach to the datum–theory relationship, a constructionist ontological position, and an interpretivist epistemological orientation.

The fieldwork is undertaken in a male category B prison. A category B HMPS establishment detains prisoners for whom the very highest conditions of security are not necessary, yet for whom escape must be made very difficult. Semi-structured interviews are conducted with prison healthcare centre staff (*e.g.* registered general nurse, registered mental health nurse, health care assistant, plus varied administration and clinical management staff), the secondary mental health team (psychologist, psychiatrist, community psychiatric nurse), prison governors, prison psychologists, primary-level mental health service users/prisoners, and secondary-level mental health service users/prisoners.

Induction and deduction are now considered. The study implements an inductive approach to the datum–theory relationship. Albeit an oversimplification, an inductive approach indicates research observations and findings lead to the

generation of theory. Whereas, a deductive approach commences with theory and hypotheses, that are subsequently tested and either rejected or accepted. To reiterate, this study adopts an inductive approach. Thus, it is the emic that determine the focus of the study, and not the etic. Emic refers to those aspects considered culturally important and specific in the boundaries of the studied social arena. Etic implies previously defined and assumed issues or context free universal hypotheses.

However, this stark and simple contrast between inductive and deductive theory does not account for the nuances, subtleties, and differing approaches available on this theoretical continuum. For example, Bryman (2004) utilises the work of Layder *et al.* (1991) to exemplify a deductive research project that does not follow the orthodox process of deduction. To clarify, deductive projects usually take six sequential steps:

1. Theory
2. Hypothesis
3. Data collection
4. Findings
5. Hypothesis confirmed or rejected
6. Revision of theory

(Bryman 2004:9).

Bryman (2004) notes how Layder *et al.* (1991) do not adhere to this linear form of deduction, as ‘the relevance of a set of data for a theory may become apparent *after* the data have been collected’ (p. 9, emphasis in original).

Thus, it is useful to highlight the complexities of research strategies and their underpinning methodologies. It is important to remember that methodological

concepts cannot be placed in convenient, neat, or distinct theoretical boxes and considered separate from other relevant ideas. There are convoluted continuities, similarities, and differences between methodological positions.

The ontological approach for the thesis is now considered.

The study implements a constructionist ontological position. Ontological debates revolve around the objectiveness of social entities. However, Hughes and Sharrock (2007) highlight that ontology and epistemology are closely related. This serves to reiterate the nuances of research methodology discussions. Hughes and Sharrock (2007) suggest ontology 'is concerned with what exists, what is real' (p. 31) and epistemology is concerned with 'the ways in which what exists may become known' (p. 31). Thus, to generalise simply, two main ontological positions exist, constructionism and objectivism. An objectivist ontological approach often renders social entities objective facts beyond human influence that have a reality external to social actors (Bryman, 2004). Objectivism is often utilised alongside deductive reasoning and a positivist position in quantitative projects dissimilar to this work. The constructionist ontological approach adopted in this study regards social phenomena as perpetually reconstructed by social actors via continual processes of social interaction. For Bryman (2004), constructionism implies social entities 'can and should be considered social constructions built up from the perceptions and actions of social actors' (p. 16). This conceptualisation of the constructionist ontological approach aligns with the philosophical underpinnings, the fieldwork conduct, and the findings of this thesis.

To further illustrate the utility of this constructionist ontological approach for this study, Bryman (2004) notes that a constructionist position challenges an

objectivist position via ‘the suggestion that categories such as organization and culture are pre-given and therefore confront social actors as external realities that they have no role in fashioning’ (p. 17). Appropriately, therefore, this work devotes much discussion to the fluid and malleable existence of prison culture and the possibility of altering the nature of social organisation in the penal milieu. These two social concepts of culture and organisation are considered acquiescent to change via social actors. This echoes a constructionist approach to ontology.

Epistemological debates are now reviewed.

Numerous epistemological positions exist including positivism, realism, critical realism, and interpretivism. To summarise, ‘an epistemological issue concerns the question of what is (or should be) regarded as acceptable knowledge in a discipline’ (Bryman 2004:11). The nature of knowledge is the general focus of epistemology. Bryman (2004) stresses one of the main quandaries of epistemological debates. This refers to the ‘question of whether the social world can and should be studied according to the same principles, procedures, and ethos as the natural sciences’ (p. 11). To generalise, an agreement with these ideals would lend itself to an adoption of positivism. However, interpretivism is adopted for this project. Interpretivism considers the subject matter of social science fundamentally different from that of the natural sciences and consequently requires altered research tools. Interpretivism places a large emphasis on understanding (and not numerically measuring) social situations. This notion of participant understanding is fundamental to interpretivism.

Bryman (2004) creates a relatively short definition of interpretivism from the numerous understandings regarding this epistemological position. This definition notes that interpretivism:

‘is predicated upon the view that a strategy is required that respects the differences between people and the objects of the natural sciences and therefore requires the social scientist to grasp the subjective meaning of social action. Its intellectual heritage includes: Weber’s notion of *verstehen*, the hermeneutic-phenomenological tradition, and symbolic interactionism’ (p. 13).

Therefore, it is fitting that this study adopts interpretivism alongside aspects of Weber’s *verstehen* methodology and strands of symbolic interactionism. These aspects of this thesis are discussed below, yet it is useful to make this methodological link overt here.

Often, continuities between schools of thought and between methodological positions are not made clear in social science work. However, these links are made in this thesis.

To reiterate, this study implements an inductive approach to the datum–theory relationship, a constructionist ontological position, and an interpretivist epistemological orientation. Thus, what follows is a discussion regarding aspects of symbolic interactionism and then debates regarding Weber occur subsequently.

Symbolic interactionism and interpretivistic principles

Bryman (2004) explores the work of the two founding fathers of symbolic interactionism, George Herbert Mead and his student Herbert Blumer. Notably, their writings are significantly different. Once again, this serves to highlight the complexities of methodology and the need to avoid the construction of convenient theoretical boxes in study design discussions such as these.

It is important to state here that this thesis does not embrace fully symbolic interactionism. This study is not a piece of symbolic interactionist work. Instead, it is just aspects of symbolic interactionism that are salient. Principally, the focus on social actors' points of view is crucial.

Therefore, a poignant interpretivistic aspect of this study is introduced below. This refers to the understandings of social actors.

Gerring (2007) calls social scientists to:

‘note that the social sciences are defined by their focus on decisional behaviour – actions by human beings and humanely created institutions that are not biologically programmed ... Social science is, of necessity, an interpretive act ... Careful attention to meaning, as understood by the actors themselves, is essential’ (p. 70, ellipses denote removed sections).

Congruently, this study explores social actors' points of view. The social actor's point of view is paramount. However, it is worth briefly considering one potential issue with this approach. Via this approach, society is considered to be an ensemble of distinct points of view. Therefore, any study that cites social actors' points of view is *theoretically* marginalising and silencing other social

actors' disparate points of view (Hughes and Sharrock, 2007). A 'crisis of representation' (Hughes and Sharrock 2007:245) is argued to occur, as all findings are inherently exclusionary. Social science results are, therefore, conceptions of reality that innately suppress alternative equally valid conceptions.

Consequently, a 'critical friend' (Sampson 2007:490) relationship between social scientist and data is adopted in this study, ensuring that the search for alternative explanations and interpretations of data are extensive, informed, and conducted with rigour. This study recognises that its results are based on the experiences and understandings of the participants only. Therefore, the possible existence of differing perspectives and opinions is acknowledged.

In addition, it must also be recognised that the social scientist (female, British, agnostic, twenty-seven years of age, heterosexual, married, England-based upbringing and education, economically affluent, and able-bodied) cannot talk *for* the interviewees. Therefore, the goal must be for the participants to talk *via* the study.

Symbolic interactionism if taken to its philosophical foundations lends itself to 'problems of perspectivalism' (Hughes and Sharrock 2007:244). Relativism becomes an issue if society is whatever it is defined as being by individuals. In addition, the existence of subjective multiple realities raises solipsism concerns, as no transcendent perspective exists, rendering social reality and consequentially the social science research process determined via a 'politics of experience' (Hughes and Sharrock 2007:245). However, arguably all social science methodological positions theoretical struggles. Therefore, is it important

to recognise these theoretical conundrums, but it is not a case for study abandonment.

Symbolic interactionism is included in this chapter again when the analyses of data are debated. However, discussions now turn to consider Weber's *verstehen* approach.

Weber and *Verstehen*

One of the numerous interpretations of Weber's methodological strand of writing implies that sociological explanation is, in part, to be constructed in relation to an understanding of a people's system of beliefs, their world view, and their social values. The dynamic of a given society is structured by the numerous and complex factors at work. These include political, economic, historic, social, and religious interests. This approach of Weber's, which has been termed the *verstehen* (understanding) method, dictates:

‘the sociologist who wishes to understand people's actions must take into account the beliefs and ideas to which those people are attached, and seek to understand the way in which holding such beliefs and ideas leads them to act’ (Hughes *et al.* 2003:91).

It is important to note at this stage that Weber's overall approach to the nature of inquiry is not adopted in this thesis, as although Weber considered the existence of human society dissimilar from the subjects of the natural sciences, Weber did not conceive a difference between the underlying pursuits of the natural and social sciences due to the existence of causal investigation (as a general requirement) across the two disciplines. It is recognised that the methodological approach of this thesis does not correspond with Weber's approach to the nature

of social science. It is, instead, just aspects of Weber's notion of the *verstehen* method that are utilised.

For example, 'methodologically, Weber insisted that the object of sociology was action constituted through subjective meanings' (Hughes *et al.* 2003:144). This implies that social scientists should concern themselves with the motivations, meanings, and values that affect social actors' actions. Congruently, this thesis explores social and institutional aspects that shape social actors' understandings, interests, and beliefs and consequently their perceptions, understandings, and actions in the prison setting regarding mental health. Weber's work on the evolution of capitalism and the involvement of the Protestant ethic exemplifies utilisation of his *verstehen* approach to sociology as a research endeavour. The *verstehen* (or understanding) method represents a pursuit for understanding via an attempt 'to grasp the ways in which the ideas, beliefs and values of people guided their actions' (Hughes *et al.* 2003:123).

Weber's *verstehen* position posits:

'if we want to understand the pattern of action of some 'typical individuals', we shall want an explanation which makes appeal to how they see the world, and one which, given that they may not see the world in the way that we do, will none the less make sense to us ... a way which allows us to see a logic in the connection between these beliefs and their conduct' (Hughes *et al.* 2003:133, ellipsis to denote removed section, apostrophes in original).

This quest represents an attempt to consider research issues, themes, and questions from the standpoints of the involved research participants.

For Weber:

‘it is the social scientist’s task to understand other human beings, often those who have quite different values and beliefs to those of the investigator ... It follows that the researcher is, thus, also acting as an ‘interpreter’ of the beliefs and conduct of other people, seeking to explain them in a way which makes sense to him or herself and those who will read the study, even though those being studied belong to a very different cultural tradition’ (Hughes *et al.* 2003:134, ellipsis to denote removed section, apostrophes in original).

To execute aptly Weber’s *verstehen* method it must be possible to examine evidence that pertains to activities, beliefs, and values. It is an empirical venture that must be attainable via the collected data. This study is appropriate for such a method’s application, as the interview questions explore social actors’ perceptions, cultural norms, values, and beliefs in relation to the setting and understandings of the social environment.

Reflexive practice

Appropriate researcher reflexivity should be an important research goal (Heyl, 2001). Researcher–subject and researcher–research relationships are pertinent and require attention. Valuable researchers must be continually self-reflective, self-critical, and self-conscious. Reflexivity requires researchers to recognise they are ‘entangled with their methods and the politics of the social world they study’ (Holliday 2007:138). It is essential researchers identify, address, and benefit from ‘the complexities of their presence within the research setting’ (Holliday 2007:138). Accordingly, social science reflexivity plays a central role in this thesis.

Reflexivity discussions note sociological observation is inherently subjective. A sociologist's report is a personal response to a situation, as sociologists are social beings that cannot rise above the realities of social life (Hughes and Sharrock, 2007). Researchers cannot escape subjectivity, so it must be embraced and accounted for (Holliday, 2007). Therefore, it is recognised that the relationship between the participants, the fieldwork locale, and the fieldworker is not impersonal; it is, instead, interpersonal, related, and convoluted.

To recap, numerous forms of social science study exist. As examples: descriptive; evaluation; experimental. This prison based qualitative medical sociology study could be characterised as naturalistic, interpretive, reflexive, and exploratory.

Study methods

Case study method

Predictably, sociologically inherent definition issues arise in relation to case study method, as 'case study is not a term that is used in a clear and fixed sense' (Gomm *et al.* 2000:2). Gerring (2007) considers the term a 'definitional morass' (p. 17). There is great variation in the form that a piece of case study work may take. The degree of detail is variable, so is the number of cases, the function of comparison, the role of context, plus the utilisation of description, explanation, analysis, and evaluation techniques. This work is a case study in the sense that it is: small-N (*i.e.* small sample size); qualitative in approach; holistic; intent on naturalistic collection of data; concerned with context; focused on a diffuse topic (*i.e.* hard to distinguish case from context); interested in the properties of a single institution (*i.e.* one prison).

Using Gerring's (2007) research design typology (p. 28), this study could be typified as a synchronic single-case study where the prison acts as the one case and the interviews act as the in-case investigations. A diachronic aspect does not exist, as the study contains no significant temporal variation. It is not longitudinal in nature.

In addition, this study could be classified X-centred, as it is the intention to investigate the effects of a particular cause without suggestions for what these might be. It is the understandings of inmates pertaining to mental illness in relation to social and institutional aspects of imprisonment that are sought without hypotheses existing for what these might be at the outset. Gerring (2007) believes that it is this exploratory nature of case study method that is one of its main strengths.

'Case study research has become extremely popular in sociology' (Gomm *et al.* 2000:1). However, like all other social science methods it has both supporters and critics. The aims, capabilities, and conclusions of case study method are sources of controversy. Case study research is often charged with causal determinism, non-replicability, subjective conclusions, absence of generalisable conclusions, biased case selection, and lack of empirical clout. Too many variables and too few cases. However, these criticisms usually emanate from social scientists who value such ideals. It should be noted, at this juncture, that the majority of the criticisms of case study research could be explained by the markedly dissimilar methodological approaches adopted by those social science researchers who utilise case study method and those social science researchers who prefer quantitative social surveys, for example.

However, that is not to say that criticisms of a research method that are based on methodological and philosophical discrepancies are null and void. Instead, such critiques can be used beneficially to continually question the method, as it has heretofore been conceptualised, and utilised to prompt critical development; method complacency is to be avoided.

Case study work is often criticised on the basis that its findings are not generalisable — in comparison to the claimed generalisability of social survey research — for example. It is this utility of in-depth and highly detailed single-case studies that is questioned. Stake's (1978) work argues case study research can have general relevance, just not of the conventional kind; it is posited that beneficial tacit knowledge originates from case study work via a process of naturalistic generalisation — this is facilitated by the indirect vicarious experiences prompted by a case study's complete and comprehensive knowledge of the particular. Case studies, therefore, facilitate learning for those readers who utilise them. This tacit knowledge is regarded as legitimate and worthy; whereas, the abstract propositional generalisations generated by quantitative social science projects are considered to, potentially, harbour over-simplicity and misunderstandings: 'generalizations can lead one to see phenomena more simplistically than one should' (Stake 1978:23). These complexity issues captivate the ethos of case study method; intricacy is sovereign.

In addition, Stake (1978) prioritises the boundary of a case, the parameters of the social group under study, and argues case studies should attempt to develop an understanding of how the social actors in the social environment view their situation. This ideal is relevant to this prison mental healthcare study that explores prisoners' and healthcare professionals' understandings of mental

health and mental illness in the prison setting; emphasis is placed on social actors' perceptions in direct reference to the prison environment.

Lincoln and Guba (1979) note all human behaviour is context dependent and therefore the attempt to fabricate law-like context-free generalisations is a fallacy, as 'generalisations are not found in nature; they are active creations of the mind' (p. 30). Accordingly, case study research places importance on, and pays attention to, the context of social interaction and actors' opinions.

Lincoln and Guba (1979) replace the idea of generalisability with that of fittingness. An intermediate position between generalisations and particularised knowledge is considered to exist legitimately. However, any such fittingness-based transfers must be regarded as 'indeterminate, relative, and time- and context-bound' (Lincoln and Guba 1979:32). The transferability of research conclusions drawn from Context A to Contexts B, C, D, *etc.* is considered feasible. This fittingness transferability is related directly to the similarities between the original fieldwork site and those sites to which conclusions are to be transferred.

However, Donmoyer (1990) does not consider similarity between the original and new contexts a necessity in order for study knowledge transfer to occur. Donmoyer (1990) debates the nature of experience. Vicarious experience is labelled an exceedingly valuable facet of case study method. It is argued case studies can beneficially transport a person to a place they have not been and have no direct experience. Case study research can develop understanding and knowledge via a substitution for firsthand experience. The vicarious experience of the research consumer (*i.e.* the reader) is argued to originate from case study method's representation of unique situations and unique individuals —

consequently enriching the reader's conception of the relevant topic. In this sense, therefore, valuable social science knowledge can be disseminated via case study work.

Gerring (2007) professes 'all case studies should at some point be *generalized*' (p. 84, italics in original). Case study research can offer new propositions that may be operationalised across other cases, providing the researcher reveals how this it to be done and what represents a reasonable cross-case test. Thus, the policy and practice suggestions in this prison mental healthcare study may be disseminated for consideration by academics and clinicians in the field of prison mental health, as 'if properly framed as a hunch rather than a conclusion – there is no need to refrain ... These hunches are vital signposts for future research' (Gerring 2007:85, ellipsis to denote removed section).

To summarise the preceding ideas, it appears consensus exists in relation to the ideas that: a) the fabrication of law-like universally applicable generalisations is not suited to this form of qualitative research; b) a rejection of these broadly applicable generalisations does not prohibit the fabrication of generalisations in some form; c) case study work can aid the understanding of social contexts beyond the site of data collection, if utilised aptly; d) thick descriptions are a necessity in order to permit similarities and differences between contexts to be analysed. Crucially, 'no case study research should be allowed to conclude without at least a nod to how one's case might be situated in a broader universe of cases' (Gerring 2007:85).

Case study method: A note of caution

Gomm *et al.* (2000) highlight numerous case study researchers often fail to meet apt methodological requirements in relation to internal generalisations in the case. At times, insufficient attention is devoted to temporal boundaries; therefore, in relation to this study, it must be remembered that an inmate's understanding of mental health and mental illness at the point of interview may be markedly dissimilar a week later. That is if it's not changed immediately as a result of the interview's interactions alone. However, alongside this diachronic dimension, synchronic aspects also deserve consideration; it should be questioned whether an analysis of one inmate's interview transcript and consequent conclusions about the prisoner's understanding of mental health and mental illness should be applied to another inmate. 'Generalisation *within* the case is often unavoidable ... Moreover, often it does not seem to be given the attention it deserves' (Gomm *et al.* 2000:111, italics not in original, ellipsis to denote removed section). According to Gomm *et al.* (2000), internal generalisations in case study work must not be inadequate, they must be considered exceedingly carefully and critically; this study recognises the complexity of internal case conclusions.

Nature of the social science interview

Semi-structured interviews are conducted with prison healthcare centre staff (*e.g.* registered general nurse, registered mental health nurse, health care assistant, plus varied administration and clinical management staff), the secondary mental health team (psychologist, psychiatrist, community psychiatric nurse), prison governors, prison psychologists, primary-level mental health service users/prisoners, and secondary-level mental health service users/prisoners.

Semi-structured interviews are used extensively and successfully in prison-based health research. De Viggiani (2006) utilises semi-structured interviews to explore aspects of the prison environment inmates feel have a negative impact on their health. Condon *et al.* (2007) also deploy semi-structured interviews to explore the opinions of inmates; in this instance, their views concerning prison health services are sought. Both Gately *et al.* (2006) and Mills (2002) implement semi-structured interviews in their work that investigates inmates' experiences of long-term mental healthcare in prison.

Interviewers must consider whether what they are asking is unjust or unreasonable, as 'at best we are supplicants, and at worst, invaders demanding booty of captive audiences' (Toch 1971:500). Social science researchers must remember they are the privileged 'recipients of non-reciprocated information' (Toch 1971:500). This lack of give-and-take renders the interview an abnormal human interaction. The imbalance of power between the researcher and the researched is worthy of attention. Interviews represent a convoluted social encounter between an interviewer and their research participant. Rapley (2004) considers interview data to reflect 'a reality jointly constructed by the interviewee and interviewer' (p. 16). The role of the researcher in the inherent researcher–researched interactions demands consideration.

The interview method assumes that it is possible to investigate elements of the social by asking people to talk, and then constructing new knowledge via the interpretation of their talk. However, interviewees' accounts are not simple descriptions of social experience; the situation is more complex. Interviews are both interactive and situational processes. The interview is a socially constructed encounter. The collection of data via this method is not a passive process; it is, instead, a construction process. This assembly process requires as

much analytical attention as the eventually coded and themed content of the participants' responses. It is vital to question whether the interviewer acts as knowledge excavator or knowledge co-constructor with the interviewee. It is important to remember that spoken language is a social medium; therefore, an interview transcript constitutes a joint accomplishment of both interviewer and respondent. The socially constrained interactions of an interview affect respondents' accounts. Product from an interview is the outcome of a socially situated activity. A social science interview, like all social science knowledge, should be considered critically in respect to its social, political, historic, and economic contexts. Relationships between an interviewee's account and the social world inhabited by the participant should be considered.

Researchers who implement interviews should remember:

‘every conversation has its own balance of revelation and concealment of thoughts and intentions: only under very unusual circumstances is talk so completely expository that every word can be taken at face value’ (Benney and Hughes 1956:137).

In addition, interviews are ‘governed by the proprieties of interpersonal relationships between people who do not know each other’ (Hughes and Sharrock 2007:99). Therefore, ‘it is not merely a tool of sociology but a part of its very subject matter’ (Benney and Hughes 1967:138). Notably, interview is not a simple social science method.

Holstein and Gubrium (1995) utilise a social constructionist approach to discuss qualitative face-to-face social science interviews. Interviews are considered to be social productions; interviewer and interviewee collaborative to construct pieces of datum. Interviews are interactional events, ‘they are constructed *in situ*, a

produce of the talk between interview participants' (p. 2). Interviewees are often, misleadingly according to Holstein and Gubrium (1995), considered to be 'vessels of answers' (p. 7). Such a position renders the interviewee 'epistemologically passive, not engaged in the production of knowledge' (p. 8). However, the adoption of Holstein and Gubrium's (1995) alternative conceptualisation of the role of the interviewer requires the active interviewer does far more than dispassionate questioning; instead, she/he activates and directs narrative production. Holstein and Gubrium (1995) argue 'if interview responses are seen as products of interpretive practice, they are neither preformed, nor ever pure. They are practical productions' (p. 18).

Interviews represent fleeting and volatile social interactions where participants can, and do, fabricate/exaggerate experiences and opinions and analysts should consider this. Interviews are context based constructions. Interviewees are prone to vagaries of memory, selectivity, and deception. Interviews in social science research are often 'presented as enabling a special insight into lived experience' (Rapley 2004:15). However, a convoluted understanding of both the strengths and weaknesses of interviews is required. Notably, the validity of interviews is questionable. Principally, what people say and what people actually think and do, can be markedly dissimilar. Furthermore, it is human nature to forget previous experiences or recount experiences in a nature contradictory to original understandings as a result of genuine memory loss or intentional fabrication. Interviewing 'is a highly subjective technique' (Bell 2005:157). The interview as a site of potential cultural/professional script reproduction, and reasons for this, are also noteworthy. 'Interviews do not tell us directly about people's experiences but instead offer indirect representations of those experiences' (Silverman 2006:117). Considering narrated experiences to possess only single interpretations is flawed.

Amongst Bryman's (2004) advice regarding interview and focus group conduct, it is suggested the interviewer should be familiar with the settings for the interviews. In relation to this study, numerous rooms in both the healthcare centre and on prison wings are utilised. However, due to the penal setting and the interviewer's restricted access/movement, often rooms are used that are wholly unfamiliar to the interviewer.

Finally, interviews are criticised for relying solely on talk and text. It is questioned whether interviews exclude, with significant consequent negative ramifications, non-verbal forms of communication in the interview and the knowledge creation process between interviewer and participant. However, the analysis chapters of this thesis do make reference to non-verbal forms of communication.

Sample

Probability sampling is implemented rarely in small pieces of qualitative research. Accordingly, it is unused in this instance. Instead, a convenience sample is utilised.

Prisoners receiving secondary-level mental healthcare are recruited via their Secondary Mental Health Team (SMHT) (*i.e.* In-reach worker). Prisoners receiving primary-level mental healthcare are recruited via their Registered Mental Nurse (RMN).

Prison NHS Healthcare Centre (HCC) staff are contacted and recruited personally, as permitted by the HCC manager. Recruitment packs are placed in

all HCC staff pigeonholes. Furthermore, personal recruitment emails are sent with permission to several members of NHS staff considered important participants for this work (*e.g.* In-reach team members). Numerous dissimilar NHS staff offer to act as participants in this study. However, zero non-mental health doctors offer themselves for interview, despite repeated recruitment attempts. Overall, the HCC and its varied staff mix is represented well in this work — minus the input of non-mental health doctors.

HMPS staff are recruited in the same manner as healthcare professionals. Direct and personal approach via recruitment packs and face-to-face invitations occur, with permission from the prison's governing governor. Despite varied recruitment attempts, it is not possible to interview any HMPS wing officers, as no wing staff agree to participate. However, prison governors do act as participants in this study, including the establishment's governing governor. Therefore, this work includes governor level experiences, opinions, and perspectives, yet cannot represent (non-governor level) HMPS frontline wing staff.

Regarding numbers of transcripts, twenty-one interviews are utilised for analysis. This number of transcripts represents four patient/prisoner, twelve NHS staff, and five HMPS staff interviews. The number of transcripts — although adequate — does not accurately represent the fieldwork undertaken for the study, as many more interviews were arranged then cancelled, or completed yet the final transcript is not represented via this thesis. Interviews failed for numerous reasons, explanations include: occasions where patient/prisoner interviews are cancelled at the very last minute due to lack of prison escort; completion of an interview minus the usage of digital voice recorder — at the request of the

participant. It is worth noting that the content of this non-recorded interview did align with the topics and issues narrated by other study participants.

To exemplify fieldwork issues further, one particular patient offered to act as a participant yet a transcript never left the establishment as several scheduled interviews were cancelled for a variety of reasons (*e.g.* court attendance) and then the prisoner transferred to a different prison. Therefore, the number of interviews arranged and initially willing participants are not comparable to the eventual number of released transcripts and included participants.

To summarise, approximately thirty participants offered themselves for interview, thirty-three interviews were booked, and twenty-two interviews were conducted.

However, the aforementioned numbers are estimates only because these fieldwork notes were not permitted removal from the establishment. As a result, cancelled interview details are no longer possessed. In accordance with the HMPS research guidelines, this information remained at the institution during the fieldwork period and was then destroyed on the final visit to the fieldwork site.

Notably, adult male prisoners are the focus for this work. Youth offenders and female prisoners are not involved in the fieldwork and do not act as participants. This sample population relates to the prison chosen for data collection. A male only Category B establishment permitted this study. The selection of the prison for the thesis was somewhat dictated by locality, as the establishment needed to be accessible by public transport. However, in addition, existing relationships between academic supervisors and prison governors/healthcare clinicians at the

host establishment were also important, as these acted as initial access routes. To summarise, the prison selected for this work was affected by its location and existent working relations. Finally, in relation to the overall prisoner population in the UK, this focus on adult male prisoners is apt, as the proportion of adult male offenders is far larger than female or youth offenders.

Implemented analysis process

As eloquently highlighted by Grbich (2007):

‘one of the most important things to note with regard to qualitative research is its flexibility. This flexibility does allow very considerable deviation and adaptation of design to occur ... In making your choice, it is important to understand that these approaches all come from very different knowledge traditions with different theories and principles underpinning them and with potentially quite different outcomes in terms of the type of knowledge to be gained. Understanding these differences will put you in a better position to clarify, justify and further adapt your choice’ (p. 1, ellipsis to denote removed section).

The study design’s ontological and epistemological positions are to be fully adhered to throughout the conduct of the study, including the analysis phase, in order to ensure methodological rigour. Flexibility is a virtue of qualitative social science work when embraced in a suitably nuanced fashion; however, flexibility must not result in methodologically unsound work.

To reiterate, this study implements an interpretivist approach to epistemology.

This position assumes that:

‘there is no objective knowledge independent of thinking. Reality is viewed as socially and societally embedded and existing within the mind. This reality is fluid and changing and knowledge is constructed jointly in interaction by the researcher and the researched through consensus. Knowledge is subjective, constructed and based on the shared signs and symbols which are recognised by members of a culture. Multiple realities are presumed, with different people experiencing these differently’ (Grbich 2007:8).

Subjectivity, intersubjectivity, researchers’ understandings, and participants’ experiences and understandings are of interest when adopting this approach. Often, such a position is criticised for its micro-level focus only, and lack of social structure appreciation. However, this study embraces social and institutional structures of the prison setting, and analyses are conducted with wider meso- and macro-level social structures and theories in mind (*e.g.* social exclusion issues).

Ziebland and McPherson (2006) argue rigour during the analyses of qualitative textual data from interviews is paramount. Furthermore, the examination of transcripts must also be systematic. Methodical and robust analysis of data are required; however, dealing with one’s vast quantity of largely unstructured qualitative data is a demanding task. Pieces of interview datum are descriptive information, and it is the role of the social scientist to interpret these data. The analysis of qualitative data poses both theoretical and practical considerations.

For example, the study's location on the level of interpretation continuum is to be decided, this ranges from pure description only, right through to the construction of innovative macro-level social theory. However, 'clear-cut rules about how qualitative data analysis should be carried out have not been developed' (Bryman 2004:398). Instead, numerous methods of qualitative analysis exist. These include response patterning, cognitive mapping, content analysis, analytic induction, constant comparison, grounded theory, and discourse analysis.

As noted earlier in this chapter, symbolic interactionism in its true form is not adopted as a theoretical approach to aid analysis, as it focuses primarily on the way meanings emerge through social interaction necessitating intense observation and familiarity with the site of data collection. Regrettably, this study cannot conduct formal observations or collect observational data due to fieldwork rules and restrictions. It is just several strands of symbolic interactionism that utilised for this thesis.

Thus, the analysis process according to a symbolic interactionist approach highlights that the social world is interactive. This implies that every social actor is connected to other social beings. Therefore, an apt exploration of the individual necessitates an analysis of the social actor in terms of their view of themselves as social objects, and their role taking processes in a given society. This idea of self as inherently social fits well with the overall position of this study that considers the context of prison based mental healthcare to be crucial. As a reminder, for this thesis, context refers to the prison social environment, the institutional set-up of the prison, and the involved social actors in the establishment.

To address the common critique of symbolic interaction (*i.e.* the neglect of social structure, power, and history), Stryker (1980) combines the microsociological and societal levels of analysis via role theory. Role theory pertains to social actors' active creation of roles in dissimilar societies that permit varying degrees of role negotiation. Social roles are relevant in this thesis, as social roles enforced in the prison environment are exceedingly overt and influential. The roles of patients/prisoners and prison staff are addressed in the analysis chapters.

The form of analysis undertaken in social science projects is governed by fitness for purpose. This refers to the aim of the study and the research questions. In this instance, thematic analysis is utilised, primarily because it is suited to exploratory research. Thematic analysis is a reduction technique that is concerned with the creation of themes. Condon *et al.* (2007) and de Viggiani (2006) successfully use thematic analysis in their prison studies that also explore prisoners' opinions concerning, and experiences of, prison mental health. Identification of the thematic framework is carried out by drawing loosely on *a priori* issues as derived from the study's questions and the objective of the project, as well as issues raised by the respondents themselves, and unexpected views/experiences that occur in the data (Pope *et al.*, 2000). It is imperative to re-read and consider the study's questions daily to maintain focus on the project aim during the analysis phase. To summarise, inductive content analysis (*i.e.* coding) generates numerous initial broad categories, then several specific themes are generated. Themes may focus on particular types of behaviour, recurring phrases, reported incidents, shared experiences or understandings.

Traditionally, there are four qualitative research design approaches: subjective, investigative (semiotic), enumerative, and iterative (hermeneutic) (Grbich, 2007). It is the nature of feedback that is central to an iterative position. Grbich (2007) terms this element ‘the *recursive spiral*: define the question, go out into the field, examine the data collected, adjust the various tools of questioning, sampling approach, design aspect and data collection in light of emerging issues, and go back into the field to find out more’ (p. 22, italics in original). Such an approach necessitates the alteration of data collection techniques as a direct result of early interpretations of these data; there is an ongoing oscillation between analysis and method during the fieldwork phase. ‘It is important to identify issues that emerge during the data collection’ (Ziebland and McPherson 2006:405).

Therefore, during the fieldwork phase of this study, preliminary data analysis (*i.e.* listening to the recorded interviews) permitted continual review and development of the semi-structured interview guide. ‘It is considered good qualitative practice to revise the interview schedule during data collection (Ziebland and McPherson 2006:407). Grbich (2007) considers this initial stage of analysis, the principle aim of which is to highlight emerging issues, to be:

‘an ongoing process which is undertaken every time data are collected. It involves a simple process of checking and tracking the data to see what is coming out of them, identifying areas which require follow-up and actively questioning where the information collected is leading or should lead the researcher. It is a process of engagement with the text ... to gain a deeper understanding of the values and meanings which lie therein’ (p. 25, ellipsis to denote removed section).

Consequently, at the end point of fieldwork, the researcher ‘should be ‘on top’ of the data as opposed to being buried under them’ (Grbich 2007:31, apostrophes in original). This method is utilised for this study and experienced as a positive approach to both fieldwork conduct and analysis management.

In this study, the interview transcription process is undertaken by the social scientist in the prison establishment. No transcription computer software or kit (*e.g.* foot pedal) is permitted by HMPS. The chaotic and noisy shared office environment is not an apt facilitator to manual transcription. Transcription ‘is itself a research act’ (Ziebland and McPherson 2006:407). Therefore, this unfavourable situation of transcription is not ideal for more than just practical reasons, as it affects negatively the first stage of analysis. Furthermore, on several visits to the establishment, a hot-desk computer is not available in either the HCC or the Psychology Department, so transcription cannot occur, rendering the fieldwork trip futile.

It is not possible to remove data from the prison before they have been examined by the Security Department; therefore, it is not permissible to remove any fieldnotes, or interview summaries from the prison. Transcripts are reviewed by the Security Department in the prison. The research contact, a HMPS psychologist, facilitates this review process inside the establishment. (*N.B.* The transcripts are anonymised before the Security Department has access). Once cleared for removal from the establishment, paper copies of transcripts are transported to the university in a locked briefcase, as requested by HMPS. At a later date, all transcripts are emailed to the social scientist in Microsoft Word format by the research contact at the prison.

The digital recorder's memory is formatted before removal from the establishment. The absence of audio recordings of interviews during the analysis phase is considered regrettable, as the written transcripts lack additional nuanced aspects both of interviewer–participant interaction and human speech that can be explored via repeated listening to an interview. Unfortunately, this transcript–recording reflection approach is not feasible in this work.

Grbich (2007) considers the process of thematic analysis to consist of two complementary data reduction techniques: block and file, and conceptual mapping (pp. 32–35). Both of these disparate yet complementary processes are utilised in this study. These two approaches, in tandem, are apt for this work (and qualitative social science research generally) when implemented sensitively, correctly, and fully.

Post-fieldwork coding of the data commences when the analyst begins to identify relevant elements, and starts to attach labels/comments to these sections in the transcript to highlight their importance. Data are not fitted into pre-existing standardised codes/groups; instead, novel labels/codes are constructed to break down the reams of continuous, linked pieces of datum into smaller organised sections. This procedure organises, fragments, and labels the data. It is important to remember that codes are invented labels with all the resultant social construction characteristics. Codes are not imposed; they are, instead, categorising constructs developed by the analyst to file and manage the data. Coding can be considered a method of organisation, as it arranges data in separate manageable units. However, coding is not a mere management project, as it involves significant and numerous interpretations conducted by the social scientist. Coding is a two-fold process of categorising and summarising the data,

and the construction of *in vivo* labels. The highlighted pieces of datum remain in context at this stage. This coding process is comparable to Grbich's (2007) aforementioned block and file technique.

Codes of different forms exist; coding comments can be purely descriptive, or highlight demographic characteristics, or they can represent a shared process that is occurring in the research setting, or a code can categorise an expressed group opinion or desire. A code may also be theoretical or conceptual in nature (*i.e.* a section of data may alert the analyst to a relevant body of academic literature or a sociological concept of interest) or denote historical aspects of the fieldwork setting. Codes may also signify method/methodology issues (*e.g.* the nature of turn-taking/overlap between interviewer's and participant's interactions). Furthermore, it is interesting to consider sections of interview transcript that remain without codes and devoid of analyst's comments. These sections of data that shall not be represented when research conclusions are formulated and disseminated.

Coding is an inductive process in this study. However, analysis is not a conceptually neutral activity, as the social scientist is affected by the preceding literature review, fieldwork experiences, and broad study questions. Ziebland and McPherson (2006) highlight:

‘qualitative studies often explore participants’ different perspectives and understandings. Therefore, we do not limit the analysis to just those issues that the researcher initially thinks are important or interesting; we also seek those that emerge from the data (*i.e.* topics that were not specifically asked about but which — directly or indirectly — were raised by respondents). Hence we look for *emergent* themes as well as *anticipated* themes (p. 407, italics and parentheses in original).

In relation to social theory and relevant literature for this study, this body of knowledge is used as a malleable and loose tool (*i.e.* not a prescriptive or defined framework) to aid the transition from descriptive codes to analytical themes. Initially formulated codes are not fixed; they are tentative, suggestive, and ripe for alteration. Coding revisions are ongoing throughout the analysis period. In the first instance, numerous codes that stay close to the text are developed, and then after extensive evaluation, a smaller number of more abstract ways of conceptualising and coding the social phenomena under enquiry are produced. Grbich's (2007) aforementioned conceptual mapping approach is utilised at this stage in this study.

For this thesis, data are analysed thematically. The 'One Sheet Of Paper' (OSOP) qualitative analysis technique is also implemented; this is very similar to Grbich's (2007) aforementioned conceptual mapping. The OSOP thematic analysis approach — as taught at a conference hosted by the Health Experiences Research Group, Department of Primary Care, University of Oxford, April, 2011 — occurs post-coding. A solitary single piece of plain paper is used to generate a report for a developing theme. This sheet of paper represents the OSOP. All differing perspectives pertaining to the theme throughout the entire body of transcripts are summarised and noted on the OSOP. Multiple pages of interview excerpts are collapsed to form the OSOP. The intention is to note the evolving story of each theme. These OSOPs resemble spider diagrams. This approach represents a horizontal cross-transcript examination of the data that is a welcome development from the vertical explorations of the distinct individual transcripts. The aim is to represent the breadth and range of experiences in relation to a theme (*i.e.* not the common perspective only). This method is useful, as it helps prevent swift or incorrect analysis (*i.e.* theme formation) that is not sufficiently convoluted and

considered, or ignores perspectives that are slightly dissimilar to the overriding experience. Patterns between relevant excerpts are explored, compared, and contrasted. Intra-theme links are assessed in order to redevelop the theme.

Qualitative social science research can be criticised for a lack of analytic transparency (Bryman, 2004). Therefore, negative case analyses are essential to worthy qualitative social science research (Patton, 2002). Negative cases must be actively sought, scrutinised, and utilised to refine evolving themes. ‘Seeking out and accounting for negative instances (*i.e.* deviant cases) that contradict an emerging account lies at the heart of a fallibilistic research strategy’ (Seale 1999:86). It is recognised that valuable research training implants a phobia for premature interpretation of data (Toch, 1971). Proposed themes must be reviewed repeatedly against the data set as a whole to ensure suitability.

Researchers should embark on ‘the conscientious seeking out of evidence that might contradict or modify claims’ (Murphy and Dingwall 2003:204) and make necessary alterations. Congruently, this study’s themes are consolidated finally only after a thorough search for conflicting experiences, perceptions, and opinions throughout the transcripts. Instances of disagreement are considered and utilised to positively develop the construction of themes.

One analysis conundrum

During the conduct of analysis for this study, one issue arises, as it is clear — in retrospect — that several topics discussed in the interviews should not be disseminated via the thesis or its resultant journal articles. Had these themes been explored in this thesis, recognition of the specific prison may have been feasible by readers who are familiar with HMPS. This is the interviewer’s

failure, as interview questions were posed that introduced identifiable aspects of the prison's contemporary situation or ongoing development processes. Throughout this thesis, significant thought is devoted to ethical considerations in relation to individual participants and the security of the prison acting as the fieldwork site; however — with hindsight — intra-prison system anonymity issues are not assigned significant attention. Future research projects shall not repeat this mistake; intra-organisation identifiable topics shall be avoided.

Notably, the Security Department at the prison has released the aforementioned data and has, therefore, cleared these sections of information for use in this study. Therefore, it is the sociologist's ethical decision to not disseminate these sections. However, these non-disseminated data do not represent a significant proportion of the interview transcripts. Consequently, this sub-section is included in the thesis as a reflexive point and not as a problem with the study as a whole.

Ethical considerations

'Ethics is a set of moral principles that aims to prevent researchers from harming those they research' (Dickson-Smith *et al.* 2008:26). The ethical implications of studying incarcerated individuals are wide-ranging from the outset, yet to also include persons with mental illness intensifies the importance of ethical deliberations. Dickson-Smith *et al.* (2008) remind health and social care researchers 'doing research on a sensitive topic is not as straightforward as methods books may have you believe' (p. x). Exploring prison mental health is typified sensitive research, as it involves imprisoned vulnerable adults and the site of fieldwork is concerned with control and security (*i.e.* HMPS exercises a form of legitimised power as endorsed by UK society).

‘Prisoners are vulnerable to exploitation and abuse by research because their freedom for consent can easily be undermined, and because of learning disabilities, illiteracy and language barriers prevailing within prisoner populations’ (Pont 2008:184). The study of incarcerated persons with mental health issues requires a nuanced and sophisticated approach to ethical considerations. Particularly, non-maleficence is vital. Common ethical pitfalls of deception, the revelation of participants’ identities, dubious bargaining, and intentional and often unintentional exploitation (Silverman, 2006) are unacceptable.

Ryen (2004) states research ethics is ‘a field socially constituted and situated’ (p. 233), arguing that ethics are relative and differ across cultures and research environments. Ethical practice is indeed a complex process. Just as a simple checklist should not be utilised to assess the quality of qualitative research, the same applies to genuine ethical practice.

Numerous social science studies have successfully included prison healthcare users as participants. ‘User involvement has become a central feature of health and social care (at least in theory)’ (Glasby 2007:145). Traditionally, mental health service users have been passive actors in the system; however, changes have been made that, in principle, strengthen their position and increase their power in the policy and practice development processes. Those who have experienced mental illness can provide ‘an insight that neither romanticises nor underestimates the meaning and consequences of mental illness’ (Lester and Glasby 2006:3). Barnes and Bowl (2001:96–97) state mental health service user research strategies should consider: whether the goals of interacting with the users are therapeutic and/or democratic; the affect of the research process on the

service establishment post-investigation; possible influences on individual mental health service users as a result of involvement.

To concur, Murphy and Dingwall (2003) consider correct ethical study to ensure non-maleficence (participants are not harmed), beneficence (research is conducted to provide beneficial results, not just for interest), autonomy (participants' decisions are respected), and justice (human beings are treated equally and fairly). In addition, Delamont (2004) highlights gaining research access to other cultures and social groups is a 'great privilege' (p. 215) and 'disengagement from the field is just as important as the entry and engagement' (p. 214). A major limitation of the forensic mental health service literature to date is the relative lack of a user perspective, as 'we still know relatively little of the experience and perspectives of people who use forensic mental health services' (Coffey 2006:73). The issue of intrusion when researching sensitive topics requires attention. However, in order to develop contextually-appropriate prison mental healthcare, the users and providers of the service should be involved. Bruce *et al.* (2007) highlight numerous studies have demonstrated the importance of patients' perceptions of mental health services in relation to treatment success, yet very little research has explored the understandings of diagnosed prisoners. De Viggiani (2006) argues the views of inmates, concerning their mental health in relation to the prison social environment, should be increasingly researched and considered.

Dickson-Smith *et al.* (2008) report whilst conducting their health-based interviews, although interviewees were aware that the purpose of the interview was research, 'many participants were expecting some advice' (p. *x*). Therefore, in this work, all prisoners are referred directly to their healthcare professionals where healthcare-based questions are posed, albeit infrequently, and no form of

health advice is proffered. The difference between social science interviews and therapy is made clear to participants.

It was planned that should any service users exhibit or verbally express distress during the course of an interview, the interview would be terminated immediately and the prisoner would be left alone with their clinician. However, this situation did not arise.

Dickson-Smith *et al.* (2008) cite four criteria for assessing informed consent:

1. Disclosure = full explanation of nature of research and forewarning of sensitive topics to be discussed;
2. Understanding = participants must wholly comprehend what they are consenting to;
3. Voluntariness = participation must be totally voluntary and potential participants are to be fully aware of this;
4. Competence = competence for consent may need to be discussed with a third party (*e.g.* gatekeeper) (adapted from p. 98).

To fulfil the aforementioned criteria, a complete description of the study is provided to all potential participants both verbally due to the literacy levels of some prisoners and in printed form, then written informed consent is obtained. In addition, the signed Consent Form notes parts of the interview transcript may be used in a PhD thesis or any resultant publications. Issues concerning legal capacity to consent are not directly relevant to this research, as the prison does not house any persons sectioned under the Mental Health Act, 1983/2007. All participants attend interviews as volunteers. No coercion is deployed. Self-disclosure as a rapport building technique is not utilised in this study. Participants are assured confidentiality and anonymity. Access to the data is

restricted. Only the principal investigator and the two academic supervisors have access to interview transcripts. In relation to anonymity, participants must not be identifiable via any published reports. Interviewees must not be identifiable via *verbatim* interview quotes. In addition, identities of interview participants are not stored on a computer or data storage device.

After collaboration with a Research Governance Assistant at the University of Nottingham, Research and Innovation Services (July through to November, 2009), university research clearance was granted after alterations to study documents (Protocol, Participant Information Sheet, and Consent Form) to comply with university regulations. The Integrated Research Application System (IRAS) forms were completed during this time.

Uncertainty arose regarding the research clearance process, as advice from the IRAS, the university, the National Offender Management Service (NOMS), and the MoJ did not concur.

However, research ethics clearance from the two NHS bodies was then sought via the IRAS. A prisoner-specific NHS REC was required and this caused a delay. The NHS REC took place in December, 2009. Both the NHS REC and NHS R&D departments subsequently labelled the work a service evaluation. Therefore, the label research cannot be utilised to discuss this study. Moreover, the university governance (that took months to secure) was no longer required.

The fieldwork was then discussed with, and granted permission by, both the NHS Healthcare Centre Manager and the HMPS Deputy Governor at the host prison establishment. The prison's Governing Governor was also aware of the project (and later acted as a participant in the study). Furthermore, clearance was

granted by the local NHS Assistant Director for Primary Mental Health and Prison Health. Study documents were then altered again to comply with the HMPS research clearance form that was submitted to the HMPS Research Contact (based in the Psychology Department) at the host prison. Subsequently, a HMPS Psychology REC was required (January, 2010). As a result, further major alterations were required to study documents (February, 2010).

In support of this lengthy process, Ramluggun *et al.* (2010) highlight ‘conducting research in prison does present difficulties’ (p. 60) partly due to the ‘paradoxical world of regulatory bodies’ (p. 60).

The aforementioned convoluted clearance process began July, 2009 and ended March, 2010; attaining clearance to conduct the fieldwork required prolonged contact with myriad organisations (who often provided conflicting advice):

University of Nottingham, Research and Innovations Services;
NOMS, Research Committee;
NOMS, Interventions and Substance Misuse Group;
Prison National Research Committee;
MoJ, Offender Management and Sentencing Analytical Services;
HMPS, Psychology Department.
HMPS, Psychology Research Ethics Committee;
NHS, Research Ethics Committee;
NHS, Research & Development;
NHS, Primary Care Trust;
NHS, Primary Care Trust Research and Evaluation Team.

Fieldwork commenced March, 2010. The first interview took place May, 2010. As demonstrated here, for a non-HMPS/NHS member of staff in the prison, the time required to arrange meetings and rooms in the establishment is considerable. The HMPS Research Contact at the prison liaised with the Security Department in order to arrange interview transcripts for review, and then release.

Fieldwork ceased early-January, 2011. All final transcripts were released late-January, 2011.

The ethical and security guidance provided by the HMPS Psychology REC was adhered to. Throughout the fieldwork phase, all arrangements detailed by the HMPS Research Contact at the prison were upheld. For example, the digital voice recorder remained at the prison in a locked drawer in the Psychology Department and then all recordings were deleted before removal of the device from the establishment post-fieldwork.

Prior to interview, the Participant Information Sheet is reviewed verbally with the participant. The Consent Form is then signed by both interviewer and interviewee. All points on the Consent Form are discussed and understanding is acknowledged by the interviewee. The nature of the work is outlined by the interviewer, then the participant is given the opportunity to ask questions concerning the project prior to interview commencement.

Heretofore, the vulnerability of the interviewer has not been discussed. Work that is based in a prison and explores mental illness raises both physical and emotional vulnerability discussions, as:

‘in listening to a person’s account of their life or their illness experience, we are effectively opening up in an embodied and personal way to the

suffering of that other person, which may give us a heightened sense of our own mortality and vulnerability' (Dickson-Smith *et al.* 2008:50).

Emotional wellbeing is self-monitored throughout the course of the fieldwork and any minor issues are discussed with academic supervisors immediately. Prior to commencement of fieldwork, physical safety briefings and security training are undertaken at the prison (*i.e.* HMPS official security awareness training and key training was completed at the prison in January, 2010).

The nature of HMPS fieldwork as a sociologist

A discussion of Jones's (1972) institutional admission procedures and the experience of conducting prison-based sociological study

To summarise Jones's (1972) work, the paper utilises critically Goffman's (1961) seminal thesis that the nature of admission to social institutions such as asylums, prisons, monasteries, and army camps instigates a process of role dispossession, alongside specific detailed cases of the author's own and concludes 'while the actual events differ, there is a central unity of process' (p. 405). What follows is a consideration of these common institution admission procedures in direct relation to the experience of conducting prison based sociological study from the social scientist's standpoint.

Jones's three case study examples include an elderly female patient entering a psychiatric hospital, a young male entering a prison, and a divorced male stockbroker proposing to holiday in Cannes. These examples are used to detail and explain Jones's twenty-four steps of institutional admission. Jones uses the term Ego to refer to the person, and System indicates the institution. Physical

and psychological alterations occur; it is considered inevitable: ‘once contact between Ego and the System has been established, it is only a matter of time before the physical transfer takes place’ (p. 407). Physical and psychological changes may not occur at the same time. Jones refers to the new prisoner as ‘an object to be transported and stored’ (p. 409). This description, that refers to a prison as a site of human storage, seems apt, as although HMPS has other aims for its prisoners, it remains the case that containment is one of these. Poignantly, Jones highlights that ‘whatever expectations Ego has, the System will have very clear ones’ (p. 409). Once again, this analysis fits well with a prison, as prisons have strict and multiple expectations of prisoners in relation to their behaviour, possessions, and location. Jones also notes how the prisoner is reduced to a surname, ‘a brief syllable or two suitable for barking out in orders’ (p. 412) and that ‘this is part of the stripping process’ (p. 412).

Whilst the paper praises Goffman’s (1961) *Asylums*, Jones wishes to add ‘elements of equal importance’ (p. 406) to the analysis of institutional admission procedures. Jones cites five sets of theoretical constructs to analyse residential institution admission procedures. Interestingly, Jones does not limit the scope of these analytical tools to the presumed social and medical institutions, yet also suggests that ‘it may be possible to cast the net wide enough to include hotels, religious communities and boarding schools’ (p. 406). Jones’s five sets of theoretical constructs (p. 406):

- (i) As a mortification of the self;
- (ii) As an initiation rite;
- (iii) As a necessary administrative process;
- (iv) As a life crisis;
- (v) As a socialisation process.

These constructs can be used to compare and contrast with the experience of conducting prison-based study from the standpoint of the sociologist. In construct (i) ‘the individual is ‘processed’ to become a cog in the institutional machine’ (p. 406, apostrophes in original). The nature of prison work is markedly similar. The prison can be considered a machine where problems occur that hinder the smooth operation of the instrument. Just as a piece of factory machinery emits warning lights and noise if a problem occurs, the prison is full of overt visual and audible alarm systems that staff members are trained to recognise. The continual unlocking/locking of prison doors in order to move throughout the establishment adds to the experience of the prison as a site of time-regulated movement and emphasises the nature of the staff member as a cog in the prison’s system of prisoner location management. Furthermore, every area of the prison is subject to continual camera surveillance, at all times. Therefore, as a social scientist, the experience of being observed continually and all movements recorded heightens one’s sense of being a very small — and not trusted — part of a larger entity that is watched and monitored perpetually.

Jones’s construct (ii) requires the individual to move ‘into a new relationship with society and a new status’ (p. 406). A sociologist, acting as a member of prison staff, is ascribed a new societal relationship in the prison that is not experienced in wider society, that of prisoner or staff (*i.e.* the prison social system is split via two overt social groups: the prisoners and the staff). This unconcealed two group social system is markedly dissimilar to wider society; it is the obvious nature of the role divide that is striking. In addition, a female staff member will acquire the title ‘Miss’ in the prison environment. This term is used by prisoners to address female staff in the establishment. This form of address can be experienced as peculiar initially by sociologists who are often not (like, for example, school teachers) familiar with being addressed by anything other

than their forename. Interestingly, discomfort initially experienced as a result of this label fades quickly and the manner with which prisoners address female staff members becomes familiar swiftly. The speed that this (internal psychological) transition to familiarity occurs is surprisingly fast. The words internal and psychological are written in parentheses above, as initial surprise and shock at this form of address is intentionally experienced internally and not portrayed overtly in the unfamiliar social situation, as the necessitated staff member control of the situation (*i.e.* a prisoner–staff interaction) commands an air of familiarity with the prison setting and its language norms.

The process of role transition appears critical to the institutionalisation literature. On entrance to the prison multiple sites of role transition can be found to exist in the initial processes experienced at the prison gate. In chronological order:

1. Adorning oneself with the overt (prison issue) black leather belt complete with robust silver-coloured key chain, black leather key pouch, personal key tally, and prison-specific identification card;
2. Entering the staff gate area and receiving visual looks of recognition from gate staff;
3. Passing through the double-doored entrance area when locked/unlocked by prison gate staff;
4. Key tally–prison keys exchange procedure;
5. Prison keys onto key chain;
6. First personal gate un-lock/lock of the visit — in order to exit gate area and access the prison establishment.

Role transition necessitates an alteration in psychological approach, from a member of the general public to a member of the prison staff (with its consequent security-orientated mindset) and a physical change, that is most

overtly demonstrated by the staff member's belt that indicates possession of keys, and therefore power and control over the subjugated social actor grouping in the social setting. This is the prisoner social group.

The process of role dispossession as detailed by Jones, with all its numerous stages, is characterised by occurrences that could be labelled mortifying or punitive (two words utilised often in Goffman's (1961) *Asylums*). Mortifying incidents are potentially degrading, humiliating, or embarrassing; whereas, punitive actions are associated with discipline, correction, and punishment. Perhaps here is a site of divergence between the experience of a staff member in an institution and the nature of admission for a prisoner. As, if mortification is intended to humble, admission to the prison as a staff member arguably epitomises the opposite, as it is a proliferation of power and amplification of social influence. On entrance to the establishment prison staff members assume a position of privilege in the environment that is associated with power, authority, and control. This status in the prison is not a social role that is held by the staff member beyond the prison's walls. It is a socially ascribed position in the prison that is not maintained beyond the establishment.

However, more interesting is whether prison staff are both the givers and receivers of punitive action. As, whilst it is true that wing staff are charged with the discipline of prisoners, it is also the case that prison staff are subject to strict HMPS regulations themselves (with deviance resulting in disciplinary action) and continual observation. It could, therefore, perhaps be argued that the whole prison establishment, as a socially constructed setting, is engrained with institutionalised regimes and rules, corrective action, and perpetual observation that affects both staff and prisoners.

The final three constructs debate a necessary administrative process, a life crisis, and a socialisation process. These are not explored here, as they do not align with the social scientist's fieldwork experiences well and are not considered salient issues for the interviewer. They are, however, posited as potentially fitting for the establishment's prisoners.

This sub-section, concerning the institutional nature of a prison establishment, concludes the Study Design chapter of the thesis. The subsequent chapter represents the first of three analysis chapters. In this initial analysis chapter, the NHS Healthcare Centre in the prison acts as the locale for debate regarding study data and relevant literature.

Chapter 4

'The provision of healthcare services behind bars for these prisoners is not for the faint-hearted, but it is uniquely rewarding'
(Smith 2010:33).

Team health at the NHS Healthcare Centre

This section of the thesis considers the NHS Healthcare Centre staff interviews. However, prior to the analysis of transcripts, several matters are worthy of address.

As detailed previously, the current correct NHS term in the host prison establishment for the In-reach grouping is Secondary Mental Health Team. However, the label In-reach is used frequently throughout this thesis, as it is the label participants — staff and patients — utilise in their narratives.

Interviews with NHS staff are conducted in the NHS Healthcare Centre (HCC) in the host prison. Multiple clinical and non-clinical meeting rooms are utilised. Semi-structured interviews are conducted with prison-based NHS clinicians including registered general nurses (RGNs), registered mental health nurses (RMNs), health care assistants (HCAs), In-reach team members (psychologist, psychiatrist, community psychiatric nurse (CPN)), plus varied administration and clinical management staff — all are NHS employees.

It is recognised that this thesis focuses on prison mental health (broadly defined). However, this chapter makes reference to non-mental health issues. This occurs as the NHS staff acting as interviewees occupy numerous dissimilar roles in the

HCC, including positions that do not relate to mental healthcare or practical clinical roles whatsoever (e.g. administration staff). This chapter is, therefore, an exploration of the NHS setting in the prison, and not solely the provision of mental healthcare.

Regarding recruitment of NHS staff, invitations to participate are placed in all staff pigeonholes — on several occasions. This process is supported by the HCC manager. It is important to consider who in the fieldwork setting offers to act as an interviewee and, conversely, who does not. Notably, no general practice doctors offer to participate. Notwithstanding this professional group absence, the spectrum of interviewees from the NHS setting is good (e.g. HCAs, RGNs, RMNs, In-reach clinicians). However, the lack of input from primary care physicians results in the deficiency of issues these employees would introduce to the analyses.

Salmon *et al.* (2007) explore explanations given by General Practitioners (GPs) concerning their choices to decline participation in research. Salmon *et al.* (2007) highlight GPs' levels of participation in research are low. GPs' reasons for this include: research and general practice are alien fields; research often lacks clinical value; GPs lack the time to participate in research. However, interestingly, 'time was an elastic resource that payment could release from the reservoir of their 'own time'' (Salmon *et al.* 2007:269, apostrophes in original) (*i.e.* GP participation can be bought). However, this study cannot offer remuneration to participants.

To generalise, with the exception of several notable topics to be discussed subsequently, the NHS staff interview narratives are markedly positive; as a result, the analyses in this chapter somewhat mirror this sanguine sentiment.

Therefore, it is important to recognise that the themes and debates represented in this thesis may not align with the workplace experiences of *all* HCC staff in the host prison establishment; this work can only reflect the input of its participants. To summarise, the HCC colleagues that do involve themselves with the study, these employees represent enthusiastic and engaged NHS staff and, as is to be expected, their narratives reflect this.

All of the themes discussed in this chapter are considered in relation to their relevance and fit across the HCC staff transcripts as an entire body of data (*i.e.* deviant case analysis). Where complication or deviation exists, this is debated in the main body of the chapter; there is not a specific section dedicated to variation or anomalies.

The title for this chapter includes the term team health. For this thesis, the notion team health refers to aspects of collegiate work in the healthcare setting at the host prison establishment. As the discussions that follow demonstrate, the employees in this locale narrate a relatively pleasurable and cooperative existence with their colleagues. To summarise, any workplace issues are instead framed as structural (*i.e.* not social) topics that, often, involve issues regarding the provision of clinical care in a custodial environment.

In terms of construction, ten sub-sections structure the interview topics to be explored in this chapter:

- Working with prisoners;
- Involvement and enthusiasm;
- The working environment;
- Communication and co-operation;
- Overarching goal;

Removed sub-section;
NHS developments in a prison setting;
'Did Not Attend' as an issue;
Prisoners with mental health problems;
Old Guard versus New Guard.

Working with prisoners

Participant: I feel safe working in this environment. You're very well protected here. You've got so many options of how to get help from somebody. If you're working out in the community or in a hospital you don't have that same level of support from trained, discipline staff. So in that respect, you know, we probably are safer in here.

The NHS HCC staff involved in this study narrate a working life in the prison establishment that is permeated with the notion of security – in a positive sense.

Interviewer: In terms of security do you feel secure and happy in this environment?

Participant: Yeah, certainly. Yep, yep, hundred percent. Prior to working here, [it was] eleven years working in mental health on a community secure unit, and it's much more secure here.

(Square brackets added by analyst.)

Smith (2010), a prison-based RGN, conceptualises prisons as 'self-contained communities, with a transient problematic population' (p. 34) and an unpredictable working environment. Congruently, HCC-based interviewees in

this study consider the prison population to represent a social group with significant health problems and needs. Moreover, the transitory nature of this HCC's patient base is acknowledged by its NHS staff. In relation to the unpredictable working environment narrated by Smith (2010), this is also echoed in the interview transcripts. However, it is aspects of the institutional working environment that are recounted as unpredictable, and not the behaviour of, or the nature of work with, the individual prisoners (*i.e.* their patients) in the HCC.

Smith (2010) highlights 'wall alarms are in every room and prison staff are alerted when voices are raised. There is a fast response from an identified team when any alarm is raised. I feel safer in a prison environment than in A&E on a Saturday night!' (p. 35). Similarly, the NHS staff interviewees in this study feel comfortable and safe working in the prison environment:

Participant: Working with prisoners has never bothered me ... I try to explain to people in the community that there is no risk here. You're safer in here than out on the streets. They [the prisoners] are very polite.

(Ellipsis to denote removed section.)

Interviewer: In terms of your personal security as an individual clinician, do you always feel safe in this working environment?

Participant: I actually feel more secure here [in the prison] than I did [working] in the nursing home.

Participant: I think it's a good environment to work in, and to me, you're in one of the safest places. It feels safer to me than when I was working in the GP practice.

Notably, where participants discuss the notion of potential security/safety issues at work, these discussions are positioned as prison establishment-level debates — in relation to the prison as a single and whole working unit that may experience establishment-level security/safety incidences. Therefore, potential security/safety issues are not considered, or spoken about, in terms of interactions with individual (unknown) prisoners or the prisoners the HCC staff work with personally as their patients.

It appears that security/safety concerns and incidences are accepted to occur in the prison — and staff are trained well for these occurrences — however these incidences are narrated as somewhat distanced from the HCC and its day-to-day work with individual patients. Safety/security-related issues are narrated in a knowledgeable, yet relatively distant and remote fashion, suggesting incidences do occur in the prison establishment, yet are removed from the usual daily practice of the HCC.

In relation to prison security, the presence of both the prison's camera surveillance system and the wing officers are presented in a positive sense:

Participant: I don't feel frightened or intimidated by going on the wing, 'cause you know there are officers somewhere about. You may not be able to see one straight away, but they are about. I feel safe. I'd walk anywhere in the prison because I know there are cameras everywhere and somebody would always see if you were lost, or if anything happened.

Thus far, HCC staff depict their work in the prison establishment and their work with prisoners as comfortable, safe, and secure; further to these experiences, enjoyment is also expressed in relation to clinician–patient/prisoner interactions:

Participant: I just enjoy being face-to-face with patients. Well prisoners, patients. I call them patients. I'm just ... I just really like to be with them and to help them.

Tuck (2009) notes forensic healthcare systems and healthcare organisational dynamics as complex, where the nature of the setting's working environment can create/exacerbate anxiety in its staff members. Interestingly, this emotion (*i.e.* anxiety) is not alluded to whatsoever by the HCC participants in this study — who work and practice in a custodial setting that provides healthcare for those with mental health needs. Therefore, in relation to the working environment, anxiety is absent from the interview transcripts, yet experiences of enjoyment and safety do exist.

However, it is worth considering this apparent staff enjoyment and safety in tandem with the healthcare setting's staff recruitment issue:

Participant: At the moment we seem to be quite well staffed, but we do have a problem with recruitment of staff. It's taken months, and months, and months of re-advertising to get the appropriate number of staff on board. Retention doesn't seem to be as much of a problem once you've got good staff in, but actually encouraging people to work in a prison environment's very difficult.

Seemingly, once staff members are in post, the clinical setting in the penal environment appears to be an acceptable, and even enjoyable, working environment; retention is unproblematic. However, encouragement to work in the prison as a NHS location can prove challenging.

It is apt to reflect briefly here on literature that explores violence in both healthcare and criminal justice settings, as this is an issue usually raised in this form of debate and is indeed included in the preceding literature review. There exists a wealth of worthy research in this area. For example, Elston *et al.* (2002) study the process of medicalisation and debate its management of deviance limits via a discussion of violence perpetrated against doctors (specifically GPs) in the NHS. Links are made to penal policy as arguably prioritising victim protection and management of risk afore offenders' problems and needs (*i.e.* a steering away from rehabilitation and issue resolution alongside the positioning of responsibility for violence on the perpetrator). GPs discuss patients' behaviours that 'fall into a 'grey area' between 'illness' and 'crime', and about individuals who are not clearly categorisable as either 'sick' *or* 'bad'' (Elston *et al.* 2002:575, apostrophes and italics in original). Violence towards GPs, as a form of deviance, can be 'accounted for and responded to in various different ways' (Elston *et al.* 2002:576); crime and illness boundaries are debated and 'mutually exclusive conceptualisations of [sickness and badness] deviance' (Elston *et al.* 2002:594, square brackets added) are critiqued. The three-way relationship between violence, illness, and deviance is clearly a complex one.

Moreover, Denney and O'Beirne (2003) examine 'the impact of violence perpetrated against probation officers' (p. 49) and note 'managerial response to violence has been largely defensive and piecemeal' (p. 49). Denney and O'Beirne (2003) appeal for evaluation of these managers' responses to violence

alongside a developed understanding of probation officers' perceptions concerning their own personal workplace safety. In relation to the National Probation Service and the risk of violence more generally, a punitive occupational culture in the probation system is problematised, especially where 'officers attempt to impose ever more stringent and detailed conditions' (Denney and O'Beirne 2003:52). Similar to the aforementioned Elston *et al.* (2002) work, definition debates are included in Denney and O'Beirne (2003). In this instance, 'what actually constitutes violence' (p. 55) for frontline probation officers is explored⁷.

Notably, participants in this study do not discuss violence in the penal setting in a problematic sense — for them as NHS staff. Violence does not represent a significant facet of their prison narratives. Although the potentiality for violence and past violent events in the prison establishment are acknowledged, their face-to-face work with prisoners is depicted as occurring daily in a fashion where violence is not a pertinent concern or experience. Consequently, violence is not addressed in-depth in this thesis.

Finally, in relation to the nature of work with prisoners more generally, Jones and Fowles (1984) note institutions, such as prisons, can cause depersonalisation of inmates as a 'consequence of loss of liberty ... through the imposition of rigid routines, through a simple assumption that systems take precedence over individuals' (p. 202, ellipsis denotes removed section). An absence of liberty and the presence of system-level regimes are characteristic of imprisonment.

⁷ *N.B.* This form of definition dispute is arguably applicable across the entire UK's criminal justice system (*e.g.* the dissimilar variants of PD diagnoses, the nature of dangerousness/risk in relation to Parole Board hearings); evidently, mental health, when considered as a broad body of convoluted academic and healthcare knowledge and practice, represents a quagmire of definition disagreements.

However, at the NHS HCC in the prison in this study, depersonalisation is actively fought against by the NHS staff — albeit perhaps inadvertently, as this is not a term or topic study participants discuss — via the conceptualisation of prisoners as autonomous disparate patients with dissimilar personal attributes, inconsistent personalities, varied health needs, and divergent life histories. This differentiated nature of the notion of patient is considered important and these patient character traits are given precedence over the operation of the system (*i.e.* the prison establishment). This is not to suggest that HCC staff disobey or deviate from HMPS's rules and regulations, far from it; these NHS staff are aware acutely of the prison's regimes, and they abide by, and work in conjunction with, these constraints aptly. Nevertheless, the HCC manage social actors/patients as individuals (*i.e.* at a micro-level); whereas, the prison itself could be characterised as, more usually, managing groups of prisoners (*i.e.* a meso-level operational set-up).

The following sub-section explores two further aspects of the participants' working lives in the prison's healthcare setting.

Involvement and enthusiasm

Participant: I love coming to work. I just love it here.

Participant: I do think we're doing a good job.

Interviewees depict their working life as a team pursuit that involves all staff at the HCC; moreover, this group undertaking is reported as conducted in an enthusiastic manner.

A shared notion of optimum health service provision exists:

Participant: I think everybody seems to be on the same level. We understand we're providing a service.

In relation to service provision, where HCC staff are asked to explain their work roles and responsibilities in the prison, the descriptive lists are often lengthy, yet there are no subsequent negative remarks concerning these multiple tasks:

Interviewer: Are you able to tell me a bit about your role here in the prison, please, so you're not a prisoner, or a governor, or wing staff, so?

Participant: I'm a registered general nurse within the prison.

Interviewer: So your day-to-day roles, is that general clinics, triage clinics, that kind of thing?

Participant: Yeah. Triage. Reception. Do the drugs. Answer emergency calls. Just everything.

Roles and responsibilities appear often numerous, yet enthusiasm for the multiple tasks exists:

Participant: Day-to-day roles are holding general clinics, working on the wings assisting the nurses to dispense medicines, also assisting with assessments. Everyday healthcare complaints right through to alcohol and drug abuse and mental health issues. So it's quite a wide ranging role, and I get involved in all sorts of things.

This narrative — that depicts multiple work tasks yet enthusiasm for the assignments — occurs often in the NHS HCC interview transcripts. However, a

diminutive number of excerpts are included here. This is due to anonymity concerns, as detailed descriptive lists of work tasks would present participant identification issues. The non-disseminated transcript sections that detail roles and responsibilities may reveal participants' identities if read by members of the host prison's HCC staff team. Therefore, these data remain absent from this thesis and resultant publications.

Attention is now devoted to the HCC as an employment setting and its cultural environment.

The working environment

Participant: There is always a good feeling here.

Participant: It's happy. A good team environment.

A healthcare setting's culture 'develops through social interaction, informal networks and meanings created by workers, rather than through 'culture change programmers', away days, or mission statements' (Parkin 2009:125, apostrophes in original). This sub-section explores aspects of social interaction and workers' informal networks of healthcare practice in this study's healthcare setting.

Interviewer: It does seem as if this Healthcare Centre is a really good setting in which to work?

Participant: Yeah.

Interviewer: The staff get on quite well?

Participant: Yeah, well, we're delivering a service, so we've all got to work together, you know, and I think it's just the role of everybody [to work together to provide the healthcare services].

In relation to service delivery, capability at work is professed by the healthcare clinicians involved in this study. NHS staff appear happy and adept to fulfil their ascribed roles. The excerpt below demonstrates this clinician considers herself/himself capable of responding aptly to the emergency radio call in this specific healthcare setting:

Interviewer: In terms of your response to the X emergency call, do you feel that you're fully equipped? Do you feel capable to respond adequately?

*Participant: I feel fine responding, as I used to work in A&E anyway, so, emergency medicine is fine for me. I can deal with that.
(X indicates the removal of a name or a similar identifiable detail.)*

Furthermore, safety in terms of adequate and prudent service provision is narrated:

Interviewer: Reception screening has a few mental health questions, yes, about care in the community or current psychiatric medication, yes? Do you feel that aspect of the reception screening is working well, what's good about it? Is it sufficient, or should there be more questions?

Participant: Umm, I think it's fine. It seems to be working well. It kind of, you know, anyone who's already on psychiatric medication automatically gets referred to the mental health team anyway [the

SMHT], so it's quite, there's a good safety net there, really, for a general nurse like me [a RGN], I feel quite safe with that whole process. So I think it is quite adequate, yeah.

Further to the interviewees' understandings of service provision as proficient and safe, one HCA narrates three additional attributes required by prison healthcare staff:

Participant: You've got to be concise and swift. Dealing with issues, but at the same time, being quite efficient.

Seemingly, efficient and concise work is required swiftly in this working environment. When considered as a whole body of data, the interview transcripts echo this labelling of important HCC staff characteristics. Moreover, the narratives profess personal fulfilment of these abilities. Therefore, these notions of effectiveness, conciseness, and swiftness do not represent idealistic work goals, yet are instead aspects of their working lives participants consider themselves to fulfil appropriately.

These service delivery characteristics are not restricted to clinical staff, they apply also to HCC staff who do not interact with patients practically in a healthcare sense (e.g. NHS administration staff). The below is a quote from an interviewee who is a member of the HCC's administration team:

Participant: I feel that I am delivering this service to the best of my ability.

As differing members of the healthcare team and their divergent work roles are included in this chapter, a short reflection on the nature of uniforms in the HCC

is interesting. Sylvia Plath (1963) — in her semi-autobiographical novel concerning mental illness and suicidal ideation — discusses the hierarchy of mental healthcare institutions and the experience of acting as a volunteer in such a hospital:

‘I felt silly in my sage-green volunteer’s uniform, and superfluous, unlike the white-uniformed doctors and nurses, or even the brown-uniformed scrubwomen with their mops and their buckets of grimy water, who passed me without a word’ (p. 155).

In this instance, work roles are depicted overtly via distinct uniforms worn in the healthcare setting. Congruently, Timmons and East (2011) highlight ‘uniforms play a key role in the delineation of occupational boundaries and the formation of professional identity in healthcare’ (p. 1035). Findings from the Timmons and East (2011) work demonstrate ‘how important uniforms are to wearers, both in terms of the defence of professional boundaries and status, as well as the construction of professional identity’ (p. 1035).

Interestingly, where topics of professional identity and purpose are discussed by this study’s interviewees, the notion of uniform is not included in their narratives. However, at the fieldwork site for this study, different uniforms *are* donned by members of NHS staff with dissimilar roles in the HCC (*e.g.* the administration staff, the HCAs, and the RGNs/RMNs all wear slightly different uniforms). Notably, the prison’s In-reach team do not wear orthodox clinical uniforms; instead, these members of the HCC wear non-standardised personal clothes. This aesthetic difference — that denotes clearly the primary and secondary clinical divide in the healthcare setting — is not discussed by any of the study’s participants.

Moreover, no reference is made by interviewees whatsoever to negative examples or experiences of clinical hierarchy in the interviews. However, this lack of reflection on role hierarchy in the healthcare setting does not necessarily equate to its absence. It is permissible that interviewees opt to not debate these issues intentionally, perhaps because the purpose of the interview is understood as not aligned with these issues. Furthermore, a different explanation is that participants select to keep these concerns or grievances *at* the HCC, as it were, as private problems for the healthcare team to debate and rectify in privacy. Alternatively, it is equally possible that the questions posed by the interviewer are not experienced by the participants as sufficiently prompting or encouraging of discussion regarding this aspect of clinical practice.

To link this sub-section regarding the HCC working environment and its subsequent, that explores communication in the setting, McMurrin *et al.* (2009) state:

‘treating patients in forensic mental health services is a team effort with various professionals contributing in different ways according to their areas of expertise ... Everyone working with a patient communicates with other members of the team to ensure a consistency of approach with any one individual patient. Working as a member of an effective and collaborative multidisciplinary clinical team can be very satisfying’

(p. 104, ellipsis to denote removed section).

As McMurrin *et al.* (2009) note, the following three features aid development of effective and satisfying team environments in forensic mental health settings: healthcare conceptualised as a team effort; diverse professional contributions valued; effective team communication embraced.

As the next sub-section exemplifies, this study's interviewees — who work in the prison's NHS HCC — narrate working lives that feature these aforementioned three facets.

Communication and co-operation

Gojkovic (2010) explores both Serbian and English prisons and the mental health services provided therein (paying particular attention to In-reach teams in the UK). An important aspect of prison mental healthcare provision, as discussed in the focus groups and interviews, is the nature of collaboration: 'interviewees emphasized the importance of communication and collaboration when dealing with a demanding and complex caseload' (Gojkovic 2010:176).

Congruently, informal yet frequent and amicable incidences of co-operation and communication amongst HCC staff are narrated by the NHS participants in this study. The notion of an amenable collaborative working environment in the prison's HCC is depicted:

Participant: What I would do, anything, any problem I have with a clinic, or any of the referrals, if I don't fully understand things, I can always go to X [the team leader] or the RMNs, and we work together.

Tuck (2009) stresses that nursing work involves emotional stresses and that complex working dynamics manifest in these healthcare organisations; furthermore:

‘working in organizations, whatever their size or task, has an emotional impact on those within them and few organizations are more emotionally

challenging than those tasked with the care of highly traumatized and traumatizing environments' (p. 43).

In relation to this study's healthcare locale, what are the complex working dynamics that Tuck (2009) argues present themselves in such clinical settings? To summarise, although the clinical working environment in the prison establishment appears eventful, dynamic, and convoluted (in a clinical sense), these complexities do not appear to be experienced as negative via HCC staff. A multitude of HCC-based experiences, interactions, goals, roles, and responsibilities are narrated by study participants, however these are not experienced as occurring in a complex, traumatic, or disconcerting fashion.

In relation to the working environment, effective team work appears important to participants. Communication and co-operation between NHS staff with disparate roles in the HCC is narrated as crucial to effective team work:

Interviewer: Good co-operation and communication seems crucial to good team working here in this Healthcare Centre, would you agree?

Participant: Yeah, definitely. It's a good working environment. It's a lot better than X prison, where all the work was done on the wings, so there wasn't a hub for healthcare staff [as there is here], so communication wasn't as good. So it is nice here, yeah.

Where necessary, RMNs refer mental health patients to In-reach; they act as service gatekeepers. This process appears to be working well and RMNs feel happy to seek clinical help and assistance from the In-reach team (who are experienced as open and giving in this respect):

Interviewer: Your referral process to In-reach, is that working well? Are you happy with the system?

Participant: I've never had any noticeable problems with In-reach at all. I just fill the form in and send it off. If I've got queries I can ring them up, or just pop into the office for help.

Interviewer: So relations are quite good between primary and secondary [mental healthcare]?

Participant: Oh yes, there's no problem there at all, I don't think.

Interviewer: So it's quite a nice working environment?

Participant: Very much, yeah.

This participant links unproblematic working relationships with the existence of a pleasant working environment in the prison's HCC.

Moreover, the nature of co-operation between the primary-level and secondary-level mental healthcare clinicians is reported as amicable and trustworthy. This relationship appears to be a requirement for apt provision of prison-based mental healthcare. The prison setting requires this form or collaborative working between the two forms of mental health service teams:

Interviewer: This idea of multi-disciplinary teams and skill differentiation, where people have specific roles, seems to be quite important here and working well, the working environment seems to be quite positive, yes?

Participant: I think, yeah, and it's really important because those patients, certainly those that need access to secondary [mental health] care, there is the need in this environment. After all, there is this drive to have services in-line with the community, which is great,

as we should be able to provide services in-line with the community, but it is different [here in a prison]. As, where somebody might have secondary [mental health] care input in the community where they manage their own medication, if they struggle, their CPN can go and help them out with that; whereas, in here, they [the secondary-level mental health patients/prisoners] access secondary care via scheduled appointments, but they often need a certain level of support from primary care, because we are [i.e. the HCC is] a twenty-four hour service in the prison, you see. In that respect it means, it means that secondary care [the SMHT] have confidence that they are going home for the weekend but they know they can pass that on [to the RMNs and RGNs] and the patient will still receive a certain level of input throughout the time that they're not here.

Teamwork is conceptualised as each clinician possessing a body of knowledge that they implement in the workplace; however, this is not considered to be a knowledge base with distinct impermeable boundaries, as sharing is discussed positively:

Participant: The [HCC as a] team works so well. We each have our own areas of expertise. We can pick up the 'phone and ask, or we can pop next door for advice and guidance, which we've done many a time. It works really well.

McMurrin *et al.* (2009) state the field of forensic mental health is affected negatively by previous high-profile incidents concerning mentally disordered offenders such as Michael Stone and Christopher Clunis; furthermore, 'what

appears to underlie many of these failings is the common factor of poor communication between the differing agencies and the professionals within them' (p. xi). Conversely, in relation to this study, communication appears to occur frequently and effectively in this particular NHS healthcare setting — according to those members of the HCC that offered to participate in the fieldwork.

Participant: I just like working with the team I work with. You're trusted to get on with your job. I could go to any of the team leaders and discuss any questions in confidence and they'll help me, so there are no problems.

The subsequent quote, from a member of the clinical management in the HCC, details further the nature of the working relationship between primary and secondary mental healthcare in the setting:

Participant: I think the model of care that we have is very good and the collaborative working between primary care and In-reach is really good: they can refer in, they can refer out, they can sit and talk about cases. They just work very well together. But also we've got really enthusiastic mental health nurses [RMNs] and I think that makes a massive difference. They enjoy working in the environment that they're working in and they have the opportunity to use their skills.

This interviewee links the notions of successful multiparty clinical endeavour with the existence of enthusiasm in the workplace; this links this sub-section

concerning collaborative working practice with the following sub-section regarding the workplace overarching goal.

As a postscript to this sub-section, Lewin and Reeves (2011) explore how teamwork is enacted in a NHS hospital setting. This interprofessional practice research concludes: ‘the study findings suggest that doctor–nurse relationships were characterised by ‘parallel working’ [e.g. ward rounds], with limited information sharing or effective joint working’ (p. 1595, apostrophes in original, square brackets added).

Initially, it may seem suitable to suggest that this prison NHS setting does not echo the NHS hospital setting discussed above, as collaborative work and knowledge transfer is narrated by participants in this study (*i.e.* parallel-only working is not the clinical model enacted). However, Lewin and Reeves’s (2011) reflection refers to working relations between doctors and nurses. Therefore, it is worth noting here that the majority of NHS HCC staff included in this study are RGNs, RMNs, HCAs, administration staff, and members of the In-reach team (*e.g.* CPNs) — not doctors (*e.g.* GPs)⁸.

Furthermore, the interviews are intentionally semi-structured in nature and questions posed continually develop throughout the course of fieldwork as a result of preceding interviews. Hence, as this NHS HCC participant grouping does not include a large proportion of doctors, the topics that doctors usually introduce are, relatively, lacking. Moreover, as the nature of both primary and secondary mental healthcare provision ‘at the coalface’ in the prison setting could be conceptualised as mainly nurse-focussed on a day-to-day provision

⁸ Although, this study does include psychiatrist and psychologist input.

basis, it is the patient/prisoner–RMN/CPN and RMN–In-reach relationships that appear important to study participants. Consequently, doctor–nurse relationships remain an absent topic from this thesis. Notably, it is recognised that this particular prison’s In-reach team does include further members (*e.g.* psychiatrist, forensic psychologist) and these clinicians do act as participants; however, generally, interviewees’ narratives focus on the two aforementioned relationships.

The following sub-section does not focus on specific relationships in the HCC; instead, the ethos of the working environment is addressed.

Overarching goal

Participant: I am very much patient-focussed with my role.

Participant: Nobody falls through the net, or, hopefully nobody falls through the net.

Overall, the NHS HCC in the prison appears to be geared towards excellent patient care first and foremost; patients’ welfare occupies the primary purpose of the HCC and this aura permeates the everyday working lives of its staff.

Participant: You’ve got to have a system of some sort so that you keep on top, be organised and have a system in place so that patients aren’t falling through the net.

Participant: There are systems in place so that we don’t miss anybody.

Tuck (2009) debates the concept of primary task. This term is analysed in relation to forensic health systems and healthcare setting organisational dynamics. The primary task of an organisation represents its primary pursuit (that must be fulfilled in order to maintain its survival). However, as highlighted by Tuck (2009), primary task is a convoluted concept that causes complications in organisations, ‘as different individuals and departments within the organization may have different definitions of the primary task’ (p. 45). However, the individual members of HCC staff involved in this study appear to share one overarching goal, or primary task, that is: *to prevent anyone falling through the net*. Moreover, Tuck (2009) notes that, in addition, ‘the views of the primary task held by those outside the organization may conflict with the views of those inside’ (p. 46). Once again, however, this is not the case in this study as HMPS, the MoJ, and the DH would likely support and encourage this ethos — that permeates the HCC as a professional and social setting.

In a confused system — such as Tuck’s (2009) theoretical medium secure psychiatric facility — the ‘ward manager described a sense of being pulled in every direction [without an overt primary task] ... As a result he was unable to complete the tasks he planned to do each day and felt he was no longer able to see the ‘bigger picture’ (pp. 46–47, square brackets not in original, ellipsis denotes removed section, apostrophes in original). In this example, the absence of a primary task for members of the healthcare setting contributes to communication problems and low morale on the ward (Tuck, 2009). This lack of healthcare staff internal stability, as debated by Tuck (2009), does not appear to exist in this study’s healthcare provision locale.

The prison HCC staff acting as participants share an intersubjective work goal (*i.e.* the concept of primary task exists): *to prevent anyone falling through the*

net. This phrase is repeated often in the NHS clinicians' transcripts. Furthermore, Tuck (2009) links primary task with effective communication and high morale amongst the healthcare team. This is also echoed in this study, as communication and morale both appear apt.

Lewis and Reeves (2011) explore ethnographically the nature of interprofessional relations in an acute healthcare setting and note 'interprofessional teamwork is widely advocated in health and social care policies' (p. 1595). However, Lewis and Reeves (2011) report 'the notion of teamwork, as a form of regular interaction and with a shared team identity, appears to have little relevance' (p. 1595) in relation to their fieldwork site. Whereas, the healthcare staff in this study's healthcare setting narrate the antithesis of Lewis and Reeves's (2011) findings, as teamwork is considered highly relevant — and this occurs amicably via regular interactions and the existence of a shared workplace conception of purpose: *to prevent anyone falling through the net*.

The work goal *to prevent anyone falling through the net* is laboured here. It may seem unusual that the NHS HCC's group desire to prioritise patient care first and foremost is highlighted as important in this study. After all, NHS staff are, more usually, expected or assumed to consider patients' welfare indispensable.

Therefore, conversely, it is actually the absence of custodial, punishment, punitive, or security offender-based thoughts, ideas, roles, perceptions, conceptions, and responsibilities that is interesting sociologically. It is the paucity of criminality-related terms to conceptualise patients — and their relationships with patients — that are crucial. The language utilised by HCC-based participants prioritises the notion of patient as social role, and not prisoner

as social role — although this is actually the reason for these patients' current social location (*i.e.* in prison). The overarching work goal is not surprising *per se*; however, when the treatment locale is considered, the shared healthcare delivery endeavour gains increased significance and importance.

To support this primary task analysis, Cashin *et al.* (2010) study forensic nursing practice in an Australian prison hospital and conclude nursing culture 'was found to be one of hope, although with no clearly articulated vision of nurse-hood or patient-hood and model within which to practice nursing' (p. 39). Therefore, Cashin *et al.* (2010) argue 'the ability to articulate practice is central to the development of mental health nursing in any context' (p. 39). This reflects positively on the HCC in this prison setting, as a communal workplace aspiration is articulated well.

The preceding sub-sections explore the working environment in the NHS HCC at the prison. At this stage, therefore, the work of Le Grand (1997) is useful and apt for inclusion. Le Grand (1997) discusses welfare provision and policy-makers' differing models of human motivation and behaviour in social policy-relevant situations. Notions of state largesse, public philanthropy, and social actors' self-interest and passivity are raised. Le Grand (1997) states:

'assumptions concerning human motivation and behaviour are the key to the design of social policy. Policy-makers fashion policies on the assumption that those affected by the policies will behave in certain ways and they will do so because they have certain motivations. Sometimes the assumptions concerning motivation and behaviour are explicit; more often they are implicit, reflecting the unconscious values or beliefs of the policy-makers concerned. Conscious or not, the assumptions will determine the way that welfare institutions are constructed ... It might

also be noted that these assumptions — or, more precisely the relationships between the assumptions and the realities of human motivation — are crucial to the success or otherwise of the policies concerned’ (pp. 153–154, ellipsis to denote removed section, em dashes in original).

Le Grand (1997) utilises three terms to categorise citizens: knights (*i.e.* altruists), pawns (*i.e.* inactive recipients of state charity), and knaves (*i.e.* egocentrics). In relation to preceding post-World War Two UK welfare strategies, alterations have now occurred, ‘from policies designed to be financed, and staffed by knights and used by pawns, to ones financed, staffed and used by knaves’ (Le Grand 1997:160); individuals are considered to be more likely self-interested than public-spirited. However, ‘our society regards altruistic or public-spirited behaviour as morally superior to self-interested behaviour’ (Le Grand 1997:162).

In relation to this study, the HCC’s team character and underlying approach to healthcare — as narrated by its employees — exemplifies an aura of altruism that is directed towards individual and distinct worthy social actors in need of, and deserving, healthcare. Moreover, these persons in need of healthcare are conceptualised as patients — their criminal justice system label (as prisoner) receives very little, if any, attention from these HCC-based workers.

How patients are conceptualised by the staff members in the NHS HCC is of relevance here as, if we utilise the work of Taylor-Gooby *et al.* (2000) that stems from Le Grand’s (1997) work as mentioned above, a link can be made between the HCC’s overarching goal and the notion of patient need. Taylor-Gooby *et al.* (2010) argue professional cultures (in this instance it is the professional values of dentists that are explored) ‘influence how practitioners understand their own

interests and those of their clients' (p. 375). There is a relationship between the professional culture of a healthcare setting and clinicians' understandings of patients' requirements.

Arguably, therefore, the overarching goal of this HCC is related to the healthcare setting's conceptualisation of its patients. Thus, that the security and custodial aspects of a patient's existence in the setting do not feature is important, as these prisoners are, instead, defined as patients with numerous and valid health needs who should be identified and offered healthcare: *to prevent anyone falling through the net*.

Therefore, it is possible to suggest that, if the social group in question (*i.e.* the prisoners in the host prison) were not understood to be wholly worthy persons with genuine healthcare requirements (*i.e.* as NHS patients are more usually defined), the underlying pursuit of the prison's healthcare setting may not be: *to prevent anyone falling through the net*.

To summarise, it appears there is a relationship between a shared overarching goal for a setting, its conceptualisation of involved social actors (*e.g.* patients, or consumers, or criminals), and then a setting's outputs — in terms of service provision (whether this be healthcare, or consumable items, or punitive action). Positively, this relationship in the host prison's HCC seems to be generating a workplace milieu beneficial for patients and their healthcare.

Removed sub-section

This sub-section title is peculiar, admittedly. This unusual sub-section is included as it represents important aspects of both this thesis' reflective nature

and of conducting fieldwork in secure settings that are somewhat shrouded with secrecy (*e.g.* prisons). Prior to submission of this thesis, a lengthy sub-section was included here concerning the NHS HCC, aspects of its physical layout, the nature of space usage by staff and prisoners, and how prisoners experience the clinical setting in comparison to prison wings. Both therapeutic community and healthcare/institutional environment literature were utilised to analyse the data. It is regrettable that this sub-section is removed; nevertheless, on reading the complete thesis it was considered necessary — by the social scientist who undertook the fieldwork.

To summarise the issue, the interviewees' quotes, the interviewer's questions, and the content of the resultant analyses perhaps permitted the specific prison establishment to be identified.

It should be noted that these sections of interview transcript (that were included in the now removed sub-section) were cleared for removal from the prison establishment by the host prison's Security Department and therefore permitted for dissemination. Notably, it was the social scientist's ethical decision to delete this sub-section of the thesis as a result of confidentiality and anonymity concerns for participants.

NHS developments in a prison setting

Where participants describe their work roles and responsibilities, the interview responses include a clear sense of pride. Moreover, evidence of autonomy coupled with flexibility in the workplace is exemplified — via a desire to develop work methods alongside the freedom to do so. These role and

responsibility developments occur at both *individual* clinician/employee level and also at clinical/administration *team* level.

The interview quote below represents a team level development example:

Participant: ... It's just that kind of role, you know, we're becoming, we're kind of developing, and we're quite flexible in terms of how we operate and how we refer to ourselves.

The excerpt below is taken from an interview with a member of the HCC's administration staff; this acts as an individual staff member example:

Participant: I've been doing it for probably two years now, me being in charge of it, and I've developed it my own way to make it easier to follow, so that nobody falls through the net.

Interviewer: So that's really interesting that you've, in a way, been able to develop your own regime, your own ways of doing the jobs that you need to do. So do you feel that you have enough personal freedom, as it were?

Participant: Oh, yes.

Interviewer: So if you felt there was a better way of doing something you'd be allowed to do it?

Participant: I'd be allowed to do it ... X knows she/he can trust me.

Interviewer: So you're given a task and then you can work out your own ways to complete it?

Participant: Yes.

Interviewer: So you don't feel like you experience any overt prison guidelines or constraints upon how you choose to operate?

Participant: No.

This particular member of the NHS administration staff has the permission and freedom to alter work methods — in relation to prescribed work roles — as desired, and is trusted to do so.

Autonomy in relation to professional roles is professed:

Participant: We have two very separate teams of mental health nurses [RMNs] and practice nurses [RGNs] and that means they can develop themselves and their own skills and their own roles.

Autonomy coupled with ownership, in relation to roles, is discussed by participants. A three-way relationship appears to exist between ownership, autonomy, and trust. HCC staff are given ownership of their roles, provided with a suitable degree of developmental autonomy, and are trusted to implement these changes)⁹.

Interestingly, the excerpt above notes that overt clinical distinctions exist in the healthcare setting, that differing clinical roles are kept separate intentionally, and that these are narrated in a positive sense. Notably, team work and relationships between professionals are reported in an optimistic fashion and this occurs in tandem with members of the HCC having distinct and defined roles and responsibilities. The differing skills sets of the members of the HCC (*e.g.* RGNs

⁹ *N.B.* These alterations in working practices, professional roles, and clinical skills all concur with DH and NHS clinical practice rules, regulations, *etc.* (*i.e.* this thesis does not report changes to healthcare services beyond the remit of official policy or guidance).

versus administration staff) are understood by staff; furthermore, these dissimilar bodies of knowledge are drawn on by the different staff members at the HCC.

In terms of the theoretical level of this understanding that is shared by staff in the HCC, this approach to the working environment does not occur at individual social actor level; instead, this working practice conceptualises HCC staff as professional and social groupings with clinical group titles (*e.g.* In-reach team, RMNs) with associated roles, responsibilities, and knowledge.

Hannigan *et al.* (2010) research myriad mental healthcare professionals' distinct clinical titles alongside the changing nature of their contributions to healthcare; fieldwork is conducted via two community mental healthcare teams in Wales, UK. Developments in roles and responsibilities are assessed in relation to ongoing DH and NHS policy developments. Hannigan *et al.* (2010) conclude 'the roles of mental health professionals [are] become increasing blurred' (p. 1, square brackets added). Conversely, for the NHS staff participants in this study, clarity of work boundaries is experienced. This contrast represents an example that the provision of community mental healthcare and the provision of prison-based mental healthcare are somewhat dissimilar endeavours.

De Dreu and West (2001) argue individual creativity and innovative ideas, alongside participation in team decisions, are positive aspects of organisations. Encouragingly, novel working methods and experiences of team inclusion are depicted via this study's participants. However, De Dreu and West (2001) highlight innovation and creativity result often from minority dissent in teams. Conversely, occasions of divergence or rebellion are not included in interviewees' transcripts in this study.

However, it is feasible that this study's interviews create/promote only positive narrations of participants' working lives that, therefore, exclude negative experiences or aspects of the HCC's working environment. For example, as the study is introduced to participants as an exploration of mental health and mental healthcare in the prison setting, it is possible that the interviews were not considered apt outlets for unrelated critique of team members (*e.g.* see footnote no. 10 overleaf). Therefore, it is not here suggested that all staff members at the NHS HCC in this prison experience wholly amicable working relationships, yet merely that the participants' narratives do not depict any negative issues explicitly.

Relations between the prison establishment, its HMPS staff, and the HCC and its NHS staff also affect the working environment at the HCC. 'Prison nursing is often complex. Working for one organisation (*i.e.* the PCT) within another organisation (*i.e.* the Prison Service) can cause conflicts, especially where resources are concerned. We are expected to abide by all the Prison Service rules, and work within the service regime' (Smith 2010:35). In this study, alterations and developments in the NHS HCC appear dependent on the HMPS situation and the co-operation of the prison establishment:

Participant: The only thing that's, not particularly a barrier, but does slow things down, is working in partnership with the prison. Now there's a positive there, in a lot of ways we work very well together, but there are sometimes, conflicting ideas. Things that I might think are good ideas for my team here [in the HCC] might actually have a significant impact upon other departments in the prison or the prison regime, and that can make things [in the HCC] quite difficult to develop, sometimes. It's clinic times,

timings of clinics, and access to patients [that are the issues] ... more than strategic development.

Notably, the HCC–prison working relationship is discussed in a well-balanced fashion here. The positive aspects are noted before issues that affect and can impede progress in the HCC. Poignantly, these matters are not depicted as impenetrable barriers, yet are conceptualised as occurrences that affect negatively the speed of change. The final section of the excerpt above reports improvement constraints are often not located at the management/strategic development level of the prison, yet are more micro-level and day-to-day regime. Constraints are discussed as procedural and routine related — and not in conflict with high-level management, development plans, and prison ideology. Frontline resources are the barriers, not prison government-level disagreement.

As a final example, HMPS staff as a resource seems to represent a significant constraint to developments in the NHS setting:

Interviewer: Other interviewees who're involved in management in this prison, that I've spoken to, have reported something that's quite positive, and that's the autonomy and the capability in this working environment to change a procedure, if they wish, so, for example, if they are managing something but formulate an idea that they feel would work better, they feel that in this, highly regulated, prison environment they actually have the capability and freedom to enact changes, is that something that you'd echo, or not?

Participant: You do, to a certain extent, as you're very governed by prison rules. I mean, for instance, when I have visitors come in, or locum GPs, erm, you have to really follow the strict guidelines,

and the problem we're having at the minute, although I know it's nothing to do with mental healthcare¹⁰, we're having trouble with hospital appointments and escorts ... we have to liaise with the prison to check there's enough staff, and they cancel, like they have today, erm, and then, it's just, we also have emergencies going out in-between. So, yes, I would say you can alter procedures in the NHS, but not if it involves the prison, as that's very restricted, many boundaries.

Interviewer: Do you think it's lack of officer staff as a resource in terms of the cancelled hospital escorts, or something else?

Participant: Yes. That's why we struggle. As each prisoner that goes out needs two officers. And then there's the risk assessment. So there's a lot of work involved in it. Because we have to complete a load of escort paperwork and a risk assessment. Detail with the prison and liaise with Security. The prison has to provide the officers to go, and, so it's all a bit of a nightmare, really.

Attention is now devoted to a separate concern of the NHS staff interviewees. This topic relates to healthcare appointments that are scheduled at the HCC, yet that are subsequently not attended by the listed prisoner.

¹⁰ HCC participants remember throughout the course of the interviews that this work focuses on both prison mental health and prison mental healthcare. Interestingly, participants often produce acknowledgements of study foci before discussing issues considered important yet not related directly. These utterances appear to act as apologies for inclusion of potentially irrelevant information and admission of possible unbecoming interviewee behaviour.

'Did Not Attend' as an issue

Participant: DNAs have been a problem. There seems to be a variety of reasons for that, and that wasn't always patient reasons. There can be issues around different officers [and escorts], no consistency. However, if the patient refuses to come there's nothing they can do about it ... Now when they've finished their appointment they [the prison officers that work in the HCC] take them [the prisoners] straight back to the wing, so they're not waiting around. So, for the patient that's coming to healthcare [the HCC], it's a more positive experience. So then the next time they don't mind coming, 'cause they know they're not going to be sitting in a chair for a couple of hours and missing gym. So, you know, it has been a problem, but it's been worked on, and there is a real improvement.

The HCC is attempting to reduce the occurrence of DNA recording. Time and effort on the behalf of NHS staff is evident:

Participant: ... We send appointment slips out, the day before, so that they know the next day they've got an appointment, so not to go to work, or whatever. Erm, what we're trying to do is look on the prison system to make sure they've not got court or visits, or things like that. So we work round that as well, to reduce DNAs.

Interviewer: Yes, access to prisoners/patients is something that's been highlighted by other interviewees as an occasional issue, a lack of

prison staff to actually escort prisoners to and from the Healthcare Centre, yes?

Participant: Yes, but that is being addressed now, because we're addressing the DNAs, for instance, as we've had a lot where they've been unable to be brought down, either for RMNs, clinics, GPs, but it's being amended again, so we're working on it, we are trying to address that now, so hopefully the DNAs will go down now.

Therefore, considering DNAs as valid patient choice is controversial:

Participant: Sometimes they come to the hatch on the wing and say they had a doctor's appointment yesterday but no one came to unlock them, so it's not necessarily their fault, but, you do often see on the system where it says 'refused' [i.e. a patient choice DNA]. I think it just comes down to poorly educated people who don't really understand the impact of their actions, for example the ramifications of not seeing an appointment through. They're just poorly educated people, really.

Irritation is displayed where prisoners choose to not attend their HCC appointments. This is not in reference to mental healthcare meetings alone, yet all health appointments:

Interviewer: You mentioned DNAs. Why do you think these occur?

Participant: There are legitimate DNAs where they're at court or similar, but the ones that don't come for whatever reason, I don't know why, it really is annoying, and an absolute waste, and I hate it. There's enough people waiting, on the mental health side, for help and

support and input, and then you've got some lackadaisical patient who's like, I'm off to the gym instead. It's infuriating.

Gym sessions appear linked with patient choice DNAs¹¹:

Participant: I think that if we're offering the service it's up to them whether they choose to take it up or not, but we're doing our best.

Interviewer: What are the general reasons for booking clinic time and then not arriving?

Participant: They might just go to the gym instead.

Furthermore, the excerpt above also displaces any DNA-related fault, blame, or responsibility from the HCC as a team/setting (*we're doing our best*) to the individual patient, as a result of choice to attend a gym session and not a healthcare appointment. This interviewee is keen to stress that the prison's HCC intends to provide the best possible healthcare services, and therefore in this instance, it is the patient's actions that affect delivery of care — and not failings at the HCC.

Comparisons are drawn between the swiftly available free healthcare available in the prison in relation to NHS care in the community.

Interviewer: What about DNAs where it's the prisoner who's opted to not come over?

¹¹ Interestingly, the gym, as a highly desired and valued prison activity and locale, appears frequently in this thesis' analysis chapters.

Participant: ... Sometimes, yes, they'll just refuse point blank. Which, I've got to say, is very irritating. When so much work has gone in to get him these appointments. At the end of the day, they do get all these services free, and very quickly. I mean, if you wanted to see someone in the community, you either have to pay, or you have to wait, and in here you don't.

To reiterate, opportunities for exercise and gym usage (alongside visits) appear occasionally preferable to clinical appointments:

Interviewer: DNAs, why do these occur, do you think?

Participant: I think they prefer the gym and going for exercise, plus visits, and things like that. We do re-book for visits and court, and the like. We don't re-book for gym.

Interviewer: Do you think anything can be done about DNAs?

Participant: I suppose we could be more flexible. I don't know how we could be more flexible. We could offer, I don't know, ask them what their preferred time would be, but I don't know, what if they all want the same time, to avoid missing exercise. Unless we altered our clinic times, but that wouldn't work with the prison regime.

This RGN suggests increased flexibility may be an option to reduce DNAs. This displays a desire to decrease DNAs via a route that benefits prisoners first and foremost. This approach to the delivery of healthcare is exemplified via the transcripts from the HCC staff as a professional grouping. The prisoners' health needs — and their more general needs, desires, and problems in the penal milieu — are important and influential for the HCC staff in this study. The excerpt also stresses, once again, the importance of gym usage for prisoners. However, the

professed potential change to clinic times is then problematised, as it is believed that the HMPS regime may not allow for this proposed alteration.

Prisoners with mental health problems

Participant: If they're locked up in their cells all day, I'm always frightened they might harm themselves, or something, so that's why I like to keep on top of things.

'Prison nursing is demanding as it involves dealing with people who have multiple, complex needs' (Smith 2010:35).

Participant: The other week we had a patient up here, who has huge mental health problems, and, erm, he suddenly came into the [administration] office, saying someone had to help him. He thinks he's got a worm growing inside of him, he'd gone into the toilet and tried to use a razor blade to cut it out. I believe he's now been sectioned [under the Mental Health Act, 1983/2007], he needs help, we realise that. What I do say is, what I've always said is, half the prisoners in here shouldn't be in prison, it's not the correct place for them, as many have huge mental health problems, and you don't realise until you work in a prison how many prisoners there are with massive mental health problems, and it's not the right environment for them, it's just not, and it's of no use locking them up here. I personally think a huge majority of them [the prisoners with mental health problems] shouldn't be in here.

Three aspects of this excerpt are sociologically interesting. Firstly, this member of the HCC administration staff expresses the working environment-based notion that the mental health of prisoners is the responsibility of the HCC as a whole healthcare delivery team and centre (and not the responsibility of just their assigned RMN or In-reach/SMHT worker): *he needs help, we realise that*. The provision of apt and effective healthcare is understood to be a group pursuit that involves all members of NHS staff — with their disparate roles — working together¹².

Secondly, the participant states that HMPS is not the correct public service to house those with significant mental health problems. Thirdly, a note on the intensity of mental illness in the penal milieu: the interview excerpt above acts as a pertinent real-life reminder regarding the severity of mental disorder that exists in the UK's prisons.

Poignantly, where issues that influence mental health are raised, these are often framed as structural facets:

Participant: ... Being locked up the hours that they are locked up, that's not going to be conducive to their mental health.

¹² It is worth noting here that when participants — who either belong to the In-reach team or work as RMNs — are asked to discuss the nature of the divide between the primary and secondary level mental healthcare clinicians, no acrimonious comments or professional hierarchical claims are professed; instead, the distinction is depicted as an effective boundary, as a mechanism for ensuring patients with certain levels of mental health severity typify the two patient groupings for the two levels of mental healthcare provided. The divide is narrated as a successful instrument to facilitate best possible healthcare routes for patients and appropriate patient groupings for the clinicians.

In addition to the time spent in cells daily, the extent of physical and mental health need in the penal setting alongside temporal facets (e.g. specific Gregorian calendar months) are important. Smith (2010) reports:

‘prison nurses have to care for prisoners in an environment that is not medically based and who have a wide variety of needs, including illness, physical trauma (mainly as a result of fighting), disability, age-related health issues (elderly prisoners), mental health needs (including those who use self-harm as a coping mechanism), and learning disability. At times it can be traumatic. ... [For prisoners] anxiety, depression and self-harm are commonplace, especially at certain times of year, particularly Christmas’ (p. 35, ellipsis to denote removed section, square brackets not in original).

Certainly, occasional incidences of patient/prisoner mental health trauma are recounted in staff narratives; however, in relation to mental healthcare generally, HCC employees consider service provision apt:

Participant: Here, in this prison, in terms of mental healthcare, I don't think there's much more that could be done, if I'm honest. I think they [the prisoners] receive excellent mental healthcare, if they need it. Very good primary, and then on to In-reach if they need it. I think, in terms of mental healthcare, access to services and the actual care is better in here [the prison] than in the community.

Mental health clinicians praise the current nature of mental healthcare delivered:

Interviewer: So, to discuss the primary mental healthcare that you deliver, which aspects do you think are working particularly well?

Participant: All of it ... Yesterday I had a [primary mental health] clinic of three, they were all brought on time, they all had their allotted time each, it was just, ideal. Nearly thirty minutes of one-to-one, then a few minutes typing it up, then on to the next patient.

This interviewee, a RMN, narrates the importance of institution-related aspects to the delivery of effective and efficient healthcare. Above, it is demonstrated that when patients are escorted — by HMPS staff — to the HCC aptly in preparation for their allotted time, clinics run smoothly in a temporal sense. This facet of time appears important to the daily running of the HCC in the prison context.

Prins (1995) argues ‘those deemed to be mad and bad will always find themselves at the bottom of the social priority pecking order, because mentally disordered offenders, who often fail to fit neatly into societal categories, are the people nobody owns’ (p. 44). Whilst this may be the case in other social, policy, or healthcare settings, this analysis does not fit with the NHS HCC in this study. The HCC staff do not narrate mental health patients (*i.e.* prisoners) as adopting a low social standing in the environment, in fact quite the opposite, as immense health-orientated concern and attention is expressed for, and devoted to, this group of healthcare users. Furthermore, a lack of ownership for these offenders with mental health issues does not exist; instead, pride is taken from the provision of apt mental healthcare. Therefore, although Prins’s (1995)

conceptualisation of mentally disordered offenders may be accurate in some settings, it is not the case for the HCC in this prison.

Furthermore, whilst discussing the organisation of healthcare, Bradby (2009) notes 'how the NHS is somewhat unresponsive to patient needs and changes in clinical practice' (p. 161). Although this may be the case across some parts of the NHS more generally, the participants in this healthcare setting are interested in both highlighting and responding to patient need.

Old Guard versus New Guard

At the beginning of this sub-section it should be noted that these two terms, old guard and new guard, are not the interviewer's creation. Instead, these two age-related concepts — that pertain to HMPS staff — are introduced by study participants. However, it should be made clear that the interviewer does utilise these labels in interview questions, yet these interviews occur subsequent to the introduction of the expressions to the study by its interviewees.

Furthermore, during the conduct of the fieldwork, the interviewer does not experience any problematic dealings with the Security Department of the host prison in relation to the content of interview transcripts (that must be reviewed in order to permit removal from the establishment). However, on just one occasion, an informal verbal comment from a member of the Security Department is raised with the interviewer via the Research Contact in the prison (a HMPS Psychologist). To summarise the unofficial enquiry — as understood by the interviewer — the terms old guard and new guard are queried with, perhaps, a hint at their inappropriateness or the establishment's unease with the interview topic. The interviewer's response — outlining that the labels are used by

interviewees and are not included in the interviews by the interviewer in a biased or leading fashion — concludes the matter and no further action occurs in relation to transcripts' content. Therefore, this reflection is not included in the thesis as a significant issue or an important aspect of the study; rather, it is alluded to briefly as it is interesting to reflect on the one interview theme that is questioned casually and momentarily by the prison's Security Department¹³.

Interviewer: What about any sort of distinction between the old guard and the new guard, two terms that have been used by other interviewees to refer to an age distinction between wing officers, is this something you're aware of?

Participant: I would say the older ones [wing officers] don't understand mental health, and hold the attitude that prisoners are here to be locked-up and punished, and that's it. I know, from speaking to older officers, they feel that prisoners now get a lot of help and privileges and it's not always appropriate. I would say, yes, it's an age thing, definitely. The younger ones [wing officers] are more aware of how they can help them [the prisoners], more keener in terms of safer custody, to prevent violence and suicide in prisons generally ... As you know, we had a prisoner who committed suicide recently, so it'll be interesting to see what happens there, as, apparently, he wrote a long suicide note blaming some of the officers, but I don't know if this is true, just heard it through the grapevine, as it were. Must be horrendous if you're one of the officers involved. I wouldn't want that on my

¹³ To add credence to this definition dichotomy at the beginning of its sub-section, HMPS staff *themselves* discuss a distinction between traditionalist guards and newer recruits (*i.e.* it is not just NHS staff and prisoners that utilise these terms).

conscience. So, I'd say the younger ones [wing officers] are better, yes, more sympathetic and empathetic [in relation to prisoners' mental health issues and resultant effects].

It should be noted that this interview transcript has been cleared for release from the establishment by the Security Department at the host prison. Therefore — from a security/HMPS/MoJ perspective — it is acceptable to disseminate and discuss the aforementioned self-inflicted death. Notably, the interviewee is careful to explain that the inclusion of specific prison wing officers in the prisoner's suicide note is unconfirmed. This thesis reiterates the unofficial nature of this narrative.

Where NHS staff are questioned regarding the length of prison officer service, the below two extracts exemplify responses:

Participant: It is the case [there is an age disparity]. They remember the old times, you know, way before methadone [often used in prisons as a heroin substitute/detox. medication]. They are not interested in healthcare whatsoever. They don't think they [the prisoners] should be entitled to it.

Interviewer: Is that problematic in your opinion?

Participant: Well, it's not right, as anyone could make a mistake and end up in prison, and they will need healthcare. But they've been here years, and that's what they've been told, and always done. That's how they had to be, before [the introduction of NHS healthcare to the prison system]. They were trained like that, and now we're telling them they need to change.

Interviewer: ... Do you perhaps notice any difference between the younger officers and the older members of staff?

Participant: The old school, oh yes. I observed that from walking through the door on the first day. You've got the old school. Certainly you've got the new starters who do seem a bit more sympathetic and do seem a bit more switched on, really.

Notably, this situation regarding length of professional career is not specific to the prison context alone. For example, Shaw (2004) demonstrates how well-established general practice doctors with a long history of clinical endeavour can often be seen as less tolerant than their younger colleagues.

However, in contrast to the age peculiarity narrated above, one RMN does not draw an age distinction between HMPS staff. Instead, a difference is highlighted between the overt hierarchical levels of prison service staff in the establishment. To summarise, wing governors and other senior member of HMPS staff are considered to be more interested in mental health, in comparison to frontline wing officers:

Participant: The senior officers are much more, what's the word, more tolerant, more open to it [mental health issues and effects]. Less prejudiced.

Here, seniority in the prison and hierarchical working roles are outlined as distinguishing features between prison service staff and their approach to prison mental health, and not age, as discussed previously. Furthermore, the excerpt below demonstrates that this member of HCC staff (who is a part of the administration team) experiences several wing staff as embracing healthcare to

be part of their working roles amicably without mentioning an age dichotomy whatsoever in the interview:

Interviewer: So the wing staff seem equally interested in the provision of good healthcare?

Participant: Yeah, I mean, I don't know if it's all wing staff, but I know the ones that do [have an interest in apt healthcare provision], as I've dealt with them.

However, this interviewee — quite correctly — notes that this interest in healthcare may be relevant to only the wing staff she's/he's worked with. This reflection makes sense, as only prison staff interested in prisoners' (non-emergency) health needs would ring and report concerns to the HCC. Notably, this is not a suggestion that any HMPS staff would ignore any prisoners' emergency healthcare needs; neither does this thesis intend to suggest that any HMPS staff neglect prisoners in their care in a serious manner. This reflection, from a member of the HCC, relates to non-emergency issues (*e.g.* primary-level mental health problems, general healthcare concerns). Crucially, this study participant makes no reference to the age of wing staff.

The interview excerpt below aptly concludes this sub-section, as it makes clear that the concept of a healthy prison is gaining momentum in HMPS and that the situation in relation to the importance of healthcare in the penal setting is proliferating slowly, yet positively and incrementally. Prison Governing Governor support is highlighted as existent and influential; however, the transfer of agenda to frontline HMPS staff is depicted as a convoluted and time-consuming pursuit.

Participant: I actually think, that, from a strategic point of view, certainly on the level of the [Governing] Governor, there is this real drive to promote healthy prisons. Promoting good mental health is really high on that agenda, which is great for us, but feeding that down through, you know, management level to prison officers, can be quite a long and difficult task. I think that it has improved, I mean, I've been here for X [several] years now, and I've noticed a huge improvement in the attitudes of the officers towards health. I just think that these things take time.

Chapter conclusion

Participant: Well I think the healthcare that they get here is very good, I do. Everything is very well catered for. Their requirements, I think, are met. I can't think of anything that would make their life better, really and truly, in terms of healthcare. Everything is provided. I'm talking about across the board [in relation to healthcare], in the Healthcare Centre and on the wings. I think they get the finest of care in the Healthcare Centre, I really do; I think they get five star treatment. There's everything here for them.

This chapter of the thesis explores the HCC staff interviews. The chapter contains ten sub-sections; crucial points from these shall now be summarised briefly.

In relation to working with patients/prisoners, NHS employees experience enjoyment and feel secure in the clinical setting. Instead, it is aspects of the institutional working environment that are recounted as occasionally

unpredictable, and not the behaviour of, or the nature of work with, the individual prisoners. Security/safety incidences are accepted to occur in the prison and staff are trained well for these occurrences. However, these incidences are narrated as somewhat distanced from the HCC and its day-to-day work with service users/prisoners.

Regarding involvement and enthusiasm in the workplace, interviewees depict their working lives as a team pursuit that is conducted in a passionate manner. A shared notion of optimum health service provision exists. In relation to service delivery, capability at work is professed by healthcare clinicians; staff appear happy and adept to fulfil their numerous ascribed roles and responsibilities. The working environment is narrated as both effective and affable. The delivery of healthcare is conceptualised as a team effort necessitating diverse professional contributions and effectual team communication. Informal yet frequent and amicable incidences of co-operation and communication amongst staff subsist; the notion of an amenable collaborative working environment in the prison's HCC is depicted. Efficient and concise work is required swiftly in this clinical milieu and interview narratives profess personal fulfilment of these requirements. Teamwork is conceptualised as each clinician possessing a body of knowledge that they implement in the workplace; however, this is not considered to be a knowledge base with distinct impermeable boundaries, as sharing is discussed positively. Interestingly, where the topics of professional identity and purpose are discussed, uniform is not debated; furthermore, no reference is made by interviewees to negative examples or experiences of clinical hierarchy in the interviews.

Positively, autonomy coupled with ownership, in relation to roles, is discussed by participants. A three-way relationship appears to exist between ownership,

autonomy, and trust. HCC staff are given ownership of their roles, provided with a suitable degree of developmental autonomy, and are trusted to implement these changes.

The HCC is attempting to reduce the occurrence of DNA recording. Time and effort on the behalf of NHS staff is evident. Gym sessions appear linked with DNA incidence.

Where issues that influence mental health are raised, these are habitually framed as structural facets (*e.g.* time spent in cells). In relation to mental healthcare generally, HCC employees consider service provision apt and beneficial.

Overall, the NHS HCC in the prison is orientated towards excellent patient care; patients' welfare occupies the primary purpose of the setting and this aura permeates the everyday working lives of its staff. The absence of custodial, punishment, punitive, or security offender-based thoughts, ideas, roles, perceptions, conceptions, or responsibilities is noteworthy. The HCC's team character exemplifies an ethos of altruism that is directed towards worthy social actors in need of, and deserving, healthcare. Moreover, these persons in need of healthcare are conceptualised as patients — their criminal justice system label (as prisoner) receives very little, if any, attention from these HCC-based workers.

Finally, relations between the prison establishment, its HMPS staff, and the HCC and its NHS staff also affect the working environment at the HCC. Alterations and developments in the NHS HCC appear dependent on the HMPS situation and the co-operation of the prison establishment. However, constraints are discussed as procedural and routine related — and not in conflict with high-level management, development plans, or prison ideology. Frontline resources

are the apparent barriers, not prison government-level disagreement. Where HMPS staff are discussed, two dissimilarities are professed; firstly, an age disparity is highlighted and, secondly, a distinction is made between those who take a specific interest in healthcare and those who do not.

To finish this chapter, a reflection regarding pride, community ethos, and the notion *the will's there and the skill's there* is poignant (and fitting, as it permeates interviewees' narratives). The HCC is understood by study participants to be a physical site of appropriate healthcare expertise and apt healthcare delivery desire. *The will's there and the skill's there* appears to represent a shared attitude at this prison's HCC. This approach permeates both the social nature of the working environment and the approach to healthcare delivery adopted in this specific clinical setting.

Where clinicians narrate this workplace ethos, a sense of pride is also included in their accounts. Smith (2010), a prison RGN, states 'I am proud to say, I love my job' (p. 35). Congruently, pride is exemplified via the narratives of the HCC staff in this prison study:

Interviewer: Sounds like you take quite a lot of pride in your work?

Participant: I do, yeah.

Jones and Fowles (1984) argue that the nature of the community in an institutional environment 'determines the nature, number and quality of its staff' (p. 201). This chapter of the thesis exemplifies a staff community that takes pride in creating a quality healthcare team with an underpinning nature that prioritises — primarily — individualised and best possible healthcare for patients.

Participant: The group goal for best possible care is crucial. They get what they need. It's a first class service, in my opinion.

Finally, therefore, the work of Patterson *et al.* (2011) can be utilised to construct an appropriate conclusion for this chapter of the thesis. Patterson *et al.* (2011) explore culture change initiatives in the NHS; ‘organisational culture is seen as key to health care quality and performance in the NHS’ (p. 2). Patterson *et al.*’s (2011) study is underpinned by Nolan *et al.*’s (2006) care delivery model — the Senses Framework. This theoretical structure explores environments and stakeholders’ experiences via six senses: ‘security, belonging, continuity, purpose, achievement, and significance’ (Patterson *et al.* 2011:2). It is argued that ‘an enriched work environment’ (Patterson *et al.* 2011:3) where healthcare staff experience these aforementioned six senses can aid the creation of enriched care environments for patients — with numerous positive ramifications. The host prison’s NHS HCC arguably represents a healthcare setting where, generally, the NHS staff (myriad roles and responsibilities) recount, experience, and even enjoy the notions of security, belonging, continuity, purpose, achievement, and significance at work. In support of Patterson *et al.* (2011), Koskinen *et al.* (2011) also argue that nurses benefit from, and engage with their work and mental health training better, when a ‘feeling of belonging’ (p. 1) is experienced at their work placement locale.

Patterson *et al.* (2011) debate the link between climate of care (as understood by staff) and quality of care provided (as understood by patients); where healthcare teams report both a shared philosophy of care and high levels of task support amongst team members, positive climates of healthcare for staff and patients can be enabled and sustained. These two constructive facets (*i.e.* shared philosophy of care and experienced team support) are reported by the HCC staff members in

this study. Overall, this thesis chapter represents a positive account of this particular prison-based healthcare locale — as narrated by the NHS staff who acted as interviewees.

Attention is devoted now to the patients'/prisoners' perspectives concerning the mental healthcare delivered by the host prison's NHS HCC.

Chapter 5

'As health care professionals we spend much of our time (with the best of intentions) planning, implementing, and evaluating care. While we try to involve patients as much as possible in this process we rarely have the opportunity to later reflect with our patients their experience of the care they have received'
(Roberts and Clarke-Moore 2009:211).

Patients'/prisoners' perspectives

This chapter of the thesis considers the patient/prisoner interviews. However, prior to the analysis of transcripts, several matters are worthy of address. Firstly, the awkward term patient/prisoner is used throughout this chapter. It is recognised that this may become irksome for the reader; however, it is considered important that the interviewees are remembered to be both patient and prisoner throughout the discussions, as these two aspects of their existence should not be deliberated as distinct or disassociated; participants' experiences as mental healthcare users are inextricably linked to the nature of their existences in the prison setting, as social and institutional aspects of the prison environment affect mental health and mental healthcare.

Secondly, the difficulties encountered attempting to arrange these patient/prisoner interviews cannot be overstated. The prison environment is not a flexible, manageable, or straightforward site for social science fieldwork. In this study, the diminutive social scientist power and influence is experienced throughout the course of the data collection period and at all stages during the conduct of sociological work in the prison setting. For example, on several occasions, the interviewer travels to the prison (without mobile telephone, laptop,

or data sticks), enters the establishment in accordance with the numerous security procedures, accesses the Psychology Department and the HCC, to then discover that the patient/prisoner shall not be escorted over to the HCC that day, or that the patient/prisoner has a court appearance or a personal visit. These issues are not raised as a critique of the NHS HCC, HMPS staff members, or the study's participants, yet merely to demonstrate the absence of social scientist organisational power or institution-relevant knowledge in the specific fieldwork setting for this thesis.

Notably, the patients/prisoners in this study appear exceedingly willing and keen to participate. One particular patient/prisoner reports that, as he receives no visits (*i.e.* meetings with friends/family from wider society), he appreciates any unusual activity, such as the interview process. The eagerness of patients/prisoners to participate in the study is considered relatively surprising, as recruitment can represent a problem for social scientists. Indeed, the patients/prisoners approached concerning participation in this study display significantly more readiness to be interviewed than the other social groups (*e.g.* prison staff). However, this is arguably unsurprising, as the other participant groupings are employed by the establishment and are charged with numerous work roles and responsibilities. Notwithstanding this aspect, the patients/prisoners display an unexpected enthusiasm to participate.

Despite this, on occasion, features of the social science interview process seem unfamiliar or uncomfortable for the patients/prisoners. For example, one secondary-level mental health service user is distressed by the visible audio recording device, so this is hidden from view under a table. Furthermore, in some instances, the literacy skills of the patients/prisoners are not aligned with the language content of the study's Participant Information Sheet and the

Consent Form¹⁴. Where this arises, all aspects of both forms are explained verbally to, and discussed with, the participant to ensure apt communication and understanding of the information.

All of the topics discussed in this chapter are considered in relation to their relevance and fit across the patients'/prisoners' transcripts as an entire body of data (*i.e.* deviant case analysis). Where complication or deviation exists, this is debated in the main body of the chapter; there is not a specific section dedicated to variation or anomalies.

Throughout the chapter — as part of the array of methods utilised in an attempt to protect participants' identities in this study — the gender of the clinicians discussed by patients/prisoners as detailed in interview quotes is neutralised.

The label In-reach is used in the patient/prisoner interviews and therefore appears in interview excerpts in this chapter, as patients/prisoners are familiar with this title and do not appear to refer to the NHS grouping as the Secondary Mental Health Team; however, it should be remembered that Secondary Mental Health Team is the current official DH/NHS term for the clinical team in this prison establishment.

Secondary-level mental health service users are interviewed in rooms on prison wings in the presence of their clinicians (*i.e.* a member of the SMHT); whereas, primary-level mental health service users are interviewed in rooms in the HCC in the presence of their clinicians (*i.e.* a RMN).

¹⁴ The content of the study's documents is dictated largely by HMPS Psychology REC guidelines, plus the requirements of the prison's Security Department (*i.e.* not the social scientist).

In general, the NHS clinicians remain verbally absent from the transcripts; however, their body language during the interviews and their physical presence in the interview rooms does affect significantly the interviews, although the ramifications are considered mainly positive (as discussed subsequently in this chapter). It is recognised that these data (*i.e.* body language and non-verbal interactions between clinician and patient/prisoner) could have been collected, as non-verbal social behaviour can be video recorded and subjected to video analysis in qualitative social science research (see Heath *et al.*, 2010). However, the utilisation of visual recording techniques for research is (generally) not permitted inside the UK's HMPS establishments. Finally, as both primary- and secondary-level mental health service users act willingly as participants, the following observations relate to RMNs and SMHT clinicians (*i.e.* both primary and secondary mental healthcare professionals). Social relations are two-way (at the very least) interactions. This section details only the experiences of the patients/prisoners, and not their clinicians. It is, therefore, a one-sided report of the clinician–patient/prisoner relationship. Notably, the clinicians' interpretations of the interactions are not recorded or explored here. However, this is not problematic inherently, yet it is a knowledge boundary that should be recognised and remembered.

In terms of construction, six sub-sections structure the interview topics to be explored in this chapter:

Clinician–patient/prisoner rapport;

Opinions concerning mental healthcare received;

A new NHS setting;

Prison wing to Healthcare Centre escorts;

Prisoner–prisoner relations and mental health;

Patients'/prisoners' perceptions of wing staff and mental health.

The following label precedes numerous sections of the chapter: Method/methodology reflection. This label signifies a discussion that explores aspects of the study that are not related directly to interview content; it is, instead, a reflection on facets of the fieldwork's conduct, study design, and interview method. To summarise, this chapter debates both interview data and the processes of their creation¹⁵.

Clinician–patient/prisoner rapport

Interviewer: So you make use of the mental healthcare here, at primary level, so you work with X [his clinician] here, what aspects of that do you find useful, or enjoyable, or, what do you feel is working well for you?

Participant: Just discussion. Discussing things. Like, how I feel, and [trails off]

Interviewer: So, it's almost as if you like having someone to talk to, that's what you find beneficial?

Participant: Yeah, yeah.

Interviewer: So, you must have a relatively good rapport, a good relationship, with X?

Participant: Yeah, yeah.

(Comments in square brackets added by analyst.

X indicates the removal of a name or a similar identifiable detail.)

¹⁵ This distinct separation of interview content from method and methodological reflections is adopted as it is fitting for the prisoner interview discussions, yet also as a result of reading Mol's (2002) work (*i.e.* an exploration of ontology in medical practice via an examination of the ways medicine enacts the disease entity atherosclerosis) that disseminates knowledge in this split-style manner — with an upper text (research data analyses) and a subtext (theoretical debates) that spans the length of the book.

Method/methodology reflection: This excerpt is selected to commence the subsection as it demonstrates three aspects poignant to the patient/prisoner interviews. The nature of the interviews with patients/prisoners is markedly dissimilar to the nature of the interviews with other social groups (*e.g.* HCC staff) involved in the study. Three aspects of this are demonstrated above. Primarily, the first question posed by the interviewer appears long and unstructured, plus it also presents multiple questions to the participant. This can be regarded as a relatively poor interview question. However, what the above quote does not demonstrate is the temporal aspect to the interviewer's lengthy utterance. The convoluted question is not vocalised swiftly; rather, the interviewer speaks slowly and elaborates the nature of the question at multiple points in response to the participant's non-verbal communication. Each comma in the question can be considered an attempt by the interviewer to re-introduce the topic or purpose of the question (as a result of the participant's body language). This occurs frequently in the patient/prisoner interviews. Other participant groupings (*e.g.* prison governors) recognise immediately the topic and purpose of interview questions; however, patients/prisoners appear often to be unsure or unfamiliar with aspects of interview questions, and the interviewer re-phrases multiple times.

This should not be considered a suggested flaw of the participants, yet rather a failure on the part of the social scientist. The clinical and academic language utilised by the interviewer is often seen to be inappropriate for the patients/prisoners involved in this study. For example, the concept rapport is familiar to both healthcare clinicians and prison staff due to the nature of their occupations and training; however, this concept is seemingly less familiar to patients/prisoners. There is no indication of correct or incorrect possession of

knowledge intended here, yet the differentiation in vocabulary, terminology, and language utilised by the dissimilar social groups in the prison setting is evident in the interviews, and it is the fault of the interviewer that the questions are often lengthy, re-worded, or pose numerous questions.

Method/methodology reflection: Secondly, the participant's initial utterance concludes with *[trails off]*. It is relatively common in the patient/prisoner interview transcripts for participants to construct short (and descriptive only) answers that end abruptly, trail off, or are not complete sentences. Furthermore, experiences and opinions are professed yet an explanation or analysis of the situation under discussion is not often offered. This contrasts with other social groups of participants who regularly detail an issue and then provide possible reasons for its occurrence. Once again, this aspect is not regarded as problematic for the study or an error of the participants, yet it does highlight the familiarity versus unfamiliarity of the distinct participant groupings involved in this study in relation to the purpose, nature, and intended outcome of social science interviews of this nature. Prison governors, for example, recognise that when asked to debate an issue — in this form of social science interview — the interviewer is usually asking about its descriptive facets, yet also perceived reasons for its presence and suggested resolutions to its existence.

Method/methodology reflection: Thirdly, the patient's/prisoner's second and third responses are merely one-word confirmations of the interviewer's suggestions (concerning good clinician–patient/prisoner rapport). This short yet positive affirmation is worthy of consideration, as it is possible that the participant does not identify genuinely with the content of the question yet, rather, responds positively to the interviewer's optimistic tone or encouraging body language. Moreover, it is unlikely that a patient/prisoner would critique

overtly his clinician in her/his presence (particularly in a custodial environment). However, the analysis process and the conduct of fieldwork in this study is undertaken by the same social scientist; therefore, knowledge from the interviews (beyond the transcripts alone) is utilised to enrich and develop the analysis (as the unaccompanied written transcripts are considered meagre and bare, and do not detail the experienced human–human interaction). In this example, therefore, it is evident throughout the interview as a whole that the patient/prisoner does experience an excellent clinical relationship with his healthcare professional. This is, however, demonstrated via both (recorded) audible speech and (unrecorded) body language.

To return to the content of the patient/prisoner interviews: overall, the interview data suggest patients'/prisoners' relationships with their mental healthcare professionals are important, working well, and valued highly.

Personal affection and admiration, plus praise for mental healthcare staff, are demonstrated via the transcripts:

Participant: She's/He's a brilliant person. I've got nothing but praise and high regard for X [his clinician].

The patients/prisoners report an enjoyable and easy therapeutic rapport with their clinicians.

The notion of rapport refers to the nature of a relationship; good rapport is associated with the following attributes: mutual trust, emotional affinity, agreement, understanding, and sympathy. Positive rapport often represents an

effective connection marked by commonality of interests (e.g. mental health difficulties) and pursuits (e.g. treatment plans).

Meetings with the mental healthcare professionals are regarded by patients/prisoners as beneficial in a mental health sense, yet also relaxing in a social interaction sense. It could be argued that this is relatively unsurprising. For example, the relaxation facet is particularly evident when the individual interview transcripts are considered as entire excerpts, as the narrated nature of prison life is depicted as the antithesis of relaxing (e.g. social tension on prison wings).

The nature of clinician–patient/prisoner interactions are perceived as notably dissimilar to other relationships in the prison setting (e.g. wing officer–prisoner). The demonstration of care is a fundamental demarcation:

Participant: ... working with people who care ...

Participant: I think people that care ... try to understand a bit more ... put more effort in.

(Ellipses added by analyst to denote sections of transcript removed).

Interviewer: So is it almost as if they have a desire to understand?

Participant: Yeah.

Here, the clinician's caring characteristic is then linked to healthcare-related effort, desire, and understanding. The healthcare professionals are depicted as

practicing their clinical skills in accordance with a culture that prioritises the caring aspect of their professional role.

Helman's (2007) medical anthropology tome — that explores 'cross-cultural issues in health, disease and medical care' (p. *ix*) — defines the concept of culture as:

'a set of guidelines (both explicit and implicit) that individuals inherit as members of a particular society, and that tell them how to view the world, how to experience it emotionally, and how to behave in it in relation to other people, to supernatural forces or gods, and to the natural environment. To some extent, culture can be seen as an inherited 'lens' through which the individual perceives and understands the world that he inhabits and learns how to live within ... Cultural background has an important influence on many aspects of people's lives, including their beliefs, behaviour, perceptions, emotions, language, religion, rituals, family structure, diet, dress, body image, concepts of space and of time, and attitudes to illness, pain and other forms of misfortune — all of which may have important implications for health and health care' (pp. 2–3, parentheses and apostrophes in original, ellipsis denotes excluded section).

Following on from this definition of culture, Helman (2007) highlights:

'doctors and their patients, even if they come from the same social and cultural background, view ill health in very different ways. Their perspectives are based on very different premises, employ a different system of proof, and assess the efficacy of treatment in a different way ... The problem is how to ensure some *communication* between them in the

clinical encounter' (p. 121, italics in original, ellipsis denotes excluded section).

Furthermore, Helman (2007) argues that a humanitarian outlook is core to healthcare professionals' approach to medicine. This humanitarian ideal concerns itself with treating illness, improving human welfare, and alleviating suffering (Helman, 2007).

Linking Helman's (2007) aforementioned concept of culture, the doctor–patient relationship framework described, and healthcare's humanitarian objective, can help explain the notion of care experienced by the patients/prisoners in this study, as the healthcare professional culture is permeated by a humanitarian ethos that prioritises a concern for patients' health and welfare (*i.e.* a caring occupational aura) that is achieved via apt clinician–patient communication in the prison setting. Moreover, the perceived absence of care in the general prison culture perhaps serves to accentuate the care understood as provided via the clinical interactions.

To refer back to the aforementioned differing views of ill health between doctors and their patients as described by Helman (2007), it is suggested that effective communication is key to unproblematic clinical encounters. The data suggest that communication between patients/prisoners and healthcare clinicians in this study — as narrated by the patients/prisoners — is productive and appropriate, and that the intended messages from healthcare professional to mental health service user are communicated effectively (plus vice-versa: from patient to clinician).

To reiterate, patients'/prisoners' mental healthcare meetings are regarded as valuable in a mental health sense, yet also comforting in a social interaction sense. Perhaps this is, in part, due to the power that patients/prisoners possess and can wield in the clinical interactions. This is not a suggestion that the patients/prisoners are in the dominant position in comparison to their clinician, as they are not; however, relative to the power these patients/prisoners possess in their usual living environment, the prison (*i.e.* in the non-clinical setting), it is an augmentation of their influence. An example of this patient/prisoner control includes the reported ability of the patient/prisoner to dictate the topic of conversation and command the pace of therapeutic discussions (*i.e.* an experienced traumatic event ceases to be debated only when the patient/prisoner considers it to have been dealt with fully). The following excerpt demonstrates this aspect (plus other matters to be discussed subsequently):

Interviewer: So a minute ago, before we began officially, you were talking about things that you've found really helpful about working with X [his clinician], and you suggested things like your relationship with X, which you find quite easy, and relaxing, and you've found that beneficial [overlaps]

Participant: I do, yes. I find that. I must say, X is very good. Very professional. I would say she's/he's very professional at her/his job. Very understanding as well, err, I've had some bad times, but she's/he's very understanding, and we sit and discuss it, you know. We get there don't we [looking at X]. Eventually. At my own pace. X does it with me, at my pace. Not anyone else's pace. And, umm, I can start on one thing, and then go on to another, switch straight over. I must say, I do find the mental health

system is very good here. And, umm, I've got nothing but praise for it.

Several components of this excerpt are noteworthy. The patient/prisoner reports that problematic life events are discussed and dealt with at his pace, and that the topic selection is his to dictate. The ability to decide on the health issue for attention in a doctor–patient interaction may seem of little consequence to wider society, as this is usual practice when visiting voluntarily a GP in the community; however, this personal ability to decree any aspect of day-to-day life is limited for prisoners, as existence in the institution is dominated by strict and repetitive daily rules and regimes.

Helman (2007) discusses the important and influential role of context in the doctor–patient consultation. Both internal contexts (*e.g.* cultural assumptions) and external contexts (*e.g.* the practical setting and the ideological system of the host society) are listed as defining who has power in the consultation and who does not, alongside influencing the type, content, and form of communication in the clinical interaction (p. 153). The importance Helman (2007) attaches to these internal and external contexts concurs with patient/prisoner depictions of the nature of their mental healthcare appointments in this study. For example, it appears that the strikingly different context of their healthcare-orientated meetings and relationships — in comparison to the context of social life on the prison wings — is experienced as empowering by the patients/prisoners in some senses (*e.g.* via the agenda-setting ability).

Method/methodology reflection: In terms of social science interview method, the previous excerpt displays several interesting issues. Firstly, the nature of conversational turn-taking is striking, as during the interviews conducted with

patients/prisoners the participant can be seen to interject and verbally interact (*i.e.* overlap) before the interviewer's question is completed. That patients/prisoners do not adhere strictly to the turn-taking behaviour usually conformed to in an interview situation is important, as this deviation from the orthodox verbal conversation style is not evidenced in interviews with other social groups involved in the study (*e.g.* healthcare clinicians).

Schegloff (2000) provides a detailed empirical account of verbal interaction organisation that explores the notion and effects of overlapping talk and focuses on this turn-taking behaviour in conversation. Schegloff (2000) defines interviews as a specialised form of talk-in-interaction. Turn-taking organisation represents the most common element of speakership: 'one party talking at a time' (Schegloff 2000:1). Turn-taking represents not politeness, yet a socially organised 'enabling institution for orderly commerce between people' (Schegloff 2000:1). Overlap management devices are debated, as multiparty simultaneous talking must cease, and the paths to curtailment are relevant. Schegloff (2000) states:

'one or more of the parties to the simultaneous talk should stop talking; and to display that it is the overlapping talk that is the grounds for stopping, they should stop talking before coming to a possible completion of the turn-constructive unit they are producing. But which one should stop? Aye, there's the rub! That is part of what an overlap management is about. All that is wanted for and by the organization of interaction is that the overlap should stop; organizationally speaking, it is a matter of indifference who withdraws. But the parties may care very much indeed or not (p. 4).

As noted previously, interviews constitute context-specific modes of talk-in-interaction. In relation to this study, the interview transcripts demonstrate that it is always the interviewer who ends their utterance in order for the interviewee's speech overlap to continue and reach its intended fruition. As suggested above by Schegloff (2000), the interviewer's affected utterances can be seen to exemplify the lack of complete turn-constructive unit production. It is always the patient/prisoner that overlaps and always the interviewer who resolves the turn-taking irregularity.

It is sociologically interesting to consider why this occurs in this study. This talk-in-interaction device utilised by the researcher does not represent a planned aspect of the interview process; however, neither does it symbolise a process that the interviewer practices intentionally once the fieldwork is underway and this facet is recognised. Instead, it is only on reflection that this feature is noticed and considered.

Arguably, this aspect of the patient/prisoner interviews demonstrates a tacit social science tool permitting interviewees to emit the maximum volume of knowledge (*i.e.* opinions, ideas, perceptions, and beliefs), and at a juncture in the interview dictated by the participant. This hints at researcher politeness, consideration for participants' views, and an attempt at interviewee agency provision in the social interaction.

However, there are also perhaps additional, and almost deviant in comparison, reasons for this action. Interviews are conducted for the benefit of the interviewer and their study. Possible benefits for the researcher may include the resolution of social issues, social change, resultant publications, future funding application beneficial ramifications, or career progression. It could be argued

that social science interviews are not wholly altruistic pursuits. Thus, there is sense in permitting an interviewee to produce speech whenever they wish, as all participant utterances possess, potentially, useful knowledge. When an overlap occurs, interviewer utterance curtailments could be seen to represent action that allows the researcher to possess the maximum volume of data for analysis and, therefore, acts as a slightly devious research method tool (albeit conceivably unintentionally).

Method/methodology reflection: Returning to the most recently included interview excerpt, another aspect of interviewing persons who are unfamiliar with the social science interview as a process of social interaction is demonstrated. In this instance, the patient/prisoner commences praising his clinician and the nature of the mental healthcare provided before the voice recorder is turned on, and the Consent Form has been signed. This is not a suggestion that the participant is at fault in any way, it is just to highlight the unfamiliar nature of the formal interview process for the patients/prisoners interviewed in this study.

Method/methodology reflection: Furthermore, as the most recently included interview excerpt demonstrates, the participant in this interview turns often to his clinician for non-verbal communication interactions (these consist of his clinician smiling and nodding in an enthusiastic and encouraging manner). This interaction — notably set in motion by the patient/prisoner — appears to act as affirmation of a certain issue's occurrence (*e.g.* a mental health service user's diagnosis), yet also a form of corroboration concerning a joint successful act (*e.g.* effective clinical discussion of traumatic events). The non-verbal communication exemplifies an appeal for event/theme/topic verification, yet also

authentication of patient/prisoner–healthcare professional collaborative working.

The patients'/prisoners' narratives depict mental healthcare appointments as joint undertakings and pursuits, and that mental health achievements or accomplishments are perceived to be multiparty achievements:

Participant: ... We get there don't we [looking at X] ... X does it with me, at my pace.

This cooperative working is both supported and perceived as a beneficial aspect of the prison mental healthcare by the users of the service in this study.

Martin and Finn (2011) debate patients as healthcare team members and conclude 'increasingly, policy encourages 'partnerships' between users and professionals' (p. 1, apostrophes in original); 'current healthcare policy emphasises the need for more collaborative, team-based approaches to providing care, and for a greater voice for service users in the management and delivery of care' (p. 1). However, Martin and Finn (2011) detail numerous challenges regarding the involvement of service users (*e.g.* the fragile nature of these contributions to clinical teams and the difficulties patients experience forging trusting relationships with clinicians). Notwithstanding these issues that can arise in healthcare settings as reported by Martin and Finn (2011), patient–clinician partnerships appear to subsist well in this specific study — as recounted by patients/prisoners.

However, the most important attribute of the patient/prisoner–mental health professional relationship is *understanding*. Understanding is narrated as crucial

for rapport. An understanding of mental health and mental illness (plus associated effects) is cited as a predominant, and tremendously appreciated, characteristic of the mental health clinicians:

Participant: ... someone who understands ...

Participant: She's/He's very understanding.

Participant: It gives you a time to vent off steam, and stuff like that. To get things off your mind, and stuff, without having to talk to a prison officer, who hasn't got a clue about mental health, do you know what I mean.

Interviewer: So you find it as a good outlet but via someone who has mental health knowledge?

Participant: Yeah, someone who understands, as a lot of prison officers don't understand.

The abundant knowledge of the clinicians is contrasted with the perceived lack of mental health knowledge and understanding of the mass of HMPS staff (although there are notable exceptions).

In tandem with the nature of understanding in the clinical relationships, empathy is also reported and welcomed:

Interviewer: You mentioned sympathy there, and that X [his clinician] empathises with you, she/he understands you [overlaps]

Participant: Yes, she's/he's very understanding.

Possession or absence of knowledge pertaining to mental health appears to link with the abilities to understand and empathise with mental health service users' health-based desires, behaviours, and needs.

Helman (2007) lists six strategies to improve the doctor–patient relationship (p. 153). The primary approach noted is a development in clinicians' understanding of illness in relation to how patients view, explain, and experience their afflictions. In reference to the patients/prisoners in this study, developed understanding in the clinician–patient relationship is not considered to be necessary; instead, understanding is a praised facet of the clinical interactions.

The professionalism of the mental healthcare clinicians is also reported and considered a positive attribute, as well as behaving in a loyal and attentive fashion towards patients/prisoners:

Participant: She's/He's very understanding and very loyal.

The patient/prisoner interviewees display great respect for their mental healthcare professionals. However, these emotions perhaps also extend to protective and defensive feelings:

Participant: She/He has a difficult job. She/He gets some stroppy people, don't you [looks at X, his clinician]. But, I mean to say, they won't get stroppy if I'm there, as I'd butt in, 'cause I won't have my X picked on.

Following directly on from this, in the same interview, the patient/prisoner is asked if he visited the decommissioned HCC in the prison:

Interviewer: Did you go to the old Healthcare Centre?

Participant: No.

This means that the relationship with his mental healthcare clinician commenced recently, as the new HCC opened and the old HCC ceased to be used in the diminutive period of time that the prison acted as the fieldwork site. The short length of the aforementioned clinical association is surprising. The behaviour demonstrated by the patient/prisoner towards his clinician, the complementary comments professed, and the overall nature of the patient's/prisoner's report of his relations with his healthcare professional arguably depicts a long-term relationship.

Crucially, the patients'/prisoners' narratives in this study suggest that relationships in the prison setting can be formed swiftly (yet also ended abruptly). It is understandable that, in the penal social milieu, some patients/prisoners develop rapidly strong and positive feelings towards their healthcare professionals, who are interpreted as caring, kind, understanding, and interested in their wellbeing.

The final facet to be noted under the current sub-heading (*i.e.* clinician–patient/prisoner rapport) is the notion of flexibility:

Participant: I've got a lot of problems, an' they've all worked round me, 'cause I don't go off the wing, you see, and they all work round me; instead of saying, like, you know, well leave him then, don't bother with him if he's not coming over here [to the HCC], they work round me.

Interviewer: So they're quite flexible and it's almost as if your care package is developed around you?

Participant: Yeah.

The patients/prisoners in this study consider themselves to be in receipt of a suitably personalised mental health service; this is clearly a positive aspect of the healthcare provision in a health sense, yet it also appears to benefit directly the social amicability of the clinician–patient relationship and aids rapport. Individualised healthcare is valued highly. This appreciation is unsurprising when the patient's life as a prisoner in the prison establishment is considered, as institutions operate regimes and rules that, on the whole, manage social actors as social groups, and not as discrete individual social beings.

Opinions concerning mental healthcare received

In relation to the NHS mental healthcare received by the patients/prisoners in this study, only positive ramifications as a result of interventions are reported by its users. Participants are very willing to profess how useful they consider their clinical appointments. Patients/prisoners describe their meetings with clinicians as — in their opinions — successful in terms of mental health outcomes:

Participant: ... I do feel better for a few days, an' that, when I've seen X...

The notions of support and assistance are evident in the patients'/prisoners' narratives. The idea of help is also expressed:

Participant: ... they've helped me a lot.

The existence and nature of patient/prisoner–clinician discussion also appears significant for patients/prisoners. The ability to debate feelings and experiences is welcomed, and regarded as beneficial. This opportunity to talk about personal/health issues (both prior and current) is reported as important and appreciated.

Participant: I was put in a home. My brother, sister, and myself were found in a cupboard. The mother had gone off. I was a baby. We were left on death's doorstep, so the doctors say. I was sexually assaulted from the age of four months old onwards. Err, where were the police? Where were social services? ... So we're talking about that aren't we [looks at X] ... The mother was very nasty [long pause] so we're discussing that [looking at X].

Method/methodology reflection: The preceding quote includes identifiable personal details and therefore introduces another study design facet, as a patient's healthcare professional may be able to identify a patient via the inclusion of such medical history information, thus affecting participant anonymity. However, this is not considered to be a significant issue for this particular thesis, as patients'/prisoners' clinicians are present for the interview process itself and are aware of their patients' involvement prior to dissemination of interview excerpts.

To return to transcript content, this notion of discussion is developed further in the patients'/prisoners' narratives to extend to considering the mental healthcare appointments as wholly apt outlets for emotions. It is this action of release that is vital. Clinical interactions are perceived as appropriate sites for emission of

feelings. The patient/prisoner–clinician meeting is regarded as a forum that permits the liberation of thoughts:

Participant: It gives you a time to vent off steam, and stuff like that. To get things off your mind ...

It is interesting to postulate potential reasons beyond the expected (e.g. perceived mental health benefit) to explore why patients/prisoners appreciate their meetings with their mental healthcare professionals to the great extent demonstrated via the interviews. The quote below is useful here:

Interviewer: Are there any aspects of living in prison that you feel particularly affect mental health, other than the ones we've already spoken about?

Participant: If you've got no visits, because I don't get any visits, if you get no family visits, and have no people to come and see you, it's harder for you on the inside, because you don't get that little link to the outside world. So, I'm even happy when I get a bank statement through ...

This excerpt does not relate overtly to the patient's/prisoner's mental healthcare; however, it does serve to illustrate that, for some inmates, a prison stay is a period of alienation and separation from the UK's free society, and that any links (even postal bank statements) to wider civilisation are regarded highly and considered pleasing. The utterance *'have no people to come and see you'* is pertinent. When considered as a whole, this patient's/prisoner's narrative depicts his existence in prison as: misunderstood, frustrating, stigmatising, mentally unhealthy, repetitive, tedious, boring, punishment-based (without sufficient

rehabilitation or preparation for release), plus additional punishment is reported as experienced as a direct result of overt mental health issues. If the nature of this life in prison is considered in tandem with the quote *'have no people to come and see you'*, it arguably becomes clearer why patients/prisoners regard their meetings with their caring, understanding, and interested mental healthcare clinicians so highly. Under these (perceived) social circumstances in the prison setting it is understandable that enjoyment is gained via the human–human face-to-face discussion with an empathetic person (who is also knowledgeable about their mental health problems).

The interview transcripts include a future-focussed element; a long-term approach to mental healthcare and the pursuit/maintenance of good mental health appears to be understood, acknowledged, and accepted by the prisoners/patients. Furthermore, this commitment to a long-term healthcare tactic is accompanied by recognition that this method may necessitate unpleasant, yet necessary, early stages:

Participant: Well I think certain, certain workers like X [nods towards clinician], made more of an effort to make me understand what's going on with me, you know what I mean, in some ways, you know, it has made things a bit worse, because I know now what's going on, but, you know, I'm more clear of what's going on, so I'm not as frightened of it, so in the long-term it's better.

Participant: ... Trying to get bad things out of the way, and moving on ...

The patients/prisoners in this study narrate personal development intentions alongside a general desire for apt rehabilitation and preparation for release to the

community in a variety of senses (e.g. good mental health, employment skills, community living tactics). Crucially, patients/prisoners argue that the prison should be responsible for providing these rehabilitation services, and that this should be a prioritised requirement and not a secondary concern for the establishment.

Winkelman (2009) argues that a patient's illness narrative depicts 'an acceptable explanation within the patient's worldview that provides a sense of confidence of eventual mastery over illness' (p. 63). The patients'/prisoners' interview transcripts in this study concur with Winkelman's (2009) illness narrative theory, as the mental health service users discuss the effectiveness of their current treatment and their mental health outlook in a positive, hopeful, and masterful manner. A feeling of agency concerning future mental health status is professed; however, this sense of control is linked with, and perhaps dependent on, the continued receipt of mental healthcare-based clinical interactions (*i.e.* health-orientated mastery appears related to continued healthcare interventions).

To conclude, in relation to the NHS care in general, the patient/prisoner evaluations are also positive:

Participant: I find the healthcare very good ... I've had angina attacks. Serious ones. I've been rushed to hospital straightaway. So the medical team is very good.

Method/methodology reflection: Overall, the mental healthcare provided is considered appropriate by its recipients. To summarise, no rapport or treatment issues are discussed by participants concerning either the mental healthcare staff or the mental healthcare received. Obviously, this is welcome news; however, it

is a questionable précis, as the patients'/prisoners' clinicians are present in the interview room during the interview process and their presence alters the nature of the interview (*i.e.* the data creation). Moreover, as these interviews occur in a custodial environment capable of administering sanctions for (institutionally labelled) deviant behaviour, the freedom to profess establishment or person-centred criticism is perhaps perceived by patients/prisoners as constrained (*e.g.* the nature of IPP sentences is worthy of consideration here). However, as detailed subsequently, the patients/prisoners are at ease professing relatively negative opinions concerning HMPS staff in the interview. Therefore, it appears that this group of mental health service users feel sufficiently comfortable to discuss issues in the presence of their healthcare professionals.

A new NHS setting

A new NHS HCC opened during the period of fieldwork. Patient/prisoner comments express approval for the environment, particularly its 'newness' feeling, and the 'newness' of the rooms and chairs. It would appear that the 'newness' of the setting is recognised and appreciated, particularly in relation to other areas of the prison establishment.

Moreover, the new environment is perceived and experienced as a hospital-type setting. This aspect is considered to be a positive and therapeutic characteristic of the new HCC:

R

Interviewer: So you make use of healthcare obviously here, via X [his RMN], it's primary mental healthcare, did you use this service when healthcare was based over in the old area?

Participant: I did use the old centre, but it's this new one now only, yes.

R

Participant: I prefer this new environment. I prefer this centre.

Interviewer: What is it that you prefer here?

Participant: It's more like a hospital environment.

Interviewer: So, more, sort of, like, a therapeutic setting?

Participant: Yeah, yeah.

(‘R’ added by analyst to denote section of transcript removed due to a lengthy period of topic irrelevance or HMPS-labelled inappropriate content).

Method/methodology reflection: In relation to the numerous *R* sections in the patients’/prisoners’ interview transcripts and the associated analyst comment in italics above, the study’s Consent Form contains the paragraph: “*All participants are reminded that any disclosure of Prison Rule breaking, criminal activities and/or harm to self or others would be reported to the Governor. In addition to this, the Security Department reserves the right to review the interview transcripts for such instances and/or any other concern which could be indicative of a threat to the security of the prison*”. Prisoners read this section prior to consenting to the interview. This stipulation is also explained verbally by the interviewer, and the topic of the interview conversation (*i.e.* prison mental health) is stressed. However, on occasion, prisoners begin to discuss potentially difficult issues (*e.g.* criminal convictions). Where this occurs, the interviewer alters the topic swiftly.

At this juncture, it should be noted that no information relevant to the security, or safety of the prison establishment is discussed by prisoners, and that no prisoners divulge information pertaining to the three categories of issues stated on the Consent Form that would initiate Governor involvement.

The aforementioned situation is problematic for social scientists working in custodial environments, as they can experience two different forms of allegiances that pull them in opposing directions. In this study, the social scientist has a duty to adhere to the host prison's Security Department stipulations and the HMPS Psychology REC rules and regulations. However, the interviewer also experiences a degree of solidarity with and support for the study participant (*i.e.* the patient/prisoner), and an interest in the patient's/prisoner's future welfare in the establishment. Therefore, a situation where negative ramifications occur for the patient/prisoner as a result of the prison's Security Department reviewing a transcript and taking action is to be avoided. After all, social science ethical practice reiterates repeatedly the notion that no harm should come to participants as a result of research involvement. Furthermore, in this study, the interviewer does not wish to be perceived by patients/prisoners as a potential informant to the prison. Had this been the case, securing interviews with patients/prisoners may have been problematic. The approach adopted in this study aims to avoid any difficult situations, concerning the transfer of prison security-relevant information from patient/prisoner to prison, by intentionally circumventing any such topics during interview.

The *R* sections in the patients'/prisoners' interviews can also denote a section of transcript removed due to a lengthy period of subject irrelevance. It could be argued that all utterances in an interview should be transcribed, as final codes/themes are not generated until the post-fieldwork stage, and therefore these data may become relevant. However, this particular study poses significant transcribing difficulties and limitations, due to the nature of the custodial environment and the lack of transcription software and devices. Therefore, the omission of prolonged sections of speech that do not relate to mental health,

healthcare generally, or prison culture is considered appropriate for this work. However, it is recognised that certain methodological approaches (*e.g.* life history, narrative enquiry) would necessitate the inclusion of these data.

To exemplify the occurrence of one type of *R* section: the patients/prisoners interviewed in this study appear occasionally to regard the interview as an apt opportunity to profess any issues or grievances associated with their lives in the prison establishment (*e.g.* repetitive inclusion of cabbage in diet). Although it is stressed by the interviewer that the discussions are to focus on the nature of mental health (broadly defined) in the penal setting, problems not related to mental health are introduced and outlined by patients/prisoners. This is mentioned here not as a report of a problem with the interviews, or as a record of unbecoming interviewee behaviour (as neither of these are considered to be the case), yet to re-illustrate the lack of familiarity with this form of social science interview.

Method/methodology reflection: Poignantly, it is possible that the non-NHS/HMPS interviewer may have represented a potential source of issue resolution for patients/prisoners. This aspect of the study is associated with a sense of regret that the social scientist experiences during the interviews with patients/prisoners. At certain junctures during interactions with patients/prisoners, the interviewer explains in an apologetic manner that, even though the patient/prisoner is devoting their time and knowledge to the study, no changes to their mental healthcare or treatment in the prison generally are likely to occur as a result of their involvement. It is explained that the interviewer cannot resolve any problems professed during the interview. The lack of social scientist influence in the prison setting is outlined to the interviewees. Although this is accepted well by patients/prisoners, where interviewees require reminding,

there can be a hint of an initial reaction of confusion, before recall of the earlier explanation. Notably, this interviewer reflection constitutes an interpretation of reactions and emotions that the social scientist cannot claim to record officially, and this study does not intend to report formally on the matter. It should also be stated clearly that this feature of the interactions with patients/prisoners does not cause genuine anxiety or annoyance for interviewees, and that at the end of the interview all patients/prisoners do understand the interviewer–interviewee relationship, and do not expect any changes in their healthcare or prison life whatsoever. However, social scientist regret persists. A discussion of negative research effects for social scientists as a result of emotive fieldwork conduct (*e.g.* studies that involve incarcerated social actors) is apt here; however, this thesis does not explore these issues fully.

This facet of both social science and natural science research (*i.e.* an often lack of change for its participants) is widely understood and acknowledged by researchers who undertake this form of work. It becomes tacit knowledge, and therefore perhaps not always explained sufficiently to participants. This characteristic should be stated more simply and clearly on Consent Forms and Participant Information Sheets (and verbally by the interviewer before commencement of interview), especially when fieldwork involves vulnerable social groups/actors with relatively limited literacy skills.

To return to the content of the interview and the mental healthcare received, one aspect of the physical layout of the HCC appears in need of development; this is the transparent nature of the separate waiting area for Vulnerable Prisoners (VPs) from the VPs' wing:

Participant: This particular Healthcare Centre is very good. X [a previous prison] I found a bit slack-ish. But this is pretty good.

Interviewer: Is that just because it's new, or its layout?

Participant: Yes, its layout, and it's new. There could be a bit more privacy for us people, from the VP wing, instead of being locked up in a room, but still in view all the time of the other prisoners. There could be a change there.

Seemingly, the distinct waiting area is welcomed, yet remaining in view of prisoners from normal location (*i.e.* those prisoners housed on regular wings) in the prison is not. Additional privacy is desired for VPs.

The excerpt below (from a different patient's/prisoner's interview transcript) perhaps elucidates this appeal for increased privacy for VPs in the HCC:

Participant: The only thing I can tell you about that is, if you're on this wing, this particular wing [the VP wing], it's a protection wing, but at least 40% of the wing are not sex offenders, but if you get seen, 'cause a lot of us are well known in the prison, if we get seen by other lads on regular wings, normal location, you get tarred with that same brush [as a sexual offender], if you know what I mean. It's just embarrassing and it makes you feel a bit small, and little, and that. It's bad enough being on here [the VP wing] as it is, having to mix with certain types of offenders [sexual offenders]. That's why a lot of people won't go over to Healthcare, for that exact reason, they don't want to bump into people they know, as you end up seeing the same people when you're outside on probation, so people can say something about you [as a sexual

offender even though you are not], and you could end up getting done in, you know what I mean.

Bradby (2009) defines stigma as ‘a condition or attribute that marks the bearer as unacceptable or inferior and renders that person (and perhaps the group with which he is identified) as polluted or shamed’ (p. 112, parentheses in original). It would appear that — as reported by the patients/prisoners in this study — sexual offenders in HMPS represent a stigmatised social group that non sexual offenders are keen to remain socially separate from. The study data indicate this stigma. Although, it is recognised that this is a one prison only case study.

However, literature exists to support this finding. For example, as discussed in this thesis’ literature review, Clemmer (1940) notes that sexual offenders are placed often in the lowest social grouping in prison settings. This stigmatisation of sexual offenders in prisons appears to continue to exist in contemporary HMPS establishments. However, this generalisation of prison culture is too simplistic. Thus, it is important to highlight that sexual offenders are not a homogenous group of prisoners across the UK’s criminal justice system. Indeed, Clemmer’s (1940) prison ethnography exemplifies the social system in just one establishment. Moreover, regarding sexual offenders in HMPS, differing security levels, differing sentence lengths, and differing original criminal acts exist.

The subsequent quote could be analysed in tandem with the preceding two extracts to support the assertion that prison life and the penal milieu (as also detailed in the literature review of this thesis) is hierarchical, stigmatising, labelling, volatile, threatening, and the peril of violence penetrates:

Participant: Inmates in prison usually all want to fight each other. They're not like proper adults, a lot of them. A lot of them are still kids in their heads. They think the way to get by is via threatening each other, and stuff like that.

Prison wing to Healthcare Centre escorts

R

Interviewer: What about missing appointments because nobody's escorted you. Does that ever happen?

Participant: Yeah, sometimes that happens, which is frustrating for me, as it's not my fault, and I need my appointment.

Occasionally there is a problem with escorts to the HCC from the prison wings. This appears to cause disappointment and frustration for patients/prisoners, as the lack of an escort is not a situation they consider themselves to have triggered. As a result, patients/prisoners feel powerless, plus undeserving of the missed clinical appointment.

Moreover, the mental health of the patient/prisoner is considered to be affected negatively, as the meeting with their mental healthcare professional is perceived as necessary and required by the patient/prisoner:

Interviewer: Can you think of anything in terms of the mental healthcare here that could be changed in the future to benefit you, and others like yourself, who use the mental health services in prisons?

Participant: Bringing us over for the appointments. As I say, my appointment today was at 2.30pm, and I've only just arrived [very late

afternoon]¹⁶. Now, how many times have we had appointments cancelled [looks at X, his clinician]? The last three appointments. No warning. I've been stuck in my cell, waiting, wondering what's going on. Not been told anything. Then X has also been sat here waiting for me. A waste of everyone's time. As I say, that needs looking into.

Interviewer: So that's the escorting process between the wing and the Healthcare Centre, yes?

Participant: Yes, the escorting. Making sure the appointments are kept, 'cause it puts me on edge, and it makes me more depressed. I know I'm starting to go through a bad patch again, so, I thought I'd warn you [looks at X]. As I say, it did annoy me, quite a lot, that these three appointments had been cancelled, and wasted, because, err, we could have discussed quite a lot, couldn't we [looks at X]. That really needs looking into. It needs sorting out. It's not X's fault, and it's not my fault, it's the prison's fault.

This extract highlights that escorts can sometimes be either late or absent. Furthermore, it appears that patients/prisoners are not always alerted to the situation, are left waiting, and then unaware of the outcome. The participant quite rightly states that the missed appointments are a waste of the clinician's time. Note that it is the prison that is blamed by the patient/prisoner for the missed appointments (and not the HCC).

NHS services and staff are perceived by patients/prisoners as markedly dissimilar to HMPS services and staff. The experienced distinction is

¹⁶ This delay exemplifies further the lack of social scientist power and influence at the fieldwork site alongside the 'waiting game' aspect of this thesis' collection of data.

exemplified via the transcripts for this study. This serves to reiterate the present divide — as depicted by patients/prisoners — between the healthcare staff and the security staff in the UK's prison service.

The loss of scheduled appointments is experienced as annoying and wasteful by patients/prisoners. The interview excerpt demonstrates that this situation can affect negatively mental health; the patient/prisoner reports that much could have been discussed in the appointment, and that when appointments are not kept this results in anxiousness and an amplification of experienced mental distress.

Clearly, this is not an ideal set-up for mental health service users and the escorting process requires development. Primarily, if appointments really cannot be attended (*e.g.* if a severe security issue in the prison requiring immediate attention occurs), patients/prisoners should be visited briefly when possible and the cancellation reason explained to them, to remove the unknowing aspect that results in additional anxiety.

In relation to this prison escorts section, Stoller (2003) studies prison healthcare — in relation to space, place, and movement — and reports participants'/prisoners' help-seeking narratives depict 'prison as a place where health care access is continually thwarted by rules, custodial priorities, poor health care management, incompetence, and indifference' (p. 2263). Whilst the NHS healthcare is not criticised by the patients/prisoners in this study, there is evidence of institutional barriers (*e.g.* occasional absence of escorts) affecting help-seeking behaviour and access to healthcare clinicians.

In the preceding interview quote, the patient/prisoner turns physically to his clinician and verbally warns him that he's beginning to experience a period of poor mental health. This can be argued to demonstrate courtesy and respect (alongside trust) towards the healthcare professional, as the patient considerately informs the clinician concerning his predicted health status.

However, it does also, once again, highlight the power possessed by mental healthcare patients in the HCC-orientated social interactions (that is an amplification in comparison to their life, as depicted by them, on their prison wings). The patient appears to warn the clinician concerning an impending mental health issue with the underpinning assumption that this will form the basis of future clinical conversation, if necessary. Although the transcript does not depict this, the healthcare professional does subsequently physically nod their head in agreement with the patient's/prisoner's comment.

The patient is setting the clinical interaction agenda. This agenda-setting ability is relatively absent from prisoners' day-to-day existence on normal location, as the prison system is dictated by highly ritualised and repetitive daily schedules that the prisoner does not possess influence to decree or alter.

McMillan and Aiyegbusi (2009) debate apt empowerment of mental health service patients in secure settings and suggest that it is useful to aim for 'patients to contribute something to the care of themselves' (p. 182). Therefore, for McMillan and Aiyegbusi (2009),:

'patients were not expected to adopt the traditional sick role and nurses supported their active involvement in the service as far as each individual woman [patient] was able and within the confines of security policies and

procedures. The anti-therapeutic effect of complete disempowerment was avoided' (p. 182, comment in square brackets added).

For example, 'nurses involved patients in the development of their care plans ... encouraging some ownership to be taken of their needs' (McMillan and Aiyegbusi 2009:182, ellipsis to denote removed section). Arguably, the patient/prisoner agenda-setting ability in this study exemplifies a form of patient empowerment that echoes McMillan and Aiyegbusi's (2009) appeal for mental healthcare patient involvement and empowerment in secure settings.

Kleinman (1988) explores 'the intimate and manifold ways by which illness comes to affect our lives' (p. *xi*). A key distinction is drawn between a clinician's attention to a disease entity and a patient's focus on its related illness-orientated experiences. Kleinman (1988) is interested in how chronic illness is both lived and responded to by long-term patients, arguing that 'the study of the experience of illness has something fundamental to teach each of us about the human condition, with its universal suffering and death' (p. *xiii*). Kleinman (1988) states:

'the role of the health professional is not so much to ferret out the innermost secrets (which can easily lend itself to a dangerous kind of voyeurism) as it is to assist the chronically ill and those around them to come to terms with — that is, accept, master, or change — those personal significances that can be shown to be operating in their lives and in their care. I take this to constitute the essence of what is now called empowering patients' (p. 43, parentheses and em dashes in original).

For the patients/prisoners in this study, a critical aspect of their mental healthcare appears to be this notion of empowerment in the clinical setting (*i.e.* to depict the topic agenda). This small amount of patient control appears to represent a valued facet of their illness experience in the social setting under exploration (*i.e.* the prison).

Winkelman (2009) highlights that patients' illness accounts act as powerful providers of empowerment and agency for healthcare users, as they form self-composed verbal outlets for rewriting medical history, recovery, present, and future, including all self-perceived influencing aspects, events, and issues. The interview transcripts of the patients/prisoners in this study concur with this conceptualisation of patient constructed narratives. The mental health service users' interview responses do serve to illustrate their elements of agency in their healthcare interactions with clinicians (*e.g.* agenda-setting), and the narrated personal health stories do depict life events in an empowering sense (*e.g.* how a prior traumatic life occurrence is utilised and discussed in a clinical setting to further understand and positively develop their mental health).

Method/methodology reflection: To conclude this sub-section, a researcher reflection is apt. The emotion of guilt is experienced by the social scientist undertaking the fieldwork in this study. For example, the most recently included interview excerpt demonstrates that the patient/prisoner has had his preceding three consecutive mental healthcare appointments cancelled (through no fault of his own). This meant, that when the social scientist met with the patient/prisoner and his clinician, every minute devoted to the conduct of the interview reduced the clinical interaction time available to the patient/prisoner post-interview. Therefore, the interviewer experiences feelings of guilt and regret (as a result of utilising valuable appointment/treatment time for a pursuit of no immediate

benefit to the patient), alongside a desire to complete the interview as quickly (yet effectively) as possible.

Prisoner–prisoner relations and mental health

Participant: Err ... there's not a prisoner I can open up to, so. I mean to say, I've had a bad experience, when I was at X prison, with a Samaritan. I was on the 'phone, and then the lady turned round and said, well you damn well do it then. I thought, fine. So I did. Didn't cut up, or anything like that, I had a plastic bag over my head, tied it with a piece of cord, got under the blankets, and then they had less than a minute to get me back round again.

Interviewer: So you've had a bad experience with a Samaritan before, yes, I see [overlaps]

Participant: So I don't trust them. Err, and I don't trust Listeners¹⁷ much. But we could do with something where we could build up a rapport with someone. But, we ain't got that.

Genuine prisoner–prisoner rapport is noted as not often formed by the patients/prisoners in this study. Connecting emotionally with wing mates is highlighted as difficult and infrequent. Trust is seen as problematic and challenging in the penal social environment. Interestingly, although perhaps not surprisingly, both rapport and trust are two facets of the patient/prisoner–clinician relationship that are valued highly by the mental health service users in this study. The interviewees' narratives depict a general lack of trust and friendship-orientated reliability in the prison's social environment; whereas, the

¹⁷ This thesis does not address the Samaritan scheme that is run by HMPS, as study participants, generally, do not utilise or debate this Listener service to a significant degree.

HCC is experienced as a site of patient–clinician trust and loyalty. However, these are the experiences of the prison’s culture by a number of mental health service users in one prison, and it should be remembered that exceedingly intense and loyal social bonds, alongside intragroup dependence, trust, and reliance do exist in the penal environment (as this thesis’ literature review demonstrates).

Method/methodology reflection: The preceding interview quote details a social actor’s account of a previous suicide attempt. This is a harrowing revelation. Suicide represents an exceedingly convoluted social act. Notably, the interviewer does not refer to this suicide attempt or pose any future questions concerning the event. This is unusual, as interviewers usually query participants’ interesting or unexpected comments.

Across the patient/prisoner transcripts as a whole, the social scientist does not discuss suicide, even where previous suicidal ideation, as an example, is mentioned by patients/prisoners. It is here suggested that it would have been inappropriate for the social scientist in this study to discuss the notion of suicide with mental health service patients for myriad reasons (*e.g.* lack of suitable mental healthcare-orientated training). Via avoiding discussions concerning suicide, the interviewer is sure to circumvent the potential situation whereby a participant may interpret any such discussion as supporting, encouraging, or condoning the act of taking one’s own life. Essentially, the issue of suicide is considered too ethically, philosophically, and morally complex for this doctoral-level work.

This discussion does serve to highlight the importance of a clinician’s presence when early-career social scientists interview vulnerable healthcare users, such as

prison-based secondary-level mental health service patients, as, post-interview, the healthcare professional can discuss with the patient any of the issues narrated. As noted previously, all conversations with patients/prisoners in this study are conducted in the presence of their mental healthcare clinician. However, it is recognised that the aforementioned social scientist's approach to suicidal ideation as professed by patients (*i.e.* ignoring the issue) would not be acceptable if the patient's healthcare professional were not present; further action would be necessitated. In such a situation (*i.e.* an expressed self-harm desire), ethical practice dictates the social science researcher discusses the matter with the patient's clinician.

It is worth mentioning here that during the period of this study when fieldwork clearance was being arranged via the numerous channels, the suggestion that a clinician must be present for the interviews was resisted initially by the research team (*i.e.* interviewer and study supervisors), considered disappointing, and labelled a negative aspect of the multiple fieldwork guidelines imposed. However, this facet of the fieldwork is now reflected on in a positive light, and with appreciation, relief, and gratitude.

Therefore, although suicide represents a topic that is not debated extensively in this thesis, self-inflicted deaths and self-harm in prison custody do represent areas for contemporary attention and address. For example, in 2007, the MoJ recorded over one hundred prisoners who were resuscitated after serious self-harm incidents. Moreover, the MoJ (2011a) has announced that there were fifty-eight apparently self-inflicted deaths amongst prisoners in England and Wales in 2010.

To return to the interviews' content, patients/prisoners depict relatively solitary prison lives:

Participant: I don't associate much, do I [looks at X]. I don't associate much with people. Erm, I'm more of a person on my own, you know. Erm, because I've been let down by people before. So, as I, well, I've had a bad time just recently, and, erm, so they thought it would be best if I was not in a cell on my own, so I've got someone in with me now, but we're getting on alright. He's there for me, and I'm there for him. We help, we try and help, each other.

The patient/prisoner links previous incidences of being disappointed by people with his current preference to conduct himself as a social recluse. Due to present mental health issues, the patient/prisoner is currently placed in a shared cell. However, it is reported that the cell mates attempt to help each other, where possible. A form of reciprocated dependence is noted. It appears that cell mates construct, or do not construct, mutually beneficial relationships swiftly in the prison environment when cell sharing is enforced. This quickly formed bond, or lack of, echoes prison culture literature that depicts prison social existence as volatile, impulsive, capricious, often superficial, and thus altering suddenly.

Stigma is a word utilised often by medical sociologists, particularly those interested in the sociology of mental health; however, it is seemingly not a familiar vocabulary tool of the mental health service users in this study. It is not used by patients/prisoners in their interview responses unprompted, and when the concept is included in interview questions, the patients/prisoners do not subsequently employ the term. Seemingly, the notion of stigma is not salient

with these participants in this study. However, numerous of the associated facets of stigmatising social behaviour are reported, yet it is just the use of the actual term stigma that is not.

Stigma as a social concept — originally a Greek term — exists because ‘society establishes the means of categorizing persons and the complement of attributes felt to be ordinary and natural for members of each of these categories’ (Goffman 1963:11). As discussed by Goffman (1963), a person’s ‘social identity’ (p. 12) involves both personal attributes (*e.g.* honesty) and structural attributes (*e.g.* occupation). For Goffman (1963), stigma denotes attitudes that ‘are incongruous with our stereotype of what a given type of individual should be’ (p. 13). However, it should be noted that ‘an attribute that stigmatizes one type of possessor can confirm the usualness of another, and therefore is neither creditable nor discreditable as a thing in itself’ (Goffman 1963:13); therefore, ‘a stigma, then, is really a special kind of relationship between attribute and stereotype’ (Goffman 1963:14). Goffman (1963) introduces three forms of stigma, and mental health is included in the second of these. (As an aside, Goffman (1963) also cites imprisonment in the list of ‘blemishes of individual character’ (p. 14) in this second stigma grouping).

‘The normal and the stigmatized are not persons but rather perspectives’ (Goffman 1963:163–164) that are generated in social situations. It appears that, for the patients/prisoners in this study, these two academic concepts (*i.e.* the normal versus the stigmatised) are not familiar ideas; however, the depicted narratives of these patients/prisoners do concur with the theoretical framework for social actors that experience a stigmatised social existence.

For this study, this (socially-removed academic versus socially-situated social actor) labelling discrepancy has parallels with the situation of the Amish social grouping in North America — ‘with their traditional family and social structure, and strictly enforced lifestyle’ (Gibbon 2010:8) — who fulfil the criteria for definition as a tribe ‘yet this word is not used by them’ (Gibbon 2010:8). Seemingly, labels and concepts utilised by academics (*e.g.* sociologists, anthropologists) are sometimes not salient with the social actors/groups being categorised and labelled. Arguably, this divergence should prompt a re-consideration of definitions/concepts, yet that is not a task for this thesis.

Patients/prisoners in this study report that they often avoid undertaking association on the prison wing:

Interviewer: How do you think other prisoners react to people who use the mental health services, do you think there is any negative stigma, or are they really supportive or empathetic perhaps?

Participant: I don't really experience not supportive or being supportive, but, like, I'm more one of them people that keeps myself to myself, stay more out of the way, I like to be, you know, I like to be on my own, an' that, but I do find that once I start coming out of my cell, you know they take that, they see that vulnerability there. I wouldn't say that it was either supportive or not supportive. I just think they don't understand. A lack of understanding. I get it with my family.

Interviewer: People who perhaps don't have enough mental health awareness?

Participant: Yeah.

Patients/prisoners appear to opt for solitary social existence in the prison environment. This chosen characteristic is interesting to contrast with the appreciation, trust, loyalty, good rapport, and perhaps even joy that are experienced via their meetings with their healthcare professionals. These (clinical-orientated) social interactions are sought, yet unfamiliar social interactions on prison wings are avoided intentionally.

A lack of mental health understanding is linked to viewing vulnerability in mental health services users in the extract above. This absence of mental health knowledge amongst the prisoner social group is an often repeated component of the prison social environment. This lack of mental health understanding links well with the subsequent sub-section concerning wing staff.

Patients'/prisoners' perceptions of wing staff and mental health

In relation to the patients'/prisoners' comments pertaining to wing staff, the remarks are mixed. Several particular wing officers are singled-out and praised highly for their attitudes and behaviours in relation to the patient's/prisoner's mental health problems and their mental healthcare. However, the majority of wing staff are perceived to lack sufficient mental health-based knowledge, understanding, and empathy. Crucially, it is believed that these members of staff should aim to possess these attributes; this is noted as in addition to the security-orientated roles that are performed by wing staff that are accepted by the patients/prisoners in this study.

Poignantly, patients'/prisoners' utilise manners, language, conduct, and communication modes that are exceedingly polite and respectful towards the interviewer and their clinician; however, when issues concerning the prison

establishment or the prison staff are raised, the tone and idiom of the discussion is often not as reserved and courteous.

A lack of HMPS staff understanding concerning mental health is highlighted:

Participant: ... A lot of prison officers don't understand, so they think you're just taking the mickey, or acting up, stuff like that ... You get punished in here, if you've got mental health problems. I've noticed that. I don't know if it's just me, but I reckon if you've got mental health problems in here, you get punished, by the officers. They don't understand and think you're just taking the mickey, when you're asking for Listeners, if you're saying you're upset and feeling a bit suicidal, or whatever.

Furthermore, this particular patient/prisoner considers his overt mental health issues and resultant behaviour to act as sources of punishment in the penal setting. Wing officers' reactions to mental health-related problems or behaviour are experienced as punishment-based.

Interviewer: Do you think that's just because they do not understand mental health problems? [overlaps]

Participant: They can't be bothered to understand. That's the problem with them. They're just like, ooh I've come to work today, and I don't have to put up with this sort of gip.

The working roles and responsibilities of wing staff are introduced. Mental health is described as not the desired remit of wing officers. Mental health is experienced by prisoners as not of interest to prison wing staff, and perhaps even

considered a nuisance to their day-to-day working life in the prison establishment.

McMillan and Aiyegbusi (2009) argue mental healthcare patients with complex needs can embark on ‘unfortunate mental health careers’ (p. 171) if housed in a secure services system that ‘may not have been set up to comprehend what they are trying to communicate’ (p. 171), thus resulting in patient distress that is expressed via challenging behaviours that are difficult for care-givers to ‘understand and respond to in therapeutic ways’ (p. 171).

The primary objective of HMPS is not to comprehend any complex behaviour that may be displayed by distressed mental healthcare users who are struggling to communicate their suffering in the penal setting. As noted by McMillan and Aiyegbusi (2009), for those persons who are charged with housing securely mental healthcare users, these misunderstood challenging behaviours can threaten the therapeutic nature of their responses, thus augmenting the lack of staff–patient comprehension and effective communication. Arguably, ‘unfortunate mental health careers’ (McMillan and Aiyegbusi 2009:171) of patients/prisoners in the penal system may be avoided if prison staff possessed apt mental health knowledge; this could provide a platform for developed understanding of mental healthcare users’ behaviour in the penal setting.

Participant: There are certain officers who understand. Obviously not every single one of them. There is a minority that you can chat to. They’re more like Dads. Whereas, there are those people [wing officers] who just think you deserve bread and water.

In the transcript excerpt above, officers' mental health-based understanding is linked to the occurrence of inmate–staff discussion. For the patients/prisoners included in this study, the ability to engage in compassionate conversations — concerning their mental health — is perceived as beneficial. This applies to all three forms of social interaction discussed: patient–clinician; inmate–inmate; prisoner–staff.

Participant: There's an officer with the same [mental illness] that I've got. She's/He's very understanding ... I think you can't beat someone who's going through it themselves. That's why I agree that drug workers who've been on drugs themselves are best, because they can relate more. You can tell somebody something, but you can't put them there. You can tell them how it feels, but they don't know how it feels.

Understanding and empathy appear important here, and it is noted that these can derive from personal experience.

The patients/prisoners narrate HMPS staff as a diverse professional group. Wide variations in practice amongst prison staff are reported:

Participant: In here it's like, I'm your PO [Personal Officer], I'll sort that out, but they never do. If you ask them, did you do that for me today Gov.?, it's, ooh I didn't have time, but they'll be sat downstairs drinking coffee and eating fry-ups in the office.

Interviewer: So you've experienced quite a lot of variation as well then, is that what you're saying?

Participant: Yeah, like, you can ask one officer to check something out for you, and they'll say yeah and do it, but you ask another, and they'll say, yeah, but never do it.

Notably, even where wing staff are discussed in a positive light in the interviews, the reported action is often not associated directly with mental health or mental healthcare. For example, one patient/prisoner praises the members of wing staff that permit him to conduct himself in a private, quiet, and solitary manner on the wing.

Patients/prisoners form a distinction between two forms of wing officers: those who understand mental health issues and those that do not (as perceived by the patient/prisoner). Moreover, those that lack the knowledge and understanding are then linked to primarily containment-orientated members of prison staff:

Interviewer: So what distinguishes these two types of officers?

Participant: They treat you like a human being, not just some scumbag that's committed a crime.

Interviewer: Yeah, so perhaps they don't just view their working role as one of security?

Participant: Yeah, definitely. That's a positive thing.

Wing officers who are understood to consider their working role to extend beyond that of confinement are recognised and appreciated by patients/prisoners. Patients/prisoners appeal for a prison system that does not position wing staff to prioritise containment alone.

Kleinman (1988) debates potential developments to the nature of healthcare generally and argues that healers' practice should alter to further embrace 'a lesson in the essentials of humanity' (p. 267) via denouncing aspects of society that affect the notions of suffering and healing (*e.g.* corroding altruism and a deterioration of 'decency into merely a professional gesture' (p. 267)).

Kleinman laments: 'physicians are encouraged to believe that *disease* is more important than *illness*, and that all they need is knowledge about biology, not knowledge about the psychosocial and cultural aspects of illness' (pp. 254–255, italics in original). However:

'even when physicians are sensitive to psychosocial issues their office staff and the paraprofessionals who collaborate with them may not be. Indeed, some of the most reductionistically mechanical and insensitive care givers I have come across are relatively low-level clerks and technicians who seem unaware that what they do is part of the patient's experience of care. Clearly, all members of the helping professionals should be trained in a framework that ... attend humanely to the illness experience. The professional sector's institutions are profession- rather than patient-centered' (Kleinman 1988:263, ellipsis to denote removed section).

To relate Kleinman's (1988) ideas to the prison setting, it could perhaps be argued that a penal social environment that stresses the importance of containment, yet neglects cultural issues affecting illness, does not provide wholly humane care for those that are suffering. Kleinman (1988) highlights that all staff who interact with patients should conduct their work in a manner that is sensitive to the experience of illness.

Winkelman (2009) — a contemporary American medical anthropologist — argues culture affects health behaviour in myriad ways. The fifth issue, on Winkelman's (2009) list of nine, records culture as 'creating health providers' and their institutions' responses to health care needs' (p. 5). The interview narratives of the patients/prisoners in this study depict a divide between the healthcare professionals' cultural approach to prisoners' mental health (and its overt and covert ramifications) in opposition to the professional cultural set-up of the majority of HMPS staff.

However, it could be argued that this cultural divide is not the fault of individual wing officers, yet is instead a result of HMPS's training and underlying professional objectives of security and containment. In relation to the preceding Winkelman (2009:5) quote, perhaps the health providers' and the institutions' responses to health and healthcare are, at present, not aligned appropriately. Congruently, Brooker and Birmingham (2009) state 'it is clear that, in many ways, mental health service provision and the criminal justice system exist in parallel universes' (pp. 3–4).

It is suggested that variations in practice between wing officers are not linked directly to length of service and/or age of the individual member of prison staff. Instead, the distinction is drawn between those who embrace the nature of care into their professional roles and responsibilities, and those who do not:

Interviewer: What about the suggestion that perhaps the newer, younger officers are more, sort of, amenable to, sympathetic to, mental health training or mental health awareness, rather than perhaps older, more established, long-term uniform officers who've been

working in the prison service for longer? Is there an age difference that you've noticed?

Participant: Nah, I don't think, I don't think there is, I just think, you know, some of them are just, a lot of them are more, you know, you've got some who are professional, like, and you've got, going back to those who're just doing it for a job, and not because they care and they want to.

Interviewer: So perhaps it's not an age thing, it's about who cares about [prisoners'] welfare?

Participant: Yeah, yeah.

However, it is noted that the general working practices and ethos of the prison officer's role and responsibilities are developing positively:

Participant: ... Over the years I've seen totally different attitudes from them [wing staff], you know what I mean, they're not too bad on 'ere [the VP wing], so, umm, but, I think, I think where we are [in prison] you're always going to get that thing where, we're criminals, and the criminal [aspects] tend to come over the mental health side of it, always. I've always noticed that.

Interviewer: Do you think because they're labelled discipline staff so that's what they focus on?

Participant: It is getting better, because, like, fifteen years ago, you know, it didn't matter about, if you've got [mental health] problems, an' that, do you know what I mean, they are more aware [now], that, you know, these could be the roots of why people are going out and doing crime and drugs, and things like that. Like I said, this is what's happening at the minute with me [receiving mental

healthcare], as everybody now is focussing on the mental health side, which should have been done a long time ago, and not just said right well we'll sort the drink and drugs out, but you're still going to have the side [poor mental health] that makes me want to take the drink and drugs.

As experienced by this patient/prisoner, containment- and security-orientated, alongside punishment-based concerns prevail, leaving health issues to be considered secondary (although the situation is developing positively).

Social and cultural conditions affect health (Winkelman, 2009). Health problems are not simply medical problems, 'but societal problems with complex cultural dimensions' (Winkelman 2009:xvii). Therefore, culturally-responsive healthcare is required. Winkelman (2009) highlights 'understanding how culture affects health enhances providers' understanding of health problems and the needed care' (p. xvii); furthermore, this cultural understanding can empower healthcare users 'to manage health care interactions with greater awareness of the cultural, social, and institutional factors affecting health' (p. xvii). Winkelman (2009) states 'health care always involves many aspects of culture, and health institutions function as cultural systems influenced by values, beliefs, and other biases' (p. xix). Winkelman (2009) also reiterates 'improving health care requires attention to cultural influences on health concerns, conditions, beliefs, and practices' (p. 2).

Therefore, cultural aspects of healthcare are relevant for healthcare professionals and patients, yet also all social actors involved in patients' social environments. In the penal setting, this includes prison staff. Cultural factors associated with the institution (*i.e.* the prison establishment) affect both health experience and

the management of health. The cultural system of HMPS could perhaps alter its mental health-orientated values and beliefs to, in turn, develop positively its practice in order to benefit and aid the illness experience of those prisoners with mental health diagnoses.

It appears long-term patients/prisoners are reporting a beneficial alteration in the prison system's, and its staff, approach to healthcare generally and its importance and influences. Although, this altering style has not yet reached a wholly apt prisoner versus patient balance (as experienced by the patients/prisoners in this study). Seemingly, the devotion of increased time and attention (alongside developed understanding and awareness) from wing staff is warranted in relation to mental health in the prison environment.

Chapter conclusion

This section of the thesis explores the patient/prisoner interviews. The chapter represents a discussion of the patients'/prisoners' perspectives in relation to mental healthcare and mental health more generally in the penal setting. The chapter commences with a Roberts and Clarke-Moore (2009) quote highlighting the importance, yet relative absence, of reflection on patients' experiences of healthcare received. Congruently, this section of the thesis focuses solely on patients'/prisoners' narratives. Attention is devoted to the content of the interviews in a topic sense, yet also to the nature of the social science interview process itself; the chapter possess both interview method and interview results analysis.

Clinician–patient/prisoner rapport is considered. Patients/prisoners report positively that relationships between service users and mental healthcare

professionals are valued highly and working well. Numerous patient/prisoner comments praise their clinicians and display great affection towards their mental healthcare professionals. An enjoyable, flexible, individualised, and relaxing therapeutic clinician–patient/prisoner rapport is narrated. The notion of inherent care differentiates the clinical relationship from other relations in the prison establishment (*e.g.* prisoner–prisoner); the NHS mental health professionals are depicted as possessing a caring professional culture. Clinician–patient/prisoner meetings are seen as sites of trust and experienced as comforting in a social interaction sense. Patient/prisoner power is discussed in relation to dictating the topic selection, an agenda-setting ability, and pacing of the clinical conversation; this diminutive amount of patient/prisoner control appears to represent an appreciated facet of their illness experience in the prison setting.

The notion of understanding is argued to be the most essential aspect of clinician–patient/prisoner rapport. An understanding of mental health and mental illness (plus associated effects) is presented as a positive characteristic that their mental healthcare professionals possess. This understanding is contrasted with the relative absence of this form of understanding amongst prisoners as a social group and prison staff as a professional group.

Patients/prisoners describe their meetings with clinicians as successful in terms of mental health outcomes. The experience of collaborative working between patient/prisoner and healthcare professional is noted, and mental health accomplishments are perceived as multiparty achievements.

Furthermore, patients/prisoners narrate a sense of enjoyment as experienced via the trusting human–human face-to-face discussions with their empathetic clinicians who are knowledgeable about mental health. Interviewees display

great respect and affection for their mental healthcare professionals. However, it is understandable that, in the penal social milieu, some patients/prisoners develop rapidly strong and positive feelings towards their healthcare professionals, who are interpreted as caring, kind, understanding, and interested in their wellbeing.

Contrastingly, genuine prisoner–prisoner rapport is noted as not often formed by the patients/prisoners in this study. Connecting emotionally with wing mates is highlighted as difficult and infrequent. Trust is experienced as problematic and challenging in the penal social environment. It appears that cell mates construct, or do not construct, mutually beneficial relationships swiftly in the prison environment. Patients/prisoners state they often avoid undertaking association on the prison wing; instead, they appear to opt for a solitary social existence in the prison environment. Notably, an absence of mental health knowledge amongst the prisoner social group is an often repeated component of the prison social environment.

Poignantly, NHS services and staff are perceived by patients/prisoners as markedly dissimilar to HMPS services and staff. The majority of wing staff are perceived to lack sufficient mental health-based knowledge, understanding, and empathy. Crucially, it is argued that HMPS staff should possess these attributes. This is noted as in addition to their security-orientated roles and responsibilities. Possession or absence of knowledge pertaining to mental health appears to link with the abilities to understand and empathise with mental health service users' health-based desires, behaviours, and needs. Mental health is experienced by prisoners as not of interest (generally) to prison wing staff, and perhaps even considered a nuisance to their day-to-day working life in the prison establishment. However, wing officers who are understood to consider their

working role to extend beyond that of confinement alone are recognised and appreciated by patients/prisoners. Patients/prisoners appeal for a prison system that does not position wing staff to prioritise containment alone; although the situation is developing positively, containment- and security-orientated concerns prevail, leaving health issues to be considered secondary.

For the patients/prisoners included in this study, the ability to engage in compassionate conversations — concerning their mental health — is perceived as beneficial. This applies to all three forms of social interaction discussed: patient–clinician; inmate–inmate; prisoner–staff.

Patients/prisoners narrate personal development intentions alongside a general desire for apt rehabilitation and preparation for release to the community in a variety of senses (*e.g.* good mental health, employment skills, community living tactics). Importantly, patients/prisoners argue that the prison should be responsible for providing these rehabilitation services, and that this should be a prioritised requirement and not a secondary concern for the establishment.

Method/methodology reflection: For the patients/prisoners in this study, several aspects of the social science interview process appear unfamiliar, unsuitable, or uncomfortable. For example, on occasion, the clinical and academic language utilised in the Participant Information Sheet, the Consent Form, and the interview questions is seen to be not aligned with the participants' language/vocabulary/terminology. The nature of conversational turn-taking is also distinctive in the interviews with patients/prisoners in this study; the participant can be seen often to interject and verbally interact (*i.e.* overlap) before the interviewer's question is completed. Another example: one patient/prisoner commences praising his clinician and the nature of the mental healthcare provided before the voice recorder is turned on and the Consent Form

has been signed. Moreover, intermittently, patients/prisoners discuss potentially difficult issues (e.g. criminal convictions) that they have been advised to avoid. Additionally, it is possible that the non-NHS/HMPS interviewer may represent a potential source of issue resolution for patients/prisoners. However, at the end of the interview all participants do understand the interviewer–interviewee relationship, and do not expect any changes in their healthcare or prison life whatsoever. A final illustration: the visible digital voice recorder causes one patient/prisoner distress, so the technical device is hidden from view.

To conclude this chapter, Kleinman (1988) debates illness narratives and explores ‘the intimate and manifold ways by which illness comes to affect our lives’ (p. xi). Kleinman (1988) highlights that although ‘medicine is intimately involved with economics ... There is a moral core to healing in all societies ... [it is] the *central* purpose of medicine’ (p. 253, square brackets and italics added, ellipses to denote removed sections). Kleinman (1988) argues convincingly that medical practice is concerned with ‘both control of disease processes and care for the illness experience’ (p. 253). Accordingly, the mental healthcare professionals’ provision of NHS care in this study — as narrated by the patients — concurs with the purpose of medicine as theorised by Kleinman (1988); the clinicians are perceived by their patients to be concerned with varied mental health illness entities and their ramifications, in conjunction with ethical concern, understanding, and care for the resultant experiences of mental health service users. This chapter represents an exceedingly positive evaluation of the NHS mental healthcare provided to the patients/prisoners involved in this study.

Chapter 6

Participant (prison governor):

*So often with services, it's all about the people who deliver the service,
and not the people who need the care,
especially if the people in need do not, or cannot, ask for change.*

Development of (HMPS) prison (NHS) mental healthcare

This chapter of the thesis represents a deliberation of the data as a whole set of fieldwork knowledge. All study interviews are considered. This chapter's debates epitomise topics as discussed amongst the disparate participant groupings. All interviewees' input are considered worthy; for example, narrated issues, views, and suggestions for change from both prison governors and prisoners are given equal credence. Whereas foregoing thesis chapters explore an aspect of prison mental health from a particular viewpoint (*e.g.* prison mental health service users), this chapter combines the dissimilar social actors' experiences and perceptions and then the social scientist produces cumulative analytical discussions.

Interview excerpts in this chapter of the thesis denote the participant's position in the prison (*e.g.* prison governor), unlike the preceding chapters. This information permits the reader to know comments' origins. The inter-prison anonymity of participants is considered before dissemination of role-specific quotes. Quotes' surrounding analyses are intentionally non-role-specific.

All of the topics discussed in this chapter are considered in relation to their relevance and fit across the interview transcripts as an entire body of data (*i.e.*

deviant case analysis). Where complication or deviation exists, this is debated in the main body of the chapter; there is not a specific section dedicated to variation or anomalies.

In this chapter's title, HMPS and NHS are noted in parentheses. This is because this thesis relates to the UK's public sector prisons and the national healthcare provided therein; however, usage of these parentheses is intended to hint towards a suggestion that the overarching debates included in this chapter are, perhaps, useful for consideration in relation to the UK's private prisons or prison establishments overseas, as examples.

Heretofore, analysis chapters represent discussions of study data in relation to relevant theory. Whilst this analysis chapter includes this form of debate, it is also a development-orientated section of the thesis that incorporates ideas for HMPS and NHS policy and practice change.

It should be made clear that the HMPS staff who act as participants in this study are not frontline wing officers only. Although the prison staff interviewees do work on prison wings and/or have daily wing experience, they do all also occupy more senior positions in the establishment (*e.g.* X wing prison governor). Recruitment of non-managerial wing staff was attempted repeatedly, yet proved ultimately unsuccessful.

In terms of construction, five sub-sections structure the interview topics to be explored in this chapter:

The nature of imprisonment;

Prisoners' time usage and activities desire;

Prison staff: Frontline service provision and (mental health) knowledge;

Dual purpose wing staff: Care and custody;
Specialists and silo working;

The nature of imprisonment

This sub-section of the chapter debates the prevalence and severity of mental illness in prisons — as experienced by this study’s participants — alongside a desire to rectify this situation; furthermore, the prison setting is argued to be inappropriate or detrimental for some prisoners’ mental health. Finally, patient crossover between addiction services and mental health services is introduced.

Although a long excerpt, the following passage (from a member of HMPS staff) acts as a useful introduction to the nature of imprisonment:

Participant (prison governor)¹⁸:

If you walk through the incarceration experience, from the dock in the court and sentencing or remanding in custody, down into the cells, waiting in the cells for ages, and then onto the bus, then into a claustrophobic cubicle on the bus, with a load of white-shirted prison officers there shouting names out, being in a holding cell with people you don’t know. So, there you’ve got: displacement, isolation, fear of the presence of unknown others, the threat of strangers, the forces sharing a living environment, which go beyond any other experience that humans are subjected to in Western society ... Being forced to eat with others, that’s not the end of the world, forced to sleep with others, that’s a bit weird, but also forced to defecate in the presence of others. To be in that

¹⁸ The participant title *prison governor* in this thesis refers to both wing-orientated prison governors, yet also the governing governor of the establishment.

situation up to twenty-three hours a day, to be forced to comply with rigid rules, which are only very briefly explained, but which other people seem to be getting along with very easily, to have your clothes and possessions removed from you, to have future uncertainties of what's going to happen to you [in terms of] sentence and location, to be separated from support networks, to lose your home, if you've ever had one ... Those things are going to make you mad, even if you're well to start with. If you are mad anyway, they're going to make you worse.

(Square brackets added by analyst. Ellipses denote removed sections.)

Across the study's three participant groupings (HCC staff, HMPS staff, and patients/prisoners), there is an agreement concerning — unacceptable — mental illness prevalence in the prison setting; this is then linked with a desire to address and resolve the issue. However, the nature of imprisonment is depicted as often detrimental to mental health.

In relation to prevalence statistics, including substance addictions and PD, up to ninety per cent of prisoners have some form of mental health problem (CMH, 2011 as sourced from Singleton *et al.*, 1988). 'Most prisoners with mental health problems have common conditions, such as depression or anxiety. A small number have more severe conditions such as psychosis' (CMH 2011:2). Rates of self-harm and attempted suicide in prison are high (CMH, 2011). 'For some [prisoners], being in prison will lead them to develop depression or anxiety' (CMH 2011:2, square brackets not in original).

Congruently, in this study, the prison environment is narrated by participants as sometimes problematic for those with mental illnesses:

Participant (prison governor):

There is a higher incidence of psychotic and other serious mental health conditions in prisons than in the community generally, and this is important, that the experience of imprisonment can worsen the distress that people are experiencing as a result of their condition.

Moreover, prison staff describe events that exemplify the severe nature of mental distress experienced in the setting:

Participant (prison governor):

We had an incident on Friday, a man with a mental health condition, I don't know what it is, was self-harming by banging his head against a wall, went to hospital [initially], then refused to go back to hospital [for non-emergency assessment], and was badly hurt. It's just, in prisons, we just think, that's another weird thing that's happened, and then we move on.

Mental illness is depicted by HMPS staff as an (albeit unacceptable) facet of prison life and working in prisons:

Participant (prison governor):

I think mental health is an increasing problem, and it's always in the forefront, because obviously we have a lot of drug users, and mental health can be drug related, so it is in the forefront, and I think sometimes when you look at a prisoner's behaviour, the way they present, often you have to bear in mind whether there are mental health issues, so, yeah, it is definitely a factor in everyday working in a prison, for everyone.

As patient crossover between addiction services and mental health services is significant in this thesis chapter, it is useful to introduce this topic early:

Participant (prison governor):

... We have a lot of lads who come in with the drug problem, but as the drug problem goes away, the mental health problem, under whatever form, can come to the surface ... We had a lad who, as he was coming out of his drug state, became rather, bizarre, shall we say, and, well, he was sectioned [under the Mental Health Act, 1983/2007] in the end.

Furthermore, the penal setting is noted as not appropriate for some persons who are directed to prison and labelled as offenders primarily (rather than mental health service users primarily):

Participant (prison governor):

... You get some people who shouldn't be in jail. For example, about six months or so ago, we have an old-ish chap in, with Alzheimer's disease, you know, prison's not the place for him. At the end of the day, there are X [less than ten] officers and X [just over one hundred and fifty] inmates here [on the wing], so if he's sitting there quiet, we're quite happy, you know, if he's sitting there quietly because he's not able to communicate or there's something wrong, we're still quite happy. It's a bad thing to say, but, you know, you can't give them all individual attention ... Back to this chap with Alzheimer's, everyone could see he shouldn't be in jail, where were the community services? After he punched the first officer in the face we realised why he was here, and we took appropriate protection, keeping him at arms' length, so he couldn't lash out.

This interview excerpt exemplifies issues that arise when illness is combined with offending behaviour in the criminal justice system. The quote below is similar in message:

Participant (prison governor):

We have huge problems with prison mental health and drug misuse, plus anger and agitation.

Moreover, the nature of relationships with offenders who have mental health issues is highlighted as occasionally problematic on prison wings:

Participant (prison governor):

... We had one [prisoner] who had a personality disorder, who was sent to X prison, who then sent him back; he was a very damaged individual. You had to be really careful, because he, well I got on really well with him, so if I said something like, ooh X's really annoying me, he'd go and belt X, you know, so you to be really quite careful. He gave me his toenails one day, that he'd pulled off.

There is strong evidence that the prison context is not always the most suitable environment for some offenders that experience mental illness. Notably, Lord Bradley's DH (2009) review highlights diversion schemes and states:

'community sentences can provide safe and positive opportunities for offenders with mental health problems or learning difficulties to progress with their lives, as well as receiving a proportionate sanction from the court ... [However] for some individuals, a custodial sentence will be necessary. Where this is the case, they should have access to appropriate

treatment, rehabilitation and resettlement services' (pp. 12–13, square brackets not in original, ellipsis to denote removed section).

Thus, when the prison setting *is* required for offenders with mental health problems, healthcare and rehabilitation services should provide apt facilities for this vulnerable social group.

To link this sub-section with its subsequent, the following excerpt demonstrates how the incarceration experience and prison environment is inappropriate for some prisoners with complex healthcare needs, yet also how in contrast certain aspects of the prison setting and regime appear appealing and comforting for some prisoners:

Participant (prison governor):

I mean, an example, although you've probably never met him, X, was an old alcoholic, in the summer he'd be out for a couple of months, and in the winter he'd do a crime, so he could come back in, and, you know, so he'd be warm and dry. You could just see that each time he was coming in he was deteriorating [with Korsakoff's dementia], you know, and I think he's now actually been sectioned [under the Mental Health Act, 1983/2007] ... We impose a regime on them here, that normality, they sleep at night, they go to the gym, OK the food's not brilliant, but they get two hot meals a day, they're looked after, they're fed and watered, it's clean, it's warm.

Prisoners' time usage and activities desire

This sub-section addresses the nature of imprisonment, prisoners' time usage, and prisoners' requests for additional worthy activities. To generalise, the prison setting is narrated as impersonal, inactive, and habitual. This sub-section particularly addresses patient/prisoner narratives. There is debate concerning the comforting versus detrimental character of routine prison life and its repetitive daily schedule. Boredom in prison and a lack of mental stimulus are narrated as problematic. Finally, apt preparation for release and reoffending rates are discussed.

To summarise, it is not aspects of prison mental healthcare *per se* that are criticised by the patients involved in this study. Instead, it is aspects of the prison social and structural settings that receive attention. In relation to patients' desires, Crinson (2009) questions whether the NHS is really a patient-led health service and discusses the NHS choice agenda and demand-side NHS reforms. Health strategy currently prioritises greater patient choice and more personalised healthcare services. Crinson (2009) debates consumerism and the exercise of healthcare service user choice in contemporary health policy. Patients — in this study — appeal for additional activities in their treatment locale (*i.e.* the penal setting). Therefore, experiences of imprisonment represent a useful starting point for this sub-section. Overall, multiple forms of isolation and inactivity are included in the patient/prisoner narratives:

Participant (patient/prisoner):

In the community you've got people you can talk to, all the time, when you've got friends, family, and whatever. In prison, you're just stuck

*behind a door for twenty-three hours of the day, staring at the TV screen.
I dread it.*

Likewise, prison establishments are narrated — by HMPS staff — as largely impersonal institutions with rigid routines:

Participant (prison governor):

Too often the prison service is a sausage factory. Get 'em in, get 'em categorised, get 'em their number, get 'em in their bunk; that's it, end of story.

As noted previously, this sub-section specifically includes patients'/prisoners' narratives. In support of this, Chambers *et al.* (2005) debate mental health nursing education and highlight:

‘the strange relationship between this very personal human [mental health] knowledge and the impersonal curriculum most mental health students are exposed to (where the emphasis is almost exclusively on the treatment of symptoms, with the vital separation of ‘them’ from ‘us’); the treated from the treaters’ (p. 114, square brackets not in original, parentheses and apostrophes in original).

As this thesis adopts a holistic approach to (mental) health and wellbeing and places great emphasis on the social and structural nature and development of a patient's living environment, Chambers *et al.*'s (2005) aforementioned (theoretical and practical) separation of the treated from the treaters is not ideal. Therefore, involvement of service users is both apt and beneficial.

Moreover, Lester and Glasby (2010) argue ‘the writings of people who have experienced mental illness first hand are invaluable in providing an insight that neither romanticises not underestimates the meaning, effects and consequences’ (p. 3). In addition,

‘until very recently, mental health service users have been almost universally perceived as passive recipients of care. However, over the past 20 years, users’ views on service provision have become more accepted as a valuable part of health and social care’ (Lester and Glasby 2010:15).

Therefore, in this thesis chapter that debates potential developments to prison mental health and prison mental healthcare, patients’/prisoners’ narratives are included as their experiences, perceptions, and understandings regarding the nature of imprisonment are pertinent for consideration.

Gillard (forthcoming) explores the emerging Peer Worker role in mental health service delivery in the community setting via Mental Health NHS Trusts and mental health organisations from the voluntary sector. The Peer Worker positions are occupied by persons who have previously utilised mental health services themselves. These employees then work officially alongside, or in, the community mental health teams. Two notions underpin this Peer Worker scheme: previous patients can aid current patients; patients should be permitted involvement in both their care and the services provided. Congruently, user-involved approaches to mental health policy and practice developments are supported in this thesis.

Prisoners’ time usage and activities desires are now considered. In relation to prisoners’ time usage, the suggestion posed is that the current amount of time

without worthy activities is problematic — for the mental health service users who act as interviewees in this study:

Participant (patient/prisoner):

I find, erm, what I do find, is that, err, we've got so much time on our hands. This is where the danger is. I think this still needs improving. You work. You come in. You have an hour's association. Then you're banged up, all night. I think there could be some more activity, or just something else to do, anything.

A desire for additional activities is professed by this social group of interviewees. Increased activity and stimulus in physical/practical and mental/psychological/emotional respects is requested, in order to decrease time spent alone and inactive:

Interviewer:

So someone to talk to and more activities seem to be things (overlaps)

Participant (patient/prisoner):

I think you've got, when you've got mental health problems, being sat on your own, with stuff, it starts to do your head in, even more.

Once again in this thesis, the enjoyment and usefulness of gym, as a mentally and psychically stimulating activity, is repeated:

Interviewer:

What about generally having more activities to do?

Participant (patient/prisoner):

Yeah. The gym is important. It's something to do. Yeah, more activities would be good. I would echo that suggestion.

Further to the existence of gym visits, patients/prisoners suggest additional creative pursuits may be beneficial in a therapeutic sense:

Interviewer:

What kind of activities, do you think?

Participant (patient/prisoner):

For people who can't really work properly, they should have a workshop or something for them. To do therapeutic stuff. Like painting. Or artwork. Or pottery. Creative things.

Where patients/prisoners do engage with creative endeavours, these are narrated as gratifying and helpful:

Interviewer:

Do you think your wing work has helped in terms of keeping you busy and a bit more distracted from mental health issues?

Participant (patient/prisoner):

Yeah, I enjoy it. I think it's therapeutic, really. Painting an' that. Yeah, it has helped, yeah.

Regarding patients'/prisoners' futures, the structured and repetitive, yet relatively deficient in action, nature of imprisonment is then linked to a lack of apt preparation (e.g. employment training) for release:

Participant (patient/prisoner):

It adds to the stress, doing the same thing every single day, it's like Ground Hog Day, that film, doing the same thing every single minute of every day.

Interviewer:

So the structure and the regime you don't find comforting?

Participant (patient/prisoner):

No ... In here, especially on this VP wing, all you do is put teabags into bags, and that's supposed to train you how to work when you get out? Prison is supposed to teach you that, isn't it?

Repetition is highlighted alongside an absence of employment training in preparation for release. Furthermore, there is an understanding from these patients/prisoners that prison *should* be teaching prisoners skills for the workplace post-sentence.

In relation to the prison regime and mental health, the repetitive nature of imprisonment is discussed in reference to negative mental health ramifications:

Participant (patient/prisoner):

... They think a TV solves everything in here. [But] people with certain mental health problems watching repetitive things on the TV every day, that's what starts winding you up, you get a bit messed up in the head, if you know what I mean. You need mental stimulation all the time.

Interviewer:

So maybe more activities would help?

Participant (patient/prisoner):

Oh, definitely 'cause you're banged up in here twenty-three hours a day. Most of the time it's twenty-four hours one day, twenty-three hours the next day. You only get out on association every other day.

A lack of mental stimulation and activities are reported:

Interviewer:

So which of your suggestions do you think would also benefit the mental health of prisoners?

Participant (patient/prisoner):

Just to give them more activities to do. More stimulation. When you're getting something out of it, but you're also putting something into it as well.

Furthermore, the experience of boredom is linked with (a perceived absence of) rehabilitation in prisons:

Interviewer:

Is boredom something that you experience?

Participant (patient/prisoner):

That's the big thing, yeah, especially in terms of rehabilitation, they don't rehabilitate anyone, when all they do is lock you in your cell, it's just pure punishment, that's it.

However, the patient/prisoners involved in this study do both recognise and support the punishment aspect of imprisonment:

Participant (patient/prisoner):

... Then I look at the fact that, we're in prison, do you know what I mean, we are here as well to be punished.

It is not punishment that is recorded as problematic; it is, instead, the experienced lack of valuable and stimulating activities that is highlighted as challenging — both in relation to mental health and preparation for release.

Overall, the patients/prisoners interviewed accept their removal of liberty yet routes to rehabilitation in a broad sense (*e.g.* good mental health, skills for employment post-sentence, an end to substance misuse) and preparation for release are sought.

An ongoing NIHR Service Delivery & Organisation (SDO) programme (project 09/1801/1069, led by Dr Pinfold) explores community health networks for individuals with SMI (*e.g.* schizophrenia, bipolar affective disorder). The rationale underlying community health networks for mental health service users is that SMI patients benefit from participation in physical and creative activities (*e.g.* walking groups, art classes). Furthermore, activities such as neighbourhood/friendship involvement and employment are noted as valuable. However, in prisons, the natures of both employment and kinship are altered in the custodial environment. The — volatile and often problematic — prison social setting is outlined in this thesis' literature review. Moreover, opportunities for engagement in additional creative and physical activities are limited for prisoners in the UK's prison establishments.

The nature of unstructured free-time in prison is now addressed. Firstly, the previous sub-section ended with an interview excerpt depicting a repeat offender

with Korsakoff's dementia who opted to return to the prison each winter. In addition, as recorded below, the routine of the prison is considered comforting for some prisoners:

Participant (prison governor):

... We get them up, they eat, they go to work, they come back, they like that routine. Prisoners like that routine, you know, some of these lads like the routine, they know what's happening, it's when you disturb the routine that they get unsettled.

Disturbances to the structured daily routine of the prison are highlighted as difficult for some prisoners:

Participant (prison governor):

There are bound to be occasions when a prisoner will experience difficulty when there's a change in the routine, for example via association time, when they're left to their own devices, when the door opens, and there's no structure to that door being opened; it's their free time, to go on the telephone, play pool, have a shower, clean their cell out, that type of thing. The average person knows what to do in that free time, but some prisoners become confused then, because there's no structure. Why's that door open? Most of the time in prison, the door's only opened to go to work, open for a meal, open for exercise. It's open for a specific reason. I think maybe sometimes this situation can cause a bit of confusion when certain individuals do not know what to do with that sudden free time.

Therefore, the notion of unstructured free-time on prison wings is, in some instances, for some prisoners, problematic.

To recap, it is not an increase in unstructured time away from the daily regime that is desired; rather, it is the inclusion of constructive activities into the regular prison schedule that is considered warranted. The feasibility of these additional activities is now debated.

Edgar *et al.* (2011), via the Prison Reform Trust, provide a guide to volunteering and active citizenship in prison entitled *Time Well Spent*; its forward states:

‘it is a fallacy that people in prison are content to wallow in a state of irresponsibility whilst lounging around wasting time just waiting for the day when the gates are opened so they can stroll back out into their feckless, crime-sullied lives ... Prison, quite rightly, is meant to separate from society those who cause serious harm and distress to others. But since the vast majority of prisoners will one day be released, an equally important function of imprisonment is to ensure with as much rigour as possible that once they are released they are able and motivated to take a positively active role in society’ (pp. 3–4, ellipsis to denote removed section).

To summarise, the active citizenship in prisons discussed by Edgar *et al.* (2011) includes five schemes: peer support; community work; restorative justice; democratic participation in prison life; arts and media projects (p. 14); many of these roles provide practical skills and help in terms of ‘job-readiness’ (p. 21). Prisoners report valuing these opportunities as they involve time with a purpose, the acquisition of skills, being trusted, and representing ‘a chance to give something back’ (p. 21).

Of particular relevance to the UK presently and the current goals of Kenneth Clarke (the incumbent Secretary of State for Justice), Edgar *et al.* (2011) link active citizenship and volunteering in prison with a potential reduction in reoffending:

‘if, as the evidence suggests, active citizenship in prisons supports desistance, then its beneficial long-term impact reaches far beyond the individual prisoner and the prison, to society at large, and wider society could only gain from its expansion (p. 20)¹⁹.

Therefore, such activities in prison may benefit both the prisoners inside the prisons’ walls and the citizens who reside beyond the prisons’ gates.

Overall, ‘too often, most of the time spent in prison is idle. Activities that give a sense of purpose in prison are the exception’ (Edgar *et al.* 2011:21). This thesis argues that this situation is lamentable and represents a waste of prisoners’ time and tax payers’ money; this is particularly the case when current high rates of reoffending and prisoners’ mental health and general wellbeing concerns are considered alongside this issue. Further to this, data from this work suggest offenders *themselves* regret the time spent inactive, thus these proposed reforms do not merely represent the imposition of un-desired change *on* prisoners. (Although, it is of course important to recognise here that this study involves only a diminutive number of the prisoner population).

¹⁹ Edgar *et al.* (2011) highlight although active citizenship and volunteering in prison might contribute to desistance, prison is only the beginning and change must also occur in relation to persons leaving prison. Therefore, assertive outreach services and post-release professional contact (*e.g.* community mental healthcare, if required) is important when considering reoffending fully.

The cost of additional activities in prison is a cause for initial concern, admittedly. Edgar *et al.* (2011) debate the costs of volunteering and active citizenship schemes in prisons; one of their activity cost solutions is to increasingly ‘involve voluntary sector organisations more intensely in delivery’ (p. 62). It is recognised that economic resources are relevant when considering implementing innovative or supplementary public services. However, perhaps in this instance, potential long-term benefits for both offenders and wider society represent worthy possible outcomes in relation to monetary expenditure.

Crinson (2009) notes how restructuring of health policy across Britain and other European Union countries over the past twenty years has shifted to highlight ‘greater individual responsibility for personal health and welfare’ (p. 36). Therefore, the implications for practice in prisons outlined in this sub-section possess health policy salience and align well with this contemporary welfare principle, as patients/prisoners are requesting additional activities in the penal setting to develop beneficially their mental health and preparation for release – both of which echo personal responsibility for health and welfare policy ideals.

Finally, the Prison Reform Trust (2011) report there are around twenty-four thousand work places for prisoners across the prison service in workshops, cleaning, and catering — mostly still menial low grade work — meaning that under a third of the prisoner population are engaged in work activities at any one time. The provision of appropriate work opportunities for prisoners is not currently a central part of the prison regime (Prison Reform Trust, 2011).

Evidently, insufficient worthwhile activities are provided for prisoners in the UK’s system. This is particularly significant and problematic when reform, rehabilitation, and preparation for release are remembered as objectives for this

public service. This relative absence of meaningful work schemes persists despite ninety-seven per cent of surveyed offenders expressing the desire to stop reoffending and sixty-eight per cent stressing the importance of securing a job on release (Prison Reform Trust, 2011). It could, therefore, perhaps be inferred that many of this country's prisoners are willing to engage with prison-based employment skills acquisition courses and it is actually the prison service itself that is failing this social group, in this respect, and thus conceivably affecting reoffending rates — although this is, admittedly, a dramatic and likely disputed suggestion.

Finally, Coyle (2005) highlights 'many prisons have well developed education and work programmes, as well as a variety of skills training courses' (p. 115) that intend to provide purposeful and constructive activities to address reoffending. Therefore, this thesis recognises that some prison establishments provide worthwhile activity schemes. However, the patients/prisoners in this study, who are housed in the host prison establishment, do experience a paucity of worthy pursuits and endeavours.

Prison staff: Frontline service provision and (mental health) knowledge

This sub-section focuses on HMPS staff, especially the interactions between landing staff and landing inhabitants. The nature of communication in prisons is raised. In addition, wing officers' length of service is debated. Mental health is then narrated as somewhat problematic in relation to its covert and non-visible characteristics; an ability to recognise mental health signs and symptoms is sought. Mental health awareness training for prison staff is proposed and then potential positive ramifications are discussed. The language of mental health and the mental health message in the prison system is questioned. Issues associated

with the training of professional groups are debated. The natures of cultural change and staff attitudes are raised. In addition, the need to focus on (mental health awareness) trainees' questions, agendas, or anxieties is highlighted. Finally, prison leadership and training engagement is considered.

Firstly, relations between prison staff and their prisoners are pertinent:

Participant (prison governor):

What about the relationship that [prison] frontline staff have with prisoners, to what extent is that relationship promoting wellbeing, or adding to distress?

Regarding these interactions between staff and patients/prisoners, Mitchell and Latchford (2010) utilise a personal construct psychology approach and question adult male prisoners regarding mental health problems and help-seeking routes; their work highlights 'the importance of both formal and informal sources of help for mental health problems in prison' (p. 773). RMNs and In-reach clinicians provide the formal mental healthcare; however, prison wing staff could embody excellent informal sources of care for mental health service users in the prison context.

However, decisions regarding prisoners' selected help sources are dependent on anticipated response, existence/absence of trust, and perceived skill level (Mitchell and Latchford, 2011); these are poignant characteristics of prisoner-staff relationships that are addressed in this thesis and are demonstrated as crucial concerns for the patients/prisoners in this study.

It is recognised by prison service staff that interactions between inmates and their wing staff are key to the prison environment:

Participant (prison governor):

The most crucial relationship is that between the prison staff and prisoners.

It is argued that the nature of the communication between prison staff and prison inmates is ripe for alteration. Increasingly civilised associations are suggested by study participants, as these may:

Participant (prison governor):

... have a fantastic impact on [prisoner] wellbeing ... that's conducive to mental health.

As an aside, heretofore, a potential association between (mental health) medication and its effectiveness in relation to the prison setting has not been professed overtly by study participants; however, this possible link is here introduced by interviewees — in respect to social interaction in the penal setting:

Participant (prison governor):

So, mental wellbeing, mental health, [it] comes down to a smile, courtesy, respect, hope, humour, personal development, and resolution of problems. It's not just about anti-psychotic medication [however] any medication will be more effective if these other things exist.

Winkelman (2009) addresses cultural competence in healthcare setting and lists thirty components of 'interpersonal difference in social interaction rules' (p. 97)

(e.g. paralinguistic cues, kinesics (touch), negotiation approaches, metalinguistic messages, proxemics (space), conflict management). This thesis does not deliberate Winkelman's (2009) cross-cultural medical anthropology theories fully; however, it is evident that sensitivity and responsiveness — in relation to interactions between patients and their carers (whether this be a NHS In-reach team member or a member of HMPS wing staff) — are beneficial in terms of therapeutic outcomes for patients.

Moreover, Lester and Glasby (2010) note 'mental health is more than simply an absence of symptoms of mental illness or distress. Mental health refers to a positive sense of well-being' (p. 2). Here is where prison officers can further assist patients/prisoners. The nature of their relations and interactions with prisoners are influential and impact the imprisonment experiences of prisoners. These relationships can be *intended* and enacted to aid wellbeing. This notion of intent is relevant when Winkelman's (2009) social support and health debates are considered. Winkelman (2009) outlines how 'the effects of social relations on health requires distinguishing social networks and support and what they provide' (p. 312); social networks comprise myriad facets including 'the quality, frequency, intensity, durability, and strength of interactions' (p. 312). It is possible — providing there exists professional group willing — to develop prisoner–staff interactions in-line with the aforementioned characteristics, in order to aid the maintenance of, or recovery to, mental health on prison wings.

Whilst prisoner–staff interactions remain the focus of analysis, the (often extensive) length of prison service is worthy of debate:

Participant (prison governor):

You can argue staff stay too long. They're too tied to working in the public service. That's frontline prison officers ... Hardly anyone resigns from the public service.

Lengthy careers of wing staff have ramifications for the establishment's occupational culture and, therefore, the individual prison setting's approach to change initiatives; this is poignant, as this sub-section represents a change initiative for the HMPS staff professional grouping. This development is discussed subsequently. Furthermore, the prolonged nature of wing officers' interactions with the penal environment re-raises institutionalisation-based concepts and concerns, yet in relation to prison staff.

It is worth including a short positive reflection here on the length of prison staff service. Previously in this thesis, beneficial ramifications of lengthy service have not been included. However, the following interview excerpt highlights one example where a wealth of wing officer experience is influential and important:

Participant (prison governor):

... Newer officers take time. But older colleagues can hear a sound and think, that's not a right noise, so we've gone out, and there's been a fight going on, you know. Experience. I hear noise and can tell if it's usual wing noise.

To return to aspects that can be problematic for staff-prisoner interactions in relation to mental health, the exceedingly complex nature of mental health/illness is acknowledged by participants, particularly these non-clinical interviewees. Prison staff state the somewhat covert existence of numerous

mental health issues, symptoms, and signs amplifies workplace issues for frontline wing staff:

Participant (prison governor):

We could almost do with an assessment tool, a reliable assessment tool, but there isn't one for mental health. It's not like for a drugs test, where I just say, pee in here, and then they're either positive or negative. If only it was that easy.

Participant (prison governor):

If only you came out in spots if you have psychosis, it'd be much better wouldn't it.

These excerpts highlight the difficulties surrounding identification of mental distress for the non-clinical HMPS staff. Mental illness is discussed in relation to its non-visible facets and how these complicate the notion of understanding mental health and working with mental health service users in the penal setting — for prison staff.

Interestingly, for prison landing staff, the route to a prisoner's mental health need recognition is often via a disciplinary course of action in the first instance:

Participant (prison governor):

Well most of the time prisoners come to my attention from [wing] staff, sometimes purely on a mental health basis, but mostly because of their behaviour that's being displayed. Mostly anti-social or, not conforming, shall we say, to what's expected according to the normal routine, or regime even. So, staff will raise their concerns predominantly through a,

sort of, disciplinary channel, at least initially, but when we look at it, it sometimes suddenly clicks, and it's mental health related.

The knowledge and power to identify signs and symptoms associated with mental illness is discussed:

Participant (prison governor):

Staff will absorb any information that will benefit staff in terms of how they deal with prisoners. Yes, definitely. In terms of the ramifications, it'll provide staff with a better understanding of prisoners' behaviours, and why a prisoner reacts in a particular way. Identifying early signs. Hopefully, if they get that knowledge, they can then use the [health] services we've got, better, via referring. So, yeah, I think, I don't think there'd be any negative ramifications. I think any knowledge, you know, knowledge is power, and I wish to empower staff to identify signs.

Therefore, the complex combination of mental health's covert facets in tandem with displayed behaviour-related effects, is somewhat challenging in terms of prison wing staff's understanding of mental illness and their relations with prisoners.

Overall, however:

Participant (prison governor):

Staff are good at recognising the difference between those prisoners that don't [conform to rules and regimes], and those that can't. It's how we deal with those that can't that needs addressing.

In order to address this situation, perhaps mental health awareness training of HMPS staff is a worthy consideration. Therefore, the analysis of prison staff mental health knowledge occupies the remainder of this sub-section. The notion of mental health language and message in the prison context is introduced alongside debate regarding the feasibility and desirability of mental health awareness training courses for prison staff.

The quote below summarises the responses where both HMPS and NHS staff are asked to comment on the proposal concerning the provision of mental health awareness training to all HMPS staff:

Participant (HMPS psychologist):

... Definitely, yes, I think it would be beneficial.

Arguably, developed mental health knowledge of prison staff would also benefit NHS HCC staff:

Participant (prison governor):

... It'd also help them with their [i.e. the HCC's] healthcare and referrals ...

The suggestion made here is that developed mental health knowledge of landing staff may aid both HMPS staff–NHS staff and HMPS staff–patient/prisoner relationships:

Participant (HMPS psychologist):

I think it's about trying to sell to them [wing staff] the idea that: these are people that they're working with, and it's about trying to manage

those behaviours, and if they're recognising the [mental health] symptoms they know when to call Healthcare for help, and when not to, plus also when to excuse someone's behaviour because they can think, and attribute it to their mental health, and therefore it's not just prisoners playing up.

Potential positive ramifications for prisoners, prison staff, and NHS clinicians appear possible.

Woodward (2007) discusses the set-up of therapeutic communities in non-therapeutic community organisations (e.g. HMPS establishments). This creation requires partnership and sharing; however, intergroup anxiety, envy, struggle, and rivalry are also encountered. Notably, the concept symbiosis is introduced:

‘symbiosis is about the association of two different organisms living attached to each other or one within the other. It is a living together and a co-operation between persons: in this case, between different milieu or regimes. The definition symbiosis implies mutual benefit to partners and this is different from the relationship between host and a parasite (Woodward 2007: 223).

Using this notion of symbiosis, mutual benefit for service delivery partners (i.e. prison landing staff and prison mental health clinicians) as a result of mental health awareness training of wing staff represents a potential outcome.

However, Woodward (2007) demonstrates the fabrication of therapeutic settings in prisons can be interpreted as threatening in relation to the existing establishment's dominant organisational culture. Both practical and philosophical disparities between the operation of a therapeutic community and

the operation of a general prison are detailed. Although this thesis is not suggesting the creation of therapeutic environments in HMPS establishments²⁰, the nature of a prison setting's dominant organisational culture is a pertinent issue. In support of this assertion, Crinson (2009) highlights Weber's account of bureaucratic organisational forms and concludes Weber's 'concerns with the cultural and institutional constitution of organisations as structures of dominant cultural values and ideology does represent an enduring legacy' (p. 41).

Furthermore, Woodward (2007) lists six issues that are to be addressed and overcome if therapeutic environments are to be fashioned in this form of bureaucratic organisation; number three: 'ignorance about the function and purpose of a therapeutic community' (p. 224). Therefore, in relation to the implementation of mental health awareness training in prisons, perhaps the function and purpose of prison mental healthcare requires clarification alongside a highlighting of the role wing staff can play, as non-clinicians in the environment, in relation to mental health patients'/prisoners' general wellbeing. An explicit explanation of healthcare and non-healthcare roles and responsibilities may be beneficial to promote engagement with training; as Woodward (2007) highlights, clarification regarding intentions is key from the outset.

Moreover, as Woodward (2007) notes, therapeutic community managers in prison settings must be the 'translator' (p. 225) of the therapeutic community 'tongue' (p. 225) to the host organisation. Although this thesis does not relate directly to the nature of therapeutic communities, this message remains pertinent. The *language* of mental health in the prison milieu is central.

²⁰ For relevant literature, see Smartt (2001) *Grendon Tales: Stories from a Therapeutic Community* and study HMP Grendon as an example.

The task for a manager of a therapeutic community ‘is to try and encourage the same process to take place within the wider organization, however the organization needs to be able to engage in the process and for that it needs the language of the process’ (Woodward 2007:229). Therefore, mental health awareness training of prison landing staff may represent an apt opportunity to further introduce informed and sensitive mental health language to the prison establishment as an organisation with its more usual (non-health orientated) occupational vocabulary.

To further this notion of mental health language, Adolphs *et al.* (2004) debate frameworks for text analysis of healthcare contexts and study communication in healthcare encounters. Corpus linguistics is applied by Adolphs *et al.* (2004) to develop understanding of communicative events in clinical settings ‘with implications for professional education and working practice in health care’ (p. 10). Communication in NHS environments is not the topic for address here; however, healthcare linguistic theory in general is applicable to a deliberation of patient/prisoner–wing staff relationships alongside a consideration of HMPS staff mental health language and vocabulary, as the notions interaction and communication are debated by this study’s interviewees:

Participant (prison governor):

It’s all about staff interactions with prisoners. That’s what makes a prison. It’s about communication and interaction.

There exists a great volume of research on language in healthcare and the interactions between doctors, nurses, or pharmacists and their patients. ‘Conversation analysis and ethnomethodology seek to understand how interactants jointly construct reality in clinical encounters and look at how

language facilitate the goals, ambitions and practical procedures of clinical work' (Adolphs *et al.* 2004:11). However, of interest here is the relationship between prison staff and patients/prisoners in non-clinical encounters. Nevertheless, applied clinical linguistics, healthcare communication literature, and healthcare encounter studies that explore language usage can 'enable practitioners to guide their interactions down the most advantageous channels so as to ensure that clients are empowered to make the most of the treatments and advice they are given' (Adolphs *et al.* 2004:26).

The notion of patient empowerment (to assist treatment adherence and effectiveness) via communication is raised. This is where prison landing staff and their verbal interactions with patients/prisoners are pertinent. After all, a NHS In-reach clinician may meet a secondary-level mental health service user perhaps once every two weeks for one hour, yet prison wing staff interact and speak with these patients/prisoners daily. Encouragingly, Armitage *et al.* (2003) report mental health nurses at Leicester prison consider the new In-reach services to be beneficial, as:

'it has increased communication and links between healthcare staff and prison officers and, most importantly, provides support and expertise for [prison] staff dealing with difficult behaviour' (p. 42, square brackets added).

Roberts *et al.* (2010) question the use of language in criminal justice more generally (*e.g.* 'if we want to understand criminal justice it is also important to understand the way in which the public discourse about it is constructed' (p. 30)). Of relevance for this study, Roberts *et al.* (2010) debate the labelling of persons as offenders as 'counter-productive' (p. 30) arguing:

‘someone who commits an offence is not an offender; they are someone who has done something. The action does not define the whole person. They may also do good things and they will certainly fit into other categories that can offer a different definition like parent or friend. By insisting that the offence overcomes all other parts of the person we are condemning them to a sub-human category for whom there is no hope’ (p. 30).

This argument considers the label offender detrimental; furthermore, Roberts *et al.* (2010) suggest ‘our language about people who have committed offences must change’ (p. 30). Although the remit of Roberts *et al.*’s (2010) work far outstretches that of this study, it is possible to use their arguments to highlight the importance of communication and language usage in the prison setting. It could also be suggested that this situation is compounded for those persons in prison who possess two labels (*i.e.* offender and mental health service user).

HMPS staff participants report the importance of mental health, as a workplace message amongst landing staff, requires development. Edgar *et al.* (2011) attempt to develop the suitability of active citizenship and volunteering schemes in prisons; it is suggested that one of the routes to success is via gaining the support of prison wing staff. The argument posed is, once the scheme is internalised and experienced as normal by landing staff, ‘less effort is required to make it work’ (Edgar *et al.* 2011:45). The service must be established as part of the regime of the prison. Therefore, perhaps both the aforementioned mental health message and the engagement with mental health awareness training and knowledge need become normality in this penal workplace setting, similar to the standardised and expected key and security training in prisons. There is clearly a

temporal aspect to establishing a practice as customary and part of an establishment's regime; therefore, long-term vision and drive are vital.

This message of mental health importance requires proliferation; however, production of a message is of little use if wing staff do not possess the time at work to, for example, attend the related training courses:

Participant (HMPS psychologist):

... There are so many courses, some mandatory, some voluntary, so many courses that this prison, and others, are under pressure to put on, so it's about trying to free the staff up to attend those that are seen as important. Unfortunately, sometimes, mental health awareness isn't seen as important, so it's put in the background ... It's about trying to prioritise that. It's about management sending out the message that this is really very important.

However, differences of opinion exist concerning this mental health awareness training of prison staff:

Participant (prison governor):

It's not really seen as a number one priority where training needs are concerned.

Notably, this does not imply that any mental health training would be resisted or refuted; it does, however, indicate that the roles and responsibilities of frontline wing staff — as conceptualised by HMPS staff — have need of training attention in other areas before mental health becomes a training priority.

Furthermore, the effectiveness and uptake of training is questioned:

Participant (HMPS psychologist):

... It's just trying to sell it to them [wing staff] in a positive way. I think sometimes training, not here specifically, but there is a view, "Ooh, I've got to go on a training course", rather negatively, so it's about getting new people interested in it.

Generally, where prison governors are asked how amenable landing staff might be to mental health awareness training, the response is positive:

Participant (prison governor):

I think staff would take it on board, because it's frustrating for them, as, on the whole, they just want to work with offenders well. It's frustrating because they haven't got the skills to identify or assist, hence the 'phone calls to Healthcare, where the call consists of them saying: 'We've got an issue here, can you come and talk to them'? On the whole, I think prison officers would respond to formalised training.

However, exceptions exist:

Participant (prison governor):

With the officers, you have your autocratics, your people who are easy going, your people who are not so easy going, you know, your people who are just here to draw their money, do their thing, and go home.

Therefore, it is noted that any such training should be billed as of long-term benefit to the profession:

Participant (prison governor):

I think if you were to pitch it at the fact that it'll help them in the long run, you know, we're not teaching about mental health to make you nursing staff, we're teaching you to identify, or classify, or seek help. If you suspect that X has a problem, 'phone this number [for example].

Edgar *et al.* (2011) highlight how support of prison officers is crucial to fully efficient active citizenship and volunteering schemes in prisons. Suggestions to overcome any resistance encountered are 'summarised under four themes' (p. 43) and this list includes 'demonstrate its benefits' (p. 43). Therefore, possible benefits and positive ramifications of any mental health awareness training must be stated clearly and concisely for landing staff, in order to optimise engagement.

Arnold (2008) outlines the nature of Prison Officer Entry Level Training — the course for new entrant prison officers — and states:

'the initial training course did impact on individuals in many positive ways, particularly in instilling self-confidence and efficacy, teamwork, loyalty to colleagues and a sense of unity, commitment and cohesion' (p. 415).

Thus, prison training courses can, and do, have positive ramifications for wing work and can be, and are, experienced as enjoyable and appreciated by frontline prison staff.

Additionally, prison staff themselves provide apt rationale for the training:

Participant (prison governor):

I think the thing is about staff having the knowledge of how best to deal with that prisoner on the wing ... I think with [prison] staff it's more about guidance and help, so that they know how to manage when the In-reach and mental health staff aren't there.

Interviewer:

Almost, sort of, bridging the gap, at weekends and evenings when In-reach are not around?

Participant (prison governor):

Yes, yes, more training to manage the vulnerable then.

So, what should this mental health awareness training consist of? The work of Tilley (2005) has utility here. Tilley (2005) debates the UK's field of psychiatric and mental health nursing knowledge and training; the sociology of knowledge model adopted 'is understood diachronically, as changing and developing over time' (p. 9). Furthermore, four dimensions of nursing knowledge are debated in relation to two continuums: personal-political and practical-theoretical (p. 9).

Thus far, therefore, Tilley (2005) provides five foci to debate mental health knowledge and mental health training. Moreover, in Tilley's (2005) edited text, Norman (2005) presents four markedly different models of mental health nurse education (p. 136). Evidently, the nature of mental health knowledge and training is convoluted and disputed.

To summarise Tilley (2005), 'knowledge camps' (Chambers and Parkes 2005:171) and difference characterise the field of psychiatric and mental health

nursing knowledge and education. Tilley's (2005) edited 'chapters arguably represent a polarisation of fields and forms of knowledge, with some favouring a more positivist approach and others an experiential one' (Chambers and Parkes 2005:171); the coexistence of 'interpersonal relations and the evidence-based health care traditions' (Norman 2005a:174) divide mental health nursing and its body of knowledge in the UK.

Forrest and Masters (2005) debate this difference between the user/carer informed approach and the traditional approach to mental health nursing education. The user/carer informed approach emphasises teaching (mental health) qualities and attitudes — not traditional mental health theories or diagnostic labels. Moreover, this user/carer approach to knowledge and education intends to challenge and inspire change in (mental health) practice and service provision via highlighting users' agendas. Therefore, prison-based mental health awareness training for wing staff should, arguably, be delivered in reference to patients'/prisoners' (mental health) agendas, needs, problems, and desires.

Norman (2005a) argues:

'the debate is between those nurses who are concerned primarily with understanding the *process* of nursing as a discrete activity based on the *relationship* between the nurse and individual *person* in *distress*, and those who are concerned primarily with *interventions* or *treatments* for *patients* with diagnosed mental *illness*' (p. 174, italics in original).

In relation to HMPS staff, it is the first of these two forms of knowledge that is relevant for mental health awareness training. It is the nature of the relationship between landing staff and distressed prisoners that is of importance — and not the clinical treatment of illness.

To clarify, Lester and Glasby (2010) highlight central tenets of both the disease model and the social causation model of mental health policy and practice. To summarise, physical pathology and classification characterise the disease approach, whereas social forces (e.g. social class, social role) and societal influences characterise the social causation approach (Lester and Glasby 2010:8–9). It is aspects of social causation theory that are relevant for HMPS staff. The clinically detailed issues of aetiology, definition, severity, and interventions remain the domain of prison-based NHS medical staff.

Participant (HMPS psychologist):

I think the main thing is training, for all sorts of staff, not just officers who're on the frontline, but, you know, all staff that are coming in contact with prisoners. Some sort of training, to tell them, look, these are the types of mental health issues, this is what we use to diagnose them, this is personality disorder, for example, this is what it is, they don't need to worry about the labels, but these are the behaviours that you might see, and this is how you can manage them. Not just a quick, you know, a quick overview of clinical names, but more about saying, look, when a guy behaves like this, this is how to help him. I think something like that would be really useful.

Clinical names, phrases, and aetiology are cited as not important or relevant knowledge for prison staff; instead, it is an understanding of the behavioural aspects of mental illness that are narrated as warranted.

Notably, the suitability of the institution's regime for mental healthcare patients/prisoners is re-raised:

Participant (prison governor):

We need strategies for how we manage that person on the wing. If that means offering them a different regime, then that's what we need to do, rather than still squeezing them through the same mechanical routine.

How is this staff–patient/prisoner relationship to be altered via the proposed mental health awareness training? Ryan (2005) situates nursing knowledge ‘in its hierarchy of social being’ (p. 217) and highlights connections between ‘the socio-professional sources that condition that work’ (p. 217) and ‘the socio-political shifts that condition the profession itself’ (p. 217). Mental health nursing is governed, to some extent, by its social, professional, and political contexts.

Ryan (2005) is debating the field of nursing knowledge and not the field of HMPS staff knowledge; however, these characteristics of knowledge are also relevant for HMPS staff as a professional grouping. The condition of the profession may need to undergo a slight socio-political shift in order to position itself as a mass of employees that desires — as a professional body — to undertake (and then implement any acquired knowledge) from mental health awareness training.

Therefore, prison staff attitudes and prison staff culture are now discussed in relation to interactions and relations with prisoners, alongside a questioning of change initiatives in institutional settings.

There is recognition from study participants that relationships between staff and prisoners could be — willing reliant — developed beneficially:

Participant (prison governor):

The use of force in prisons and the way people speak to each other could be altered culturally. It's not difficult to change, but people need to want to.

Lester and Glasby (2010) note ‘the culture of an organisation is also important in implementing change’ (p. 49) in the field of mental health policy and practice. It is important to consider the cultural nature of prison officers’ work in the prison setting. The possibility of cultural resistance to any mental health awareness training is to be considered. This apprehension is echoed in the patient/prisoner interviews:

Participant (patient/prisoner):

It would be useful, but, they might be stuck in their old ways, and not want to take it onboard, so they may not be really bothered about it all, and not want to learn or understand.

Maltman and Hamilton (2011), at Rampton Hospital (Notts. Mental Health NHS Trust), evaluate PD awareness workshops for prison staff (predominantly wing officers) and conclude professional attitudes are crucial. ‘Positive professional attitudes towards personality disordered clients have been linked with extensive clinical and strategic benefits. The largest influences on such attitudes are associated with staff training, supervision and support’ (Maltman and Hamilton 2011:244). Pre- and post-workshop staff attitudes towards prisoners with PD are debated. In relation to patient/prisoner benefit, significant improvements on the

security versus vulnerability sub-scale (via the attitudes towards PD questionnaire) are recorded. Furthermore, Maltman and Hamilton (2011) discuss practical implications:

‘the findings indicate that personality disorder awareness training should initially engage with trainees’ perceptions of their personal security and vulnerability when working with this client group, rather than aiming to increase liking, enjoyment and acceptance of such offenders’ (p. 244).

Therefore, perhaps mental health awareness training for prison landing staff should commence by addressing wing officers’ concerns, queries, understandings, and beliefs in relation to mental illness and mental healthcare in prisons, before attention is devoted to the training’s intended knowledge, outcomes, and implications (*i.e.* make the trainees the focus of the training via concentrating on any prison officers’ anxieties, disquiet, or questions first and foremost).

Alimo-Metcalfe *et al.* (2007) note leadership in NHS Mental Health Crisis Resolution teams is at its best when a work environment is fashioned that empowers staff. The mental health awareness training debated in this thesis chapter arguably represents an apt opportunity to empower prison landing staff via the provision of mental health knowledge useful for work on prison wings — for both staff and prisoner benefit. The suggested format of the training session (*i.e.* commencing with a focus on wing staff’s mental health concerns and queries) places these social actors as those who are empowered during the training event. The suggestion is not for NHS mental health staff to *teach* knowledge to HMPS staff; instead, the intention is to provide a forum for *debate* regarding mental health and illness — that concludes with landing staff

possessing useful and appropriate tools in order to better understand and aid mental health service users' lives on prison wings.

The work of Hinshelwood (2001) is appropriate for inclusion at this stage. Hinshelwood (2001) explores the delivery of mental healthcare in institutions and discusses the notion of anxiousness in the settings and potential defensiveness of such environments. Hinshelwood (2001) reiterates mental health institutions' *raison d'être*:

‘in mental health work, staff are confronted with a particularly grave problem. By the time people come to a mental hospital they are at the end of the line. Our institutions are set up with the prime purpose of dealing with unwanted anxieties — they are unwanted by society (p. 42).

‘Thus, the particular work that is required of psychiatric staff is ‘anxiety work’ (Hinshelwood 2001:42, apostrophes in original). Although this thesis focuses on prison establishments and not the mental health institutions that Hinshelwood (2001) debates, these reflections have utility, as the issue is arguably compounded for prisoners who are also in receipt of mental healthcare; this social group not only possesses Hinshelwood's (2001) mental health patient attributes (*i.e.* as conceptualising society's unwanted anxieties), yet also acquire the offender label in the prison milieu; a double burden.

Hinshelwood (2001) links this idea of anxiety work and an institution's culture of enquiry with the argument that constant reflection and enquiry promote ‘an alive and healthy institution’ (p. 113);

‘continuous enquiry about the hospital's structures, procedures and rituals is necessary for staff to remain open, as far as possible, to anxieties, however painful and conflictual, which need to be reflected on.

The culture of enquiry is the maintenance system for servicing the reflective space' (p. 113).

To draw connections between Hinshelwood's (2001) work and the aforementioned prioritisation of prison landing staff queries during the suggested mental health awareness training, Hinshelwood (2001) posits:

'mental health [as a discipline] needs to recognise itself in general as a reflective practice, a practice which expresses, in words or in actions, the thoughtfulness that has gone into it. A space needs to be opened for reflection, enquiry and linking to happen *between* people ... A reflective space tends to have the following four elements: ... No. 3. A supportive and non-judgemental system' (p. 178, ellipses denote removed sections, italics in original, square brackets added).

Therefore, this reiterates the notion that any training courses offered to HMPS staff perhaps ought to be provided in a manner that creates — intentionally and overtly — an open, compassionate, and non-condemnatory environment to discuss mental health-based debates, myths, or anxieties.

Notably, this discussion concerning the provision of mental health training for prison staff is not explored in this thesis only (although this chapter does analyse the proposal in respect to literature in a novel sense). Mental health knowledge of prison staff as a professional grouping is also debated in exceedingly recent literature (*i.e.* work published during the course of this doctoral work);

'as detailed in the Bradley Review, staff working in the criminal justice system (including probation staff) require at least a 'basic' level of mental health awareness in order to both identify and effectively work

with the high proportion of offenders with mental health disorders' (Sirdifield *et al.* 2010:39, parentheses and apostrophes in original).

Sirdifield *et al.* (2010) evaluate a mental health awareness training package trial for only probation staff; the mental health tuition undertaken incorporated multiple foci including: 1.) myths/stigma/stereotype recognition; 2.) factors affecting mental health; 3.) sign and symptom recognition. Overall, high levels of staff satisfaction with the training were recorded and a high proportion of the staff considered the knowledge acquired applicable to their working lives:

‘the training produced an increase in mental health literacy amongst probation staff, and staff anticipated being able to apply the learning from the course in a variety of ways in their practice’ (Sirdifield *et al.* 2010:41).

Sirdifield *et al.* (2010) conclude with the call for:

‘a national strategy to focus on aiding staff working across the criminal justice system in identifying offenders with mental health disorders, making appropriate sentencing proposals, and making appropriate referrals to specialist mental health services’ (p. 41).

This national strategy appeal from Sirdifield *et al.* (2010) propounds an extensive agenda and pursuit, as it addresses the entire criminal justice system. Notably, this thesis does not possess supporting data to debate the criminal justice system in this broad sense; however, this thesis’ debates can be utilised to advocate and support this call for a national response.

Moreover, in a directly related paper, Sirdifield *et al.* (2010a) debate ‘the concept of a pan-European probation training curriculum’ (p. 23); a European-

wide common training approach to criminal justice system (probation) staff in relation to mental health awareness. In addition, the Offender Health team at NHS West Midlands provide short online/computer-based mental health training packages for probation staff and prison officers. It is hoped that these training materials shall be available on the Prison Service Intranet in the near future. Furthermore, Musselwhite *et al.* (2004), via the Institute of Health and Community Studies at Bournemouth University, trialled (with twenty-four participants) a mental health training package for new wing-based liaison officers in the Prison Service alongside training for the, then new, ACCT plans. Clearly, there is increasing appetite (from some quarters) for this absence of mental health knowledge across the penal system to be addressed.

The Institute of Mental Health (a partnership between the University of Nottingham and Nottinghamshire Healthcare NHS Trust) has developed a fully accredited mental health education, training, and development scheme that provides opportunities (and formal university degrees) for people working across the healthcare, social care, and criminal justice sectors. The *Personality Disorder Knowledge and Understanding Framework* training is commissioned by the DH and the MoJ and is intended to develop staff attitudes, skills, and behaviours. Frontline staff from the criminal justice system are invited to undertake this course. The availability of this PD-focussed training for HMPS staff is here welcomed. Further details can be found at: <http://www.personalitydisorderkuf.org.uk/>. In addition, the Institute of Mental Health have also created a programme for informal and formal dementia carers entitled *Improving Dementia Education and Awareness*. The intention of these new training materials is to improve quality of life for people with dementia via addressing the knowledge of their carers. This underlying approach is similar to the aim of the mental health awareness training of prison staff suggested in this

thesis. Carers' possession of mental health knowledge — including non-clinical informal carers (e.g. prison wing staff) — appears salient.

A link can be made here between the NHS in wider society and this criminal justice system-based discussion. Regarding the NHS, the British Broadcasting Corporation (BBC) Health Correspondent, Nick Triggle, reported the issue on Dec. 16th, 2011 (<http://www.bbc.co.uk/news/health-16206169>, last accessed Feb. 10th, 2012). To summarise, staff in many NHS hospitals lack sufficient dementia-relevant knowledge. NHS hospital staff told reviewers they felt they lacked the skills to deal with dementia patients, with less than a third saying they had sufficient dementia training. Parallels can be drawn here in relation to mental health familiarity and understanding in the prison context.

Finally, a comment concerning prison leadership and training engagement is appropriate to conclude this sub-section. Alimo-Metcalfe *et al.* (2007) explore — for the NIHR SDO programme — the impact of leadership factors in implementing change in NHS Mental Health Crisis Resolution teams. Links between quality of leadership and staff attitudes and wellbeing alongside organisational performance are questioned. Alimo-Metcalfe *et al.* (2007) argue positive leadership qualities correspond to positive staff attitudes to work and wellbeing at work. Effective NHS mental health team leaders are those who engage with their staff; 'leadership behaviours that involve 'engagement' have much the greatest impact on staff's attitudes to work and their well-being at work' (Alimo-Metcalfe *et al.* 2007:vi, apostrophes in original). Good clinical NHS leadership, therefore, includes 'engaging with others' (Alimo-Metcalfe *et al.* 2007:x).

Hence, it is here suggested that prison governors attend prison-based mental health awareness training events alongside prison landing staff, participate in the mixed HMPS role session fully, and engage in the session on an overtly equal hierarchical footing as their colleagues. This would represent the leaders of the prison establishment engaging in the training course *from within* rather than prescribing the exercise *from above*, alongside engaging with, and debating, the mental health knowledge and attitudes regarding prison mental health *with* their colleagues — rather than the establishment merely dictating desired staff attitudes and approaches to prison mental health without visible management involvement and support.

Before addressing the underlying roles and responsibilities of prison landing staff in the following sub-section, a reflection regarding the NHS modernisation debate is apt. Currie *et al.* (2009) debate recent DH efforts in relation to modernisation of the NHS's clinical workforce; it is highlighted attempts by policy-makers to reconfigure a workforce can be constrained by professional identity concerns and 'attempts at occupational closure' (Currie *et al.* 2009:267) by powerful professional groups. The notion of professional bodies and their willingness to embrace novel workplace aims, practices, and bodies of knowledge is relevant to this thesis and links well this sub-section with its subsequent.

Dual purpose prison wing staff: Care and custody

This sub-section debates workplace objectives of prison wing staff. The notions of care and custody are raised. Roles and responsibilities of prison landing staff are discussed. It is suggested that custody-related endeavours prevail afore care concerns. A potential change regarding the professional purpose of HMPS staff

is deliberated. Role distinctions between medical and non-medical staff, in relation to prison mental health, are clarified. Myriad work tasks alongside a lack of resources in the prison context are narrated. Finally, the cultural nature of the workplace is addressed.

Participant (patient/prisoner):

... But, I think, I think where we are anyway [in prison] you're always going to get that thing where, we're criminals, and the criminal side tends to come over the mental health side of it, always. I've always noticed that.

Participant (prison governor):

Trouble is, it's the identifying, and the dual diagnosis problem. Is he mad, or is he just bad? Or is it the drugs?

As exemplified above, both prison staff and patients/prisoners describe issues concerning HMPS's practical and ideological position on the care–custody spectrum. To overview the interview narratives, containment of criminals prevails first and foremost with mental health concerns (relatively) neglected, the mad versus bad debate continues, and substance misuse and dual diagnosis prisoners represent contemporary concerns for the prison service.

To typify the conundrum HMPS must tackle:

Participant (prison governor):

The question is, is prison going to promote stress or wellbeing? What's the option here? [At present] I don't think we're promoting wellbeing.

Gojkovic (2010) explores the delivery of mental healthcare in prisons and debates this care–custody relationship as experienced by wing staff, thus the work is suitable for discussion at this point. Gojkovic’s (2010) national study of English prisons’ mental health services’ organisation and provision reports tension for mental healthcare staff in relation to ‘delivering care in a punitive environment’ (p. 284). However, ‘tension of care and security is perhaps best evident in the case of prison officers who are in daily direct contact with offenders’ (Gojkovic 2010:285) and who ‘may not always recognize the symptoms of a mental health problem’ (Gojkovic 2010:285).

Therefore, prison landing staff and their roles and responsibilities are addressed in this sub-section. The aforementioned tension for these HMPS employees between care and security is explored.

Poignantly, the phrase ‘Care and custody’ is included in this sub-section’s heading and not ‘Care versus custody’; predictably, therefore, this portion of the chapter represents a discussion of a combined prison officer role, and does not intend to debate care and custody as irreconcilable work goals.

These notions of custody and care are debated by prison staff:

Participant (prison governor):

... If they’re locked up twenty-two hours a day, I think that is when it becomes very detrimental to their mental health, because, you know, we haven’t really got the time to interact with them. If you’ve got one officer with twenty-five cells, that’s thirty or forty prisoners, if you’re not going to work, then you’re locked behind your door, as the officer’s got other things to be doing, he’s not got time to come and talk to you ... if he just

comes out and gets his meal, walks off, doesn't say anything, you don't care, in all honesty, you know.

This interviewee does explain subsequently that there should be the feasibility to devote additional one-to-one time with prisoners who require additional staff time and attention.

In order to analyse the previous quote, Crinson (2009) debates the health policy decision-making process and includes some of Weber's ideas concerning bureaucratic organisations' tendencies (e.g. 'a continuous organisation with a specified function, whose operations are governed by a system of abstract and formal rules, not by personal considerations' (p. 40)). Bureaucratic organisations, such as public sector prisons, are argued to constrain human difference. Therefore, the lack of individualised prisoner management/attention depicted by the study participant fits with this analysis of bureaucratic organisations. The diminutive staff-prisoner interaction narrated above is recognised as regrettable by the participant. The prison situation described is noted as problematic and in need of alteration. However, it is questioned whether sufficient staff resource exists for this additional, albeit warranted, interaction on prison wings.

Therefore, in relation to a relative lack of resources in the prison setting and numerous tasks for the establishment, the work of Hinshelwood (2001) — who explores institutions, mental illness, and therapeutic communities — is pertinent. Whilst discussing institutional morale, Hinshelwood (2001) states:

'the purpose of an institution may be multiple, with several functions. There may be a conflict of priorities or the functions may get confused with each other and not properly clarified with those who are supposed to be carrying them out. In addition, the resources of the institution may be

inadequate for serving all the functions and all the needs of the patients, so that stricter priorities and more restricted definitions of the functions must be thrashed out' (p. 29).

Several aspects of this quote are noteworthy. Primarily, Hinshelwood (2001) highlights institutional settings can operate with confused aims resulting in staff experiencing perplexing work goals. Therefore, any HMPS attempt to further combine care and custody roles for landing staff ought to be implemented in a fashion that outlines concisely and clearly expected employees' responsibilities and purposes. Confusion is to be avoided. Perhaps the more problematic issue, as reiterated by Hinshelwood (2001) above, is the resource problem. At present, where staff resources are stretched on prison wings, custody concerns prevail.

However, the interview excerpt below demonstrates a participant's response where an increase in the caring aspect of prison officers' duties is suggested:

Interviewer:

Let's turn to the more traditional boundary between health staff who are concerned with care, and prison staff who are concerned with discipline; do you feel it's possible, or desirable, to blur this boundary? Or, is it preferable to have these distinct roles in the establishment?

Participant (prison governor):

I think you shall always have the officers that, shall we call them, the traditionalists, that see themselves as a prison officer with a white shirt, a set of keys, and sort of, dealing with the more disciplinarian side of prison, shall we say. But I think, certainly with more and more modern prison officers, the new staff that are coming in, it [i.e. care] is highlighted more and more, the element of care, as opposed to just, lock

'em up, shall we say. Existing staff, the older staff, are becoming more and more onboard with that. So I don't think there is a conflict, I just think newer staff take it onboard ... Whereas, older staff are a bit more stuck in their ways.

Furthermore, the distinction is made between the natures of clinical mental healthcare services versus providing for prisoners' general wellbeing in the setting:

Interviewer:

Can you foresee any issues with these dual purpose prison officer ideas?

Participant (prison governor):

No, I don't think it could be a hindrance, really. The only smoke screen to it all, I'd suggest, is that it's a well known fact that a high percentage of prisoners have got mental health issues of varying degrees, so I don't think we need healthcare training per se, we need training in coping and management strategies, how to offer sound advice, and how to deal with individuals with mental health issues.

Therefore, any concerns relating to the blurring of healthcare responsibilities is addressed, as wing staff would have no clinical responsibilities in relation to healthcare. Instead, the suggestion relates to the provision and the maintenance of a prison wing that aids general health and wellbeing for prisoners.

Participant (prison governor):

It's coping strategies that [prison] staff need.

There is scope for developed post-healthcare meeting (*i.e.* a patient's/prisoner's clinical appointment with their RMN or In-reach worker) assistance for mental healthcare patients/prisoners on wings:

Participant (prison governor):

... it's the general aftercare on the normal wing that's perhaps lacking, or sometimes weak.

Therefore, the utility of the aforementioned mental health awareness training of prison staff as a professional grouping could be linked to an ability to recognise and manage mental health-related behavioural issues in prisons on the wings — to aid the care aspect of imprisonment.

Nonetheless, there is perhaps one central tension that underlies this — care and custody — suggestion. Whilst debating contemporary mental health in the UK, Lester and Glasby (2010) note:

‘there is still a central paradox at the heart of mental health policy and practice. While there are legal structures that encourage partnership working, better acute and community mental health provision and policy directives that seem to be taking user involvement more seriously, compulsory mental health treatment in the community and ongoing social exclusion suggest an underlying culture of coercion’ (p. 51).

The nature of coercion in the field of mental health represents a perennial quandary. This impasse is particularly problematic in custodial settings, such as prisons. The removal of liberty and enforced custody is a current facet of imprisonment in the UK and this implies some level of duress. Therefore, there exists a certain paradox in this care and custody workplace ideal.

However, notwithstanding this conjectural contradiction, it is here argued that these two pursuits (*i.e.* care and custody) in their practical senses in the prison context should not be considered incommensurate, as mental health service users/prisoners — the subjugated social actors in the setting — require these qualities in *equal measure* of their subjugators, as they are both offenders *and* patients.

Furthermore, the desire of the professional grouping to embrace additional workplace roles and responsibilities is questionable. The morale of staff in institutional settings is noted as dependent on two aspects: ‘a convincing sense of purpose and a sense of belonging to an integrated social group that devotes itself to the purpose’ (Hinshelwood 2001:33). Therefore, it could be argued that in order for care (in tandem with custody) to exist on prison wings as an overarching work goal for prison officers, the professional grouping need embrace the purpose further²¹.

Hinshelwood (2001) debates the notion of community personality — and the dramatisation of this endeavour in healthcare settings:

‘we have discovered that the culture the individual is part of has effects on him, and thus that culture should itself be a part of the therapeutic investigation. Equally, that cultural system is in some ways the product of those who make it up — all of them. And they in their role-behaviour and role relationships reconstitute it every day’ (p. 54, em dash and hyphen in original).

²¹ This thesis does not argue that prison landing staff do not care for prisoners whatsoever — as this would be unfair and inaccurate; instead, this thesis appeals for both a careful consideration of, and a proliferation of, this aspect of their working lives.

Therefore, a social medium is argued to be a composite of its individuals and their daily beliefs and actions. Furthermore, all a social environment's engaged social actors are affected by the social system. To summarise, cultural settings are both effected by individual social actors, yet also affect their social actors.

To extend the theoretical point, consequently, prison wings could perhaps be altered to further foster a workplace culture that prioritises the mental health of prisoners — and landing staff are an important social grouping in this social milieu that affect the cultural nature, ethos, and operation of the setting.

There is support at prisoner governor level for these developments:

Participant (prison governor):

I think it [i.e. mental health awareness training] is the single change that will have the most effect ... from promoting distress to promoting wellbeing [on prison wings], to get us closer to the wellbeing side of things.

The attitudes of staff regarding change initiatives are markedly influential. Therefore, in relation to a setting's organisational performance, Powell *et al.* have just commenced a newly commissioned NIHR SDO programme project (no. 10/1011/11) concerning staff satisfaction and evidence from the NHS Staff Survey. Powell *et al.* intend to analyse links between organisational performance (*e.g.* patient satisfaction, yet also including individual staff attitudes, engagement, and satisfaction) and the Human Resources Management theoretical model. Evidently, relations between a professional grouping's workplace culture, staff attitudes, and the social and institutional processes of a setting are ripe for further consideration and research, particularly in respect to patient experience

and benefit. As the preceding debates regarding prison staff in this thesis chapter demonstrate, this situation is also relevant for the setting of this case study — a HMPS establishment.

Furthermore, to add contemporary credence to this care and custody sub-section, a BBC Radio 4 three-part series, from the Bishop Rt Rev. James Jones, entitled *The Bishop and The Prisoner* (January, 2012) airs — unusually — prisoners' voices *verbatim* on radio, debates the purpose of imprisonment, and the potential transformation from offender to useful citizen; overall, the discussion focuses on reducing reoffending with the central argument: containment alone is neither effective nor sufficient. Similarly, this thesis argues a certain amount and form of care, alongside custody, is required.

Finally, Ramluggun *et al.* (2010) report 'the conflation of knowledge and experience of staff working in prison places them in a favourable position to contribute to the current reform of offender health' (p. 70). Certainly, the experiential knowledge of prison staff is remarkably valuable. In addition, this thesis also supports the involvement of wing staff in the development of future mental health policy and practice and HMPS's approach to prison mental health; after all, this professional group spends more time with this patient group than the clinicians.

This being the case, custody *and* care are arguably crucial and — equally important — workplace goals.

Specialists and silo working

This sub-section deliberates partnership working between differing services in the prison setting (*e.g.* substance abuse and mental healthcare). Crossovers between services are highlighted; dual diagnosis prisoners are discussed. The multiple needs of prisoners are stressed.

Whilst debating the paradoxes of fashioning therapeutic mental health institutions, Hinshelwood (2001) notes:

‘boundaries between disparate groups, sub-groups and cultures are the prime sites to spot institutional pathology’ (p. 71).

Further to this, the OHRN (2009) highlight seventy-five per cent of all prisoners has a dual diagnosis (*i.e.* mental health problems combined with alcohol or drug misuse). Moreover, drug use amongst prisoners in custody is high and many prisoners have never received help with their drug problems (Prison Reform Trust, 2011). Additionally, Her Majesty’s Chief Inspector of Prisons for England and Wales (2010) records approximately half of the surveyed prisoners experiencing alcohol misuse issues also report drug problems and/or emotional or mental health concerns. HMPS institutionalises a population that experiences high levels of both substance abuse and mental illness alongside the aforementioned challenges of practice noted by Hinshelwood (2001) (*i.e.* distinct professional and cultural groups — operating in a somewhat detrimental manner — thus affecting the therapeutic nature of the institution).

Moreover, Crinson (2009) outlines several usual characteristics of bureaucratic organisations — such as prisons — that stem from Weber’s work concerning bureaucracy as a mode of organisation; these tendencies include: ‘tasks are

specific and distinct and carried out by formal categories of staff who specialise in certain specified tasks and not others' (p. 40). In response to this, the nature of silo working in the penal setting is discussed here by a study participant:

Interviewer:

In terms of dual diagnosis, co-morbidity, etc., is it your feeling that alcohol or substance misuse teams work adequately with the secondary mental health team, for example, in relation to prisoners with both substance misuse and severe mental health problems?

Participant (prisoner governor):

No, I think it's terrible. I think we've got a lot of resources here, a lot of people here, CARATs teams, etc., and I don't have any assurance about them working in a multidisciplinary way, or a casework way. If you look at the queue of men in the methadone queue, that queue will contain our dual diagnosis people. That requires a lot of information sharing from wing staff, who need to be empowered ... The observing of the patient in his everyday life is a factor that I think would help, so you've got wing staff that need to be empowered (and then you've got CARATs workers who are [empowered]) and I just don't see them making referrals back to other services in the way that I would want, and then the psychiatric professionals who perhaps need to be asking questions of the first two groups ... In that [methadone] queue we need to put more resources into getting to the bottom of what really happens. It's a false premise to think you could deal with someone's substance misuse problems if they also have a psychiatric condition. That's just not going to happen. You need to treat them both together.

The various services provided in the prison establishment for those prisoners with substance misuse and mental health needs are depicted as operating — unhelpfully — in discrete fashions:

Participant (prison governor):

We've got too much silo working, and specialists, that's what it is, there's a lack of confident collaboration between specialists; it's just not helping ... We just need a case management approach that's not 'Let's all see this man separately', but 'Let's start with the man and his needs, and we will collaborate'.

To advance beyond these health-related services only, participants' narratives depict the realm of mental health as that of healthcare workers (broadly defined) and not the remit of wing officers:

Participant (HMPS psychologist):

I think it's very much seen in silos ... At the moment it's seen as the responsibility of this department and the responsibility of CPNs over in Healthcare [In-reach]. It's not seen as anyone else's responsibility. It's almost like: 'Oh we've got a problem but we don't know anything about it, so let's just push it out and they'll deal with it'. It's not seen as a whole prison approach. It's very much seen as: 'Oh they [health professionals] can deal with it, as they know what they're talking about and we [landing staff] don't'.

It should be recognised that it is not the case that mental health collaborative working exists perfectly in non-prison UK mental health policy and practice

settings. For example, Lester and Glasby (2010) highlight ‘insufficient partnership working across health and social care’ (p. 1) nationally. Therefore, the nature of silo working and an absence of cooperative working in relation to mental health are not unorthodox or specific to the prison environment.

Furthermore, in relation to the UK’s criminal justice system more broadly, Sirdifield *et al.* (2010) state probation staff report inadequate alcohol service provision for the probation population and a desire to improve communication between the probation service’s health and alcohol services/agencies.

However, to return to this study, the crossover between several prison services is apparent:

Participant (HMPS psychologist):

... We [HMPS Psychology Dep.] do often have the same caseload [as the NHS In-reach team], and we do often have questions that need answering, or information to give them.

Notably, the multiple needs of prisoners are well accepted. Pre-imprisonment illegal drug use and alcohol abuse is commonplace for the UK’s population of offenders. Recently (*i.e.* Jan., 2012), the NHS National Treatment Agency for Substance Misuse published a practical guide entitled *Improving Access to Psychological Therapies (IAPT): Positive practice guide for working with people who use drugs and alcohol*. One of the aims of the document is to assist IAPT teams and substance misuse services in HMPS to fashion closer and increasingly collaborative working relationships. Positively, therefore, it appears this notion of silo working is, incrementally, receiving policy and practice attention.

The CMH (2011) review dual diagnosis issues for the UK's criminal justice system and highlight, although approximately seventy per cent of NHS In-reach team patients possess substance misuse needs, only around one in ten In-reach teams operates a specific dual diagnosis service.

The CMH (2011) report:

‘this is partly due to differences in priorities between mental health teams and substance misuse teams. The latter have had to prioritise those substance misusers with dependency problems, whereas mental health services have a somewhat broader interest in the impact of substance misuse on wellbeing and treatment care and this may fall below the threshold for substance misuse teams’ (p. 5).

In relation to prisoners with both severe and non-severe alcohol problems, ‘there is inadequate support for offenders who misuse alcohol at all levels’ (CMH 2011:6). Moreover, ‘the poor provision is further exacerbated by misalignment between health and criminal justice agencies and a lack of equivalence between alcohol and drug service commissioning’ (CMH 2011:6). However, the CMH (2011) note substance misuse services shall soon alter to be the responsibility of Public Health England — later in 2012; therefore, now is perhaps an opportune moment to fashion a more collaborative commissioning approach to dual diagnosis services across the criminal justice system (and consequently reduce silo working).

Study participants narrate emotive examples and experiences regarding dual diagnosis prisoners:

Participant (prison governor):

... They're cared for as much as we can ... An example, ooh I sound like an old dinosaur now, there was a chap down in the SEG [segregation unit] who had an amphetamine psychosis, absolute barking, twelve police brought him in, he was an eight man unlock. In the end, we were basically saying, you stand at the window, face out, put your arms out, else we're not going to put this meal in, well, very quickly, after two missed meals, he decided he was going to play ball. So he did that. We'd take his tray out, put a clean meal in, shut the door. Nobody got assaulted and he got his meal. So we arranged a way for him to get his meal, but that's not helping him in any sort of way, really; however, eight weeks or so down the line, he's on the wing, amphetamine psychosis gone, he normalised over that period of time ... We've got another lad who, emotionally, gets quite up and down, and you think, well, are the drugs masking this, or are the drugs causing this, and that is the real hard bit, you know. It's a really hard thing to fathom.

In addition, the existence of related self-harming behaviour in the prison environment is also debated:

Participant (prison governor):

... Drug users use drugs or alcohol to suppress mental health issues, as well, a way to manage it. A lot of them would say that some use self-harm as a way of managing ... So when they come in, and come off the substances, you could see there were mental health issues. I think it is [i.e. mental illness] more prevalent than many people imagine in this environment.

Now that the situation has been outlined, the nature of joint services and approaches can be considered.

In relation to potential problems associated with collaborative working across commissioning/providing/professional boundaries, information sharing is noted as an issue:

Participant (HMPS psychologist):

Here in this department we're quite happy to share ... Sometimes, I think there's been instances where people have been quite closed about information, and it's been a shame, as we do put ourselves out there and say let's share information, let's look at how to manage them, and I think, certainly in this job, you've got to, but, like I say, it doesn't always work.

It is worth noting that the criminal justice system–NHS interface is not questioned in relation to imprisonment in HMPS establishments alone. Lea (forthcoming) explores multi-agency management of individuals with enduring (moderate to severe) mental health needs regarding interactions with the police. The absence of a harmonious working culture between the NHS and the police is highlighted alongside a lack of effective joined-up working between the criminal justice system and the NHS. Therefore, this thesis' collaborative working debates are shown to be somewhat relevant to the UK's entire criminal justice system.

An ongoing NIHR SDO programme (project 08/1803/225, led by Dr Senior) is currently researching a pilot electronic multi-agency information sharing system for mentally disordered offenders; the intention is to improve communication across organisational boundaries (*i.e.* between health, social, and criminal justice

agencies). Therefore, it appears an appetite for this form of modification is developing gradually.

Moreover, Sirdifield *et al.* (2010) identify silo working as a barrier to access for offenders involved with the probation service. In support of this, 'joint care planning between mental health services and drug and alcohol services should take place for prisoners on *release*' (DH 2009:20, emphasis added). Evidently, there is need for both research and development in relation to the nature and conduct of communication and cooperative practice across differing professional bodies that have contact with prisoners spanning all aspects of the UK's criminal justice system, including post-sentence.

However, where Lester and Glasby (2010) debate different models of partnership working across mental health policy and practice, five forms of barriers to cooperative working are cited: structural; procedural; financial; professional; perceived threats to status, autonomy, and legitimacy (p. 149). All of these principles pose potential problems in relation to collaborative work between the criminal justice system and its varied health services (broadly defined). It is recognised that partnership working is a convoluted endeavour and that the number of barriers is sometimes greater than the number of facilitators. Notwithstanding this complexity, the pursuit of interagency working that emphasises shared responsibility for assessing healthcare need and action, alongside long-term collaborative goals, in tandem with the 'intention to secure the delivery of benefits or added value which could not have been provided by a single agency alone' (Lester and Glasby 2010:148), is to be encouraged.

Heretofore, smoking as an addiction in the prison setting has not been debated, as this study's participants do not raise the topic; however, Schroeder and Morris

(2010) argue those persons with mental illnesses and/or substance abuse problems (in the US) — who also smoke — suffer premature mortality rates. ‘Tobacco use exerts a disproportionate toll on those with mental illnesses and substance abuse disorders’ (Schroeder and Morris 2010:308). It is suggested that this population requires tailored tobacco cessation treatments, as at present in the US, ‘persons with serious behavioural health disorders die on average 25 years earlier than does the general population, and many of the causes of those premature deaths relate to smoking’ (Schroeder and Morris 2010:308). Notably, smoking prevalence in both US and UK prisons is high. Therefore, in relation to this study, prison services that address prisoners’ addictions (*e.g.* drug, alcohol, smoking) perhaps ought to operate in some form of collaboration with mental healthcare clinicians, as patients often straddle services and may benefit from a more collaborative package of mental health and substance misuse care.

In addition, in contrast to this UK prison context, Nomura (2009) reports those involved with psychiatric services in Japanese prisons desire an increasingly overt division between medical care and issues regarding the administration of justice in the correctional setting; unfairness in relation to the treatment of mentally disordered offenders is recorded in Japan. Therefore, whereas a closer relationship between the NHS and HMPS is suggested in this thesis, it appears a separation and demarcation of tasks (*e.g.* administering treatment versus assessing penalties for crimes) is sought by Nomura’s (2009) research participants — who criticise the current notion of ‘correctional medicine’ (p. 186) in Japanese prisons. This reflection is worthwhile, as it is important to remember that this thesis takes HMPS only as its focus.

Finally, Stevenson *et al.* (2011) debate information exchange in criminal justice–health partnerships and conclude the current policy climate advocates a ‘joined-

up approach to services, with effective multi-agency working across the *entire offender pathway*' (p. 160, emphasis not in original). This thesis supports the idea that improved inter-agency working, commissioning, management, communication, and practice represents a useful objective across the entire criminal justice system, particularly in relation to both the provision and receipt experiences of mental healthcare and substance misuse services in prisons.

Chapter conclusion

This thesis chapter covers five specific sub-sections; therefore, before the chapter's concluding comments, a brief synopsis of these sections is provided.

The nature of imprisonment is demonstrated to be often detrimental for mental health. The prevalence and severity of mental health issues in the prison context is noted as challenging. Mental illness is depicted as an (albeit unacceptable) facet of prison life and working in prisons. However, there exists a desire to rectify this current quandary. The penal setting is reported as not appropriate for some persons who are directed to prison and labelled as offenders primarily (rather than mental health service users primarily). However, where the prison setting *is* required for offenders with mental health problems, healthcare and rehabilitation services should provide apt facilities for this vulnerable social group.

Regarding prisoners' time usage and activities issues, boredom in prison and a lack of mental stimulus are narrated as problematic. It is not aspects of prison mental healthcare that are criticised by patients in this study. Instead, it is aspects of the prison social and structural settings that receive attention. Multiple forms of isolation and inactivity are included in the patient/prisoner interviews;

moreover, prison establishments are narrated by staff as largely impersonal institutions with rigid routines. Increased stimulus in physical/practical and mental/psychological/emotional respects is requested, in order to decrease time spent alone and immobile. The enjoyment and usefulness of gym, as a mentally and psychically stimulating activity, is repeated habitually. Where patients/prisoners do engage with creative endeavours, these are experienced as gratifying and helpful. Patients/prisoners accept their removal of liberty yet developed routes to rehabilitation in a broad sense (*e.g.* good mental health, skills for employment post-sentence, an end to substance misuse) and preparation for release are requested.

The nature of communication between prison staff and prisoners is raised. Prison staff report the somewhat covert existence of numerous mental health issues, symptoms and signs amplifies workplace issues. Mental illness is discussed in relation to its non-visible facets and how these complicate the notion of understanding mental health and working with mental health service users in the penal setting — for prison staff. Therefore, the complex combination of mental health's covert facets in tandem with displayed behaviour-related effects, is somewhat challenging in terms of prison wing staff understandings of mental illness and their relations with prisoners.

In order to address this situation, mental health awareness training of HMPS staff is considered. Developed mental health knowledge of landing staff may aid both HMPS staff–NHS staff and HMPS staff–patient/prisoner relationships. Additionally, mental health awareness training of prison landing staff represents an apt opportunity to further introduce informed and sensitive mental health language to the prison establishment as an organisation with its more usual (non-health orientated) occupational vocabulary. HMPS staff participants report the

importance of mental health, as a workplace message amongst landing staff, requires development. Clinical names, phrases, and aetiology are noted as not relevant knowledge for prison staff; instead, it is an understanding of the behavioural aspects of mental illness that are warranted. There is recognition from study participants that relationships between prison staff and prisoners could be developed beneficially. Notably, any prison staff courses ought to be provided in a manner that creates an open, compassionate, and non-condemnatory environment to discuss mental health-based debates, myths, or anxieties; furthermore, prison governors should perhaps attend training events alongside prison landing staff, participate in the mixed HMPS role session fully, and engage in the session on an overtly equal hierarchical footing as their colleagues.

Workplace objectives of prison wing staff and the notions of care and custody are raised. Roles and responsibilities of prison landing staff are discussed. Arguably, custody and care are important and equally vital workplace goals. Prison wings could be altered to further foster a workplace culture that prioritises the mental health of prisoners — and landing staff are a vital social grouping in this social milieu that affect the cultural nature, ethos, and operation of the setting. Moreover, the involvement of wing staff in the development of future mental health policy and practice and HMPS's approach to prison mental health is imperative; after all, this professional group spends more time with this patient group than the clinicians.

Finally, the nature of silo working in the penal setting is discussed. Various services provided in the prison for prisoners with substance misuse and mental health needs are depicted as operating often in disconnected fashions; this is considered unhelpful. Improved inter-agency functioning represents a valuable

intention across the UK's criminal justice system, yet particularly in relation to the provision and receipt of mental healthcare and substance misuse services in prisons — for clinicians and prisoners alike.

To conclude this chapter, reflections regarding the nature of health policy and practice are suitable. Crinson (2009) studies health policy as a discipline and outlines differing theoretical frameworks; 'in particular, the differences in the way in which political power is conceptualised' (p. 7), as 'policy-making is fundamentally a political process involving the exercise of power' (p. 38).

Health policy debates include philosophical, moral, and political facets alongside three further contested dimensions: structure versus social agency; state-made societies; society-made states (Crinson 2009:36). Crinson (2009) argues 'we should retain a critical assessment of the overarching objectives of government in the development of particular policies' (p. 52). Therefore, it is important to take account of the current coalition government's stance on offending and their agenda for the prison service more broadly. To summarise in relation to the prison portion of the criminal justice system, recent press releases and likewise political attention is devoted to the need to reduce reoffending (<http://www.justice.gov.uk/>, last accessed Feb. 9th, 2012).

Furthermore, in relation to healthcare, the CMH welcomes the news that, on February the 8th, 2012, the House of Lords voted for mental health parity of esteem. This amendment to the Health and Social Care Bill is designed to give the Secretary of State for Health an explicit duty to support both physical and mental health — to give mental health a higher priority in the new health system in England (<http://www.centreformentalhealth.org.uk>, last accessed Feb. 9th, 2012).

Congruently, the developments suggested in this thesis chapter align well with the political agenda that displays a desire to address the UK's cycle of reoffending and rehabilitation alongside a highlighting of the importance of good mental health in tandem with physical health.

Policy is a concept that proves difficult to define; however, health policy debates ought to embrace social organisation and social structure aspects alongside a consideration of policy practice as political in nature. In support of this, Crinson (2009) states:

‘policy as a concept is neither a specific, not indeed a concrete phenomenon, so to attempt to define it poses a number of problems. It is more fruitful to see policy as a course of action, ... or decision network, rather than a single identifiable decision’ (p. 7, ellipsis denotes removed section).

Thus, if the developments in this chapter are to be typified as a single thrust course of action, this itinerary for change petitions HMPS and the NHS to work increasingly collaboratively in order to address both general and mental health needs of prisoners via an augmented consideration of the social and institutional aspects of the penal milieu and the delivery/receipt experiences of healthcare in this environment.

Crinson (2009) highlights six characteristics — as outlined by the Government initially — that modernising policy measures should, ideally, embrace: strategic (*i.e.* long-term goals); outcome focused; joined-up (*i.e.* across organisational boundaries); inclusive; flexible and innovative (*i.e.* cause-focussed, not treating of symptoms); robust (*i.e.* operational in practice). These six features of policy

formation also ally with the commentary of this chapter, as the potential developments do include: a long-term temporal outlook; a discussion of potential outcomes; a collaborative policy approach; an inclusive framework for healthcare (*e.g.* service user input); a cause-focused agenda (*i.e.* a focus on the environment and resultant mental health outcomes); a discussion of implementation processes and issues associated with the development of ideas into practice.

The field of health policy analysis comprises overlaps between seven areas of academic and practical endeavour: Social exclusion initiatives; Environmental protection; Health and safety at work; Food standards; Promoting participation in sport; The social care system; The formal healthcare system (Crinson 2009:11). Conceptual tools from both political science and sociology are often utilised to analyse health policy. Differing levels of health policy analysis exist;

‘at a general analytical level, health policy can be conceptualised in terms of macro and micro social processes. At a macro level this involves the assessments of the workings of social and institutional structures such as the state, the market ... At a micro level of analysis, the focus is on the impact of policy at the level of the practice of healthcare professionals, as well as upon the experiences of the users ... ’ (Crinson, 2009:13).

Usefully, therefore, this thesis chapter addresses both macro and micro health policy and practice debates. Potential developments span the spectrum of the prison service. For example, further cooperative work between varied NHS healthcare services and HMPS represents macro-level analysis as morass public service institutions are addressed. Whereas, discussions of rapport and the notion of language usage between individual patients/prisoners and prison wing staff represents micro-level analysis of social interaction and communication. As

Crinson (2009) notes above, micro-level policy analyses involve focus on the experiences and idiosyncrasies of healthcare clinicians/users; this thesis fulfils this requirement.

One final reflection for this thesis chapter, the DH (2009a) *A Guide for the Management of Dual Diagnosis for Prisons* states ‘everyone working for the Prison Service has a duty of care towards every prisoner. This duty includes any prisoner with a co-existent mental health and substance misuse problem’ (p. 3). This thesis echoes the appeal for a *whole prison* approach to the care of prisoners and an operating framework for prison health that involves roles and responsibilities for *all* members of prison staff.

Chapter 7

'It is clear that, in many ways, mental health service provision and the criminal justice system exist in parallel universes'
(Brooker and Birmingham 2009:3).

Conclusion

A return to the study's questions

Poignantly, Ziebland and McPherson (2006) note when the analyses from qualitative research are disseminated, 'it is necessary to identify the story the *can* be told with the data — which is not always the same as finding the story that you would *like* to be able to tell' (p. 410, italics and em dash in original). Therefore, it is crucial to consider how study data and study analyses do address study questions as opposed to how the social scientist wishes them to do so.

Study questions are here reiterated to commence this sub-section:

Overarching study question

How could prison mental healthcare be developed?

Underlying study questions

1. In relation to prison mental healthcare and the mental health of male prisoners at the fieldwork site, what are the remaining areas for development according to the involved social actors?
2. Do interviewees desire similar developments to prison mental health services; if not, are the dissimilar suggestions grouped (*e.g.* linked by gender or employment/social role in the setting)?

3. Are there aspects of the prison's social environment that affect mental health or mental healthcare?
4. Are there aspects of institutional existence that affect mental health or mental healthcare?

Albeit an oversimplification, to typify, Chapter 6 addresses the overarching study question (and underlying study question no. 1) and Chapters 4 and 5 explore the remaining three underlying study questions. To demonstrate, a few of the specific links between study questions and data analyses shall now be outlined.

Regarding the overarching study question (*i.e.* How could prison mental healthcare be developed?), numerous potential prison mental health and prison mental healthcare developments are professed and examined in this thesis. Several of these are now presented.

To exhibit one issue, time spent alone and inactive in prison cells is noted as problematic for mental health and mental healthcare by clinicians, patients/prisoners, and prison staff alike. This issue is narrated across Chapters 4, 5, and 6. Therefore, in Chapter 6, resultant analytical discussions both encourage yet also appraise the proliferation of worthwhile activities for prisoners in the penal setting. Notably, all development suggestions in the thesis are evaluated.

As a further example, Chapter 5 reports mental health understanding is crucial for clinician–patient/prisoner rapport. This notion of understanding and the possession of mental health knowledge are also addressed in Chapter 6, the developments orientated section of the thesis. Therefore, another development suggestion includes the mental health awareness training of prison staff (and the

accompanied critical deliberations of this scheme) in Chapter 6. Additionally, Chapter 6 also makes recommendations regarding roles and responsibilities of prison wing staff and their interactions and relationships with mental health service users/prisoners. Finally, Chapter 6 concludes with an assessment of silo working in the prison service and potential developments. As is appropriate with improvement suggestions, the possibility of inter-agency working is critiqued as well as supported.

In relation to the three remaining underlying study questions, a small number of examples are worth highlighting.

2. Do interviewees desire similar developments to prison mental health services; if not, are the dissimilar suggestions grouped (*e.g.* linked by gender or employment/social role in the setting)?

To recap, participants' narratives (*e.g.* experiences, opinions, suggestions) in this study align via social group role in the setting (*i.e.* NHS staff, prisoner, HMPS staff). Thus, analysis chapters are created to fit with this participant alignment.

Although, particular opinions *are* supported collectively. For example, across the study's three participant groupings, there is an agreement concerning unacceptable mental illness prevalence in the prison setting and this is then associated with a desire to address and resolve the issue. Moreover, the nature of imprisonment is depicted as often detrimental to mental health — by all participants.

However, one interesting demographic peculiarity is debated by participants across the aforementioned three social groups in the setting with regard to the

age of prison staff and length of service. Congruently, this aspect is deliberated — from opposing standpoints — in Chapters 4, 5, and 6.

One last example. Consider the excerpt below (from Chapter 6):

Mental health is then narrated as somewhat problematic in relation to its covert and non-visible characteristics; an ability to recognise mental health signs and symptoms is sought.

This extract pertains to HMPS staff. Prison staff depict mental health as convoluted and challenging in the setting due to its non visible features. Notably, this experience is not shared by the other two participant groupings in this study (*i.e.* patients/prisoners and NHS staff). Thus, a divergence occurs between the social groups. However, the second facet of the quote — that prison officers should possess the capability to recognise these complex mental health symptoms — *is* supported across the three participant groupings.

Attention is now devoted to the final two underlying study questions.

3. Are there aspects of the prison's social environment that affect mental health or mental healthcare?
4. Are there aspects of institutional existence that affect mental health or mental healthcare?

Regarding these two underlying questions, myriad relevant aspects are analysed across the analysis chapters. Essentially, social and structural issues dominate the thesis, particularly Chapters 4 and 5. The prison based exceedingly complex three-way relationship between culture, mental health, and mental healthcare is addressed. Moreover, aspects of the institution and its ethos and regime are

deliberated. Poignantly, prison orientated *cooperation* and *communication* topics are discussed in all three analysis chapters. Workplace objectives, environments, and occupational cultures are also analysed. Other pertinent debates include: prisoner–staff relations and rapport; access processes to health services; nature of clinical practice in the institutional setting; mental healthcare *provision* issues; patient experiences of mental healthcare *receipt* in the penal milieu; prison staff mental health skills, roles, and responsibilities; inter-agency working.

Implications for research, policy, and practice

In 1984 Jones and Fowles stated ‘the official view in British prisons is still that deprivation of liberty is the punishment — conditions in prison should not add to it. The state of the prisons does not bear this out’ (p. 203). Similarly, the contemporary prison system in the UK continues to experience issues (*e.g.* overcrowding) that can affect negatively conditions in the institution and resultantly an inmate’s incarceration experience. Awofeso and Guggisberg (2011) highlight ‘prison settings generally worsen the precarious health profiles of incarcerated individuals’ (pp. v–vi) and report ‘the experience of incarceration, it is widely acknowledged, is likely to exacerbate mental health problems’ (p. 150). Furthermore, ‘for prisons to be ‘health promoting’, substantial investments are required in prison architecture, staff training, prison policy reform, and prison health services’ (Awofeso and Guggisberg 2011:vi–vii, apostrophes in original).

Notwithstanding this worthy call for developments, Siva (2010) notes future prison health strategies must not forge unattainable goals or pose overambitious solutions — in a monetary sense — ‘amid the current financial climate’ (p. 447). This economic orientated concern is also echoed via this thesis. HMPS’s resources are certainly an important consideration.

Wilson and Cumming (2010) pose the question: What is the solution for mentally ill prisoners? Their response:

‘a combination of treating prisoners the same as the rest of the population, and at the same time being honest about the differences between prisons and other settings, would be a good starting point ... [Furthermore], honesty about the total failure of the principle of equivalence as a guide to managing a prison health care centre would be a better place to start considering what to do about this forgotten group of severely ill prisoners’ (p. 50, ellipsis to denote removed section, square brackets not in original).

The clinical specificity of offenders with mental health problems as a patient group is noted here alongside a recognition that the penal milieu represents a setting for healthcare delivery that is not equivalent to the community locale.

In addition, Awofeso and Guggisberg (2011) debate reactive interaction — a theoretical explanation for health behaviour — and highlight:

‘each individual’s personality extracts a subjective psychological environment from the objective surroundings, and it is that subjective environment that shapes personality sensitivity to environmental factors and behaviour ... Different people who are exposed to the same environment interpret, experience, and often also react to it very differently’ (p. 151, ellipsis to denote removed section).

This acts as a reminder that the notion of altering a particular health service in relation to a specific social site of healthcare practice is an exceedingly convoluted pursuit.

Therefore, in relation to the development of services in institutional settings, such as prisons, Jones and Fowles (1984) conclude their tome concerning the nature of institutions with the reflection:

‘we hope that we have learned to be modest in our own ambitions for future work on institutions; to avoid what Etzioni once called ‘Utopian aims seen from Olympian heights’; to concentrate on the basic needs and right of individuals; and to be concerned with the art of the possible — with middle-range idea-and-reality theory which can be operationalised into a theory of practice. Institutions are at once a threat and a portent: a symbol of liberty lost and affliction accepted. If they are to remain part of our society, it is time for some fresh thinking’ (p. 205, apostrophes in original).

Regarding this call for novel approaches to institution based health, the subsequent list of implications for policy, practice, and research stem from the data collected via this study and their analyses, the two journal papers published, and a consideration of the literature and theory regarding prison mental health included in this thesis:

- A model for mental healthcare that considers the communities served by the prisons may prove fruitful; social exclusion issues and pre-offence health and social needs are important.
- The subject of place is salient certainly when deliberating the mental health of prisoners as a social group, as it is evident that the incarceration experience can affect negatively prisoners’ mental health; context is crucial.

- In order to consider aptly issues that concern the mental health of prisoners (*i.e.* aetiology, prevalence, severity, interventions, and outcomes), the prison setting as a social and structural place requires further attention.
- The prison establishment is not always conducive to good mental health, and is not often a useful catalyst for mental healthcare. For some prisoners, it is not the mental healthcare itself that is criticised. Instead, it is aspects of the prison regime and the nature of institutionalised existence that are considered to affect negatively mental health. Therefore, alterations in the prison context in relation to the social environment and institutional set-up are apt.
- Social and institutional aspects of the custodial setting are challenging for good mental health and can have negative ramifications on both the provision and receipt of mental healthcare in the penal milieu.
- Prison culture can be defined as including the prisoner–staff–surroundings three-way relationship in tandem with the traditions, habits, rules, attitudes, customs, and codes that govern the social organisation and interactions of the prison; aspects of prison culture and resultant impacts on mental health require additional research attention.
- Arguably, an ideological and practical shift towards viewing and practicing incarceration *primarily* as a period of time to develop inmates' preparation for release (via addressing social exclusion issues, literacy and numeracy skills, and the promotion of good mental health, as examples) is worthy of consideration. The creation of prison establishments where containment is considered *secondary* to the positive development and rehabilitation of prisoners is a valuable suggestion.

- There are aspects of the social and structural ethos and regime of prisons that, at present, affect the provision and receipt of mental healthcare and patients' attempts to strive for good mental health in the setting — these warrant future research and development.

Policy recommendations

To recap, aspects of the prison *social environment* and aspects of prison *institutional existence* are salient for this thesis.

For this study, *social environment* deliberations refer to communication processes, social group labels, rapport building, and relationships between social actors in the penal milieu. Characteristics of *institutional existence* examined in this thesis include the prison timetable, healthcare centre escorts, staff roles and responsibilities, prisoners' time usage, and layout of the NHS setting. To summarise, these *institution existence* explorations have a structural, regime, and practical nature; whereas, the *social environment* discussions relate to social characteristics and population demographics, relations between social groups and individuals, and social actors' personal experiences of the prison locale.

Therefore, for policymakers, the overall recommendation is that considerations of these prison establishment characteristics are important. Context is crucial. Regarding the delivery of prison healthcare, the prison setting is dissimilar to the community setting for myriad reasons. Many of these reasons are demonstrated and analysed in foregoing thesis chapters. To abridge into one sentence, the mental healthcare policy that guides mental healthcare practice in the prison locale ought to further recognise, research, and rectify where possible these aspects of mental healthcare provision and receipt in the penal milieu.

For policymakers, it is useful to remember here that very few persons remain incarcerated for life in the UK. In addition, repeat offending is a current issue and Kenneth Clarke is intending to reduce these reoffending rates. Furthermore, HMPS is overcrowded and, more importantly, its outcomes do not mirror its aims. There is need for improvement across the prison service. Crucially, prison mental health is pertinent, as good mental health, or the effective management of an enduring mental health condition, is important for positive involvement in society post-release. Thus, the analysis chapters of this thesis include numerous recommendations for change in relation to prison mental health and prison mental healthcare. It is not suitable to restate all these here. However, four examples are given.

Firstly, Chapter 5 includes a sub-section entitled **Clinician—patient/prisoner rapport**. Patients/prisoners narrate successful meetings with their mental healthcare clinicians as cooperative multiparty achievements. This collaborative aspect of their healthcare is supported by patients/prisoners and perceived as beneficial for their mental health. Thus, for policymakers, a further consideration of patients/prisoners as increasingly active members in their healthcare meetings and decisions is warranted, as positive ramifications for patients/prisoners appear possible.

Secondly, this same sub-section of Chapter 5 also includes the notion of understanding. This ability to understand is labelled by patients/prisoners as the most important and appreciated attribute of mental healthcare clinicians. Here, patients/prisoners link understanding with possession of mental health knowledge. Furthermore, it is suggested that understanding is a *necessity* for effective rapport between healthcare staff and patients/prisoners. Notably, rapport between wing staff and patients/prisoners is also desirable in the prison

setting. Therefore, for policymakers, it is important to consider whether this possession of apt mental health knowledge and a resultant aptitude for understanding mental health service users can be extended to prison wing staff. This impasse is explored in Chapter 6 of the thesis.

Thirdly, Chapter 6 includes a sub-section entitled **Prison staff: Frontline service provision and (mental health) knowledge**. This third example somewhat follows on from example two above as within this sub-section mental health awareness training of prison staff is debated. Woodward's (2007) concept of symbiosis is analysed. This theoretical and practical approach to marrying organisations and services may prove useful for policymakers in this field. Arguably, policymakers might utilise the notion of symbiosis to address and manage any professional group or organisational culture issues when joint working or sharing of healthcare roles and responsibilities in the prison setting are introduced in future. Woodward (2007) stresses the idea of cooperation, highlights that mutual benefit to partners is the aim, and that this is markedly different from the relationship between host and parasite. An understanding of the nature of collaborative working is crucial for criminal justice system policymakers, particularly in relation to the provision of prison mental healthcare and the somewhat overlapping roles and responsibilities of healthcare staff and prison staff.

This policy recommendation introduces well the fourth and final example noted here.

Finally, Chapter 6 includes a sub-section entitled **Dual purpose wing staff: Care and custody**. The work and knowledge of prison staff is debated. The recommendation for policymakers is that mental health awareness training

specifically regarding the covert and invisible facets and ramifications of mental health problems may prove beneficial. This knowledge would permit prison staff to better recognise, understand, and manage mental health related behaviours on the wing and the mental health experiences of patients/prisoners in the prison establishment.

Originality

Although innovative analyses and implications have been discussed throughout the three analysis chapters, it is worth devoting a specific sub-section to originality in this concluding thesis chapter. The uniqueness of this work takes three forms. Inventive characteristics are demonstrated via findings, method/methodology analyses, and the theoretical orientation.

This study explores the social and institutional nature of imprisonment with respect to mental health and mental healthcare in tandem with relevant theory for this field. Regarding theoretical approach, one novel theoretical aspect of this work is the utilisation of Weberian *verstehen* sociology. Heretofore, prison research has not embraced this strand of Weber's work. Furthermore, to link this novelty with a methodological feature of this thesis, aspects of symbolic interactionism are also important. Thus, this thesis combines a prison investigation with *verstehen* theory and facets of symbolic interactionism. This is an original approach to this form of prison based medical sociology endeavour.

In relation to novel method and methodology, the main innovative feature is included in Chapter 5. This is the patients'/prisoners' perspectives chapter. Chapter 5 incorporates numerous reflections on the nature of social science interviews with prisoners who are also mental health service users. These

debates, that analyse the construction and creation of interview data, are particularly original in the prison context. For example, the analytical debates regarding Schegloff (2000) and turn-taking behaviour in conversation are remarkably novel when utilised to discuss interviews with prisoners who are NHS patients.

The third strand of originality is found via the study's findings. It is not appropriate to repeat all study findings here. However, it is useful to demonstrate the novelty of just a few.

This thesis demonstrates that the penal milieu in relation to an extensive variety of issues impacts mental health and mental healthcare. These range from the overarching ethos of imprisonment right through to individual interactions in the setting. To précis, mental healthcare *provision* and *receipt experiences* and *environments* are important for clinicians and patients/prisoners alike. Four words are emphasised above. These four concepts are crucial for this thesis. Clinicians' *provision experiences* and *environments* in tandem with patients'/prisoners' *receipt experiences* and *environments* are significant for this medical sociology work. The analytical culmination of these four concepts in a study that explores prison mental health and prison mental healthcare is new.

Moreover, this thesis argues the prison environment is not conducive to good mental health, and is not often a useful catalyst for mental healthcare for myriad reasons. Notably, the custodial treatment setting is important here. Thus, the prison based exceedingly complex three-way relationship between culture, mental health, and mental healthcare is addressed. Therefore, the recommendation is that prison mental healthcare ought to be increasingly fashioned in accordance with the prison social environment, the institutional set-

up, and the specific health requirements of patients/prisoners. The proposition is that *context is crucial* to the provision of wholly apt prison mental healthcare. At present, healthcare is not commissioned with sufficient knowledge of, or attention paid to, the prison social environment and the institutional regime. Thus, *context is crucial* is the leitmotif for this thesis. This thesis leitmotif and its underpinning arguments are salient yet original for the field. To reiterate, this work innovatively suggests that in order to appropriately consider issues that concern the mental health of prisoners, the prison setting as a communal and procedural place requires further research and development attention.

Three more analysis discussions have been selected to demonstrate this thesis' originality. These are now detailed.

Firstly, Chapter 4 includes a sub-section entitled **Working with prisoners**. This sub-section concludes with a discussion regarding the conceptualisation of prisoners by the HCC staff who acted as participants for this study. To summarise, patients are narrated as autonomous, worthy, and disparate individuals. Thus, the NHS employees in the prison manage social actors as *individuals*. Whereas, the prison establishment and its staff via rules, practices, and regimes organise and manage social actors as *groups*. There is, therefore, an interesting and previously not discussed opposition between how the prison establishment and healthcare staff can understand and deal with prisoners.

Secondly, Chapter 4 includes a sub-section entitled **Overarching goal**. This sub-section incorporates an exploration of Tuck's (2009) work regarding the concept of primary task. Congruently, this study's data indicate HCC staff experience an intersubjective work goal: *to prevent anyone falling through the net*. Notably,

the prison health literature to date does not contain discussions of workplace goals for prison NHS staff. Therefore, these analytical debates are original.

Thirdly, the conclusion to Chapter 4 includes a shared HCC staff attitude to daily healthcare practice in the prison: *the will's there and the skill's there*. The notion of pride is evident in these clinicians' narratives. Alongside this, a strong and amicable community ethos in the HCC is experienced by this study's participants. Heretofore, this aspect of prison work for NHS staff has not been debated in the field. Thus, this section of the thesis also represents novel analysis and addition to the literature.

Study method reflection

O'Connell Davidson and Layder (1994) note, whilst conducting ethnographic work and its qualitative analysis,:

‘there is a strong possibility the researcher will interpret what is going on from the point of view of his or her own cultural and social position. Bias may thus occur through the imposition of preconceptions and stereotypical assumptions’ (p. 169).

Therefore, during the conduct of fieldwork and analysis for this study, all developing interpretations are considered in relation to their fittingness with the data. Furthermore, this is undertaken in tandem with the ongoing intention to ensure analytical debates reflect these data and not the social scientist's biases or expectations.

Moreover, O'Connell Davidson and Layder (1994) argue analyses and interpretations of study findings ‘must be recognisable and ‘make sense’ to the

people who are subjects of the study’ (p. 181, apostrophes in original). Congruently, during the analysis phase of this study, emerging themes and thesis sub-sections are considered in relation to the (albeit assumed) acknowledgement, recognition, and identification of interviewees.

However, where Ziebland and McPherson (2006) debate testing and confirming research findings, an important reflection is considered to be ‘asking whether the data are representative or whether only those informants who are easy to contact, or who represent an elite, have been included’ (p. 409). This is poignant for this study, as prison wing officers (who do not also occupy managerial roles) and non-mental health doctors (*e.g.* GPs) are not represented — despite numerous and varied recruitment attempts. Therefore, the experience, knowledge, ideas, and issues that these two professional groups would have added to this thesis are absent.

With hindsight, it is possible to observe that this study would have benefited, principally, from the inclusion of frontline prison wing staff in the sample. In this thesis, much attention is devoted to wing staff and their relationships with patients/prisoners, their social interactions with this patient/prisoner social group, their understandings regarding mental health and illness, and their workplace roles and responsibilities. Although the prison staff who act as participants in the study do engage in daily wing work, they also assume managerial positions. Notably, prison governors do not experience or undertake the same daily employment tasks as landing staff. Thus, it is regrettable that no prison wing staff are included in this thesis.

Regarding epistemology, this thesis explores various forms of knowledge. The interviewer gains experiential knowledge via visits to the host prison

establishment and the resultant encounters with persons and places in the prison context. Furthermore, practical knowledge concerns are debated, as the skills and competencies of both NHS and HMPS staff are addressed. Finally, propositional knowledge is included via the dissemination of statements from participants alongside analyses of these expressions, comments, experiences, and practices in relation to relevant theory. In order to undertake useful analysis and produce viable propositional knowledge from a study's data and their related theories, it is often argued that the same social scientist should complete the fieldwork *and* the analysis — as experiential knowledge from the social setting is crucial (see Heron, 1981). This thesis adheres to this recommendation.

Reflexivity is debated at length by May (1999). Several comments are worthy of consideration in relation to this thesis. Firstly, 'reflexive concerns arise from an acknowledgement that the knower and the known cannot be separated' (p. 1). Secondly, foregoing 'authors have focused upon the social location of the researcher' (p. 3). Therefore, 'it follows that social researchers must submit to critique their very ways of thinking about the world' (p. 4). However, recently, 'relations between the knower and the known are no longer to be confronted as issues in the path towards better understanding, yet celebrated as an inevitability and defining of the limit of what can be known' (p. 4). Moreover, May (1999) argues, if social scientists are to be suitably reflexive, 'they would recognise the futility of an attempt to 'mirror' reality' (p. 5, apostrophes in original). These final two points are vital for this thesis. It is important to identify the boundaries and limits of a study's knowledge. It is recognised that this thesis does not (and could not) directly emulate the lives of the participants. Arguably, no study is an exact replica of its fieldwork site. To elucidate what *can* be known from this study requires a return to its sample. This thesis can debate and disseminate only *involved* participants' narratives and their experiences of the host prison

establishment. To exemplify, had this study included different social actors from the same social setting, it is likely its analytical discussions would have differed in content to some extent.

Additionally, this thesis' analyses split the participants via their professional groupings (*e.g.* HMPS staff and NHS staff). This framework suits the study data well; however, analyses via demographic characteristics (*e.g.* gender) may also have proven sociologically interesting. Moreover, it is likely the resultant debates would have been different from those expounded in this thesis. Thus, it is important to recognise that the approach adopted for analyses of data alter the illustrations and explanations of these data and consequent study dissemination content.

Study content reflection

Before demonstrating what this study adds to the field of prison mental health and where its debates corroborate, develop, yet also occasionally challenge differing aspects of relevant research, it is worth first reflecting on the literature review included in Chapter 2 of this thesis. It is important to discuss how study analyses relate to a study's initial literature review.

The literature review concluded with six summary points regarding the field of prison health research to date:

1. Prison healthcare continues to require development (de Viggiani, 2006);
2. Prison is not conducive to good health (Earthrowl *et al.*, 2003);
3. Imprisonment can create or exacerbate mental illness (Mills, 2002);
4. Comorbid mental health problems are prevalent (Steel *et al.*, 2007);

5. Ineffective health services are not a new phenomenon (Steel *et al.*, 2007);
6. Mental health determinants warrant investigation (de Viggiani, 2006).

To recap, these six arguments are expounded and explored throughout this thesis and, to summarise, are generally reinforced.

As noted above, the analysis chapters of this thesis can be compared and contrasted with the literature review chapter and its arguments; certainly, both parallels and dissimilarities exist. Just two of these are now demonstrated.

Firstly, **The social world of prison staff** sub-section in the literature review includes the work of Tait (2008) regarding the character of the prison officer. Tait (2008) argues a radical reassessment of the role of the prison officer is currently required. The idea of prison officers as ‘turnkeys’ (p. 3) must be supplanted; instead, ‘the care *of* and contact *with* the inmates in his or her charge’ (p. 3, italics not in original) should be the primary occupation of prison officers. Tait (2008) argues developing caring inmate–officer relationships often helps inmates manage their period of imprisonment, increases prison officer job satisfaction, and develops prison officer career aspirations. Such relationships require prison officers to listen, understand, and respond to inmates’ needs. Crucially, Tait’s (2008) arguments support and complement the **Dual purpose prison wing staff: Care and custody** sub-section in Chapter 6.

Secondly, the literature review also includes a sub-section entitled **Institutional settings and mental health**. Barton’s (1976) tome is useful for consideration and comparison. Barton’s (1976) mental hospital-based study reports the fabrication of a disease, entitled Institutional Neurosis, as a direct result of institutionalised life. It is the aetiology of the disease which is of relevance here.

The probable aetiology of Institutional Neurosis is related to the psychiatric institution's environment:

1. Loss of contact with the outside world;
2. Enforced idleness and loss of responsibility;
3. Brutality, browbeating and teasing;
4. Bossiness of professional staff;
5. Loss of personal friends, possessions and personal events;
6. Drugs;
7. Ward atmosphere;
8. Loss of prospects outside the institution (Barton 1976:77).

Barton (1976) specifically suggests Institutional Neurosis may occur in prisons and notes it is 'the all-enveloping tissues of constraints and lack of privacy' (p. 74) that typify those institutions at risk. Accordingly, the three analysis chapters of this thesis debate, and arguably support, six out of the eight factors of institutional existence recorded by Barton in 1976. However, numbers three and four (*i.e.* Brutality, browbeating and teasing and Bossiness of professional staff) are not aspects of imprisonment that are narrated by the participants in this study.

Attention is now devoted to study content reflections in relation to more recently sourced literature.

Accountability for health, including mental health, is often debated in relation to four social groups' roles and responsibilities (*i.e.* the individual, the family, the state/the public, and the society's healthcare system). Whilst in prison, it could be argued that a person's individual responsibility is limited. Furthermore, the roles that family members can play are also reduced. Therefore, it is the responsibility of the society's healthcare system and the government to provide

for the health needs of this forcefully detained social group. However, at present, unmet mental health need exists in the UK's HMPS. 'The prison is a complicated and multi-layered institution with many contrasting and, at times, competing pressures' (Coyle 2005:133). The provision of mental healthcare in the penal setting is a convoluted endeavour. The creation of an environment that promotes good mental health for its incarcerated represents a significant challenge for this public service.

Recently, Ridge *et al.* (2011) argue 'subjectivities and distress among men are an important area for critical sociological research. Very little is known about men's subjectivities or the meanings they give to — and how they cope with or seek help for — distress' (p. 145). Men's experiences of mental illness continue to be relatively under-researched; an improved understanding of their mental health distress remains warranted. Notably, Chapter 5 of this thesis explores this gap in the literature and adds to this field of gender health theory.

Additionally, Bjørngaard *et al.* (2009) state 'there is evidence for higher morbidity among prison inmates than in the general population. Despite this, patient satisfaction with the prison health services is scarcely investigated' (p. 1). Under-representation of prison healthcare users persists; however, this study does address and include this sample group. Bjørngaard *et al.* (2009) research patient/prisoner satisfaction in Norway. This thesis also involves a large element of user participation. (As an aside, an interesting difference in study outcomes exists, as Bjørngaard *et al.* (2009) report low prisoner satisfaction with health services whereas the patients/prisoners in this work praise highly both their clinicians and their care).

The work of Patterson *et al.* (2011) firstly confirms ‘the theorised link between climate for care (staff experiences of their work environment) and quality of care as reported by patients’ (p. 4, parentheses in original). Secondly, clinical team ‘shared philosophy of care’ (p. 4) is noted as essential. In support of this Patterson *et al.* (2011) research, the healthcare participants in this study also report experiencing a collegiate workplace goal and an enjoyable clinical environment alongside patients/prisoners recording useful and apt mental healthcare.

Seddon (2007) conducts research regarding prisoners with mental illnesses and states the imprisonment of offenders with mental health problems is one of the most dismaying, unsettling, and controversial aspects of contemporary penal practice. Therefore, future policy options are explored. Difficulties in the field of prison mental healthcare are posited as resource and structure related; ‘in these terms, the solution ultimately lies in committing adequate resources and radically reorganising the administrative structures, systems and processes’ (p. 166). Although, ‘initiatives at that level and of that kind will not address the roots of the problem’ (p. 166); instead, ‘what is needed is no less that a radical re-think of the whole confinement project’ (p. 166). Indeed, despite this thesis not possessing adequate data to support this appeal for reform empirically, it does support the sentiment that resources and slight organisational alterations would likely be insufficient to address wholly the existence of offender mental health issues in prisons. Certainly, ‘tinkering at the margins whilst pursuing largely the same course is unlikely to deliver the goods’ (Seddon 2007:166).

Furthermore, Edgar and Rickford (2009), from the Prison Reform Trust, argue:

‘from first contact with the police to release from prison, people with mental ill health who come into conflict with the law often find that their mental health needs are *neglected* while they are under the authority of the criminal justice system’ (p. 166, emphasis added).

Additionally, ‘once in prison, many prisoners who have mental health problems find it difficult to cope with the *environment*’ (Edgar and Rickford 2009:168, emphasis added). Significantly, in relation to the three analysis chapters of this thesis, the first issue is not reported by the healthcare clinicians, prison staff, or the healthcare service users; the concept *neglect* is not raised. Conversely, aspects of the prison *environment* dominate the thesis; this aligns with the second issue cited by Edgar and Rickford (2009). To summarise, the analytical discussions of this work provide counter knowledge for the field yet also corroborate certain components of prison health literature.

Nevertheless, a number of the analysis debates and sections of the literature included in this thesis are neither entirely surprising nor novel debates — for those with an interest in the provision of care in institutional settings. ‘That these discussions are not new reflects the historical roots of prison mental health care and highlights how the problems of the past can be perpetuated’ (Hughes 2000:60); certain issues appear perennial. However, further to this, ‘interesting theories are those which deny certain assumptions of their audience, while non-interesting theories are those which affirm certain assumptions of their audience’ (Davies 1971:309). Thus, this thesis presents and analyses those topics that possess a somewhat historical sentiment in a manner that does not merely affirm pre-established conceptualisations of the subjects. Therefore, enduring offender health debates are discussed in the three analysis chapters in relation to

comparatively unusual branches of theory and links are made between atypical bodies of knowledge and to matters concerning contemporary UK society more broadly. To précis, data discussion chapters utilise literature not included in the thesis literature review to promote innovative analyses.

Numerous topics associated with the incarceration of persons in the UK are not addressed in this thesis due to deficiency of space, time, and — more importantly — lack of salience with study participants²². For example, debates surrounding risk management (*i.e.* patchy information sharing, issues with inadequate assessment, risks on wings versus opportunities on wings) in HMPS are not included. There exists a vast volume of worthy literature in this area and these discussions are pertinent when offenders who are also mental health service users are discussed.

Beyond the prisons' walls, Lester and Glasby (2010) debate the contemporary strategic importance of mental health, as 'mental illness now touches most peoples' lives' (p. 3). For example, at a global level, depression is forecast to be the second most common cause of disability by 2020 (Lester and Glasby, 2010). Moreover, 'at a global level, at least two-thirds of people with a mental health problem will receive inadequate or no treatment' (Lester and Glasby 2010:5). Notably, problematic mental health and unmet mental health need are not specific to only the UK's criminal justice system and its prisons.

²² However, the semi-structured interview guide and the interviewer's technique are also influential here.

In addition, this thesis takes just one part of the criminal justice system as its focus — prisons; however, Bean (2008) argues insufficient attention is devoted to those with mental disorders in the probation service and in police custody. Therefore, it is recognised that these fields are ripe for research and development.

Also, Bean (2008) suggests:

‘the term ‘mentally abnormal offender’ is a misnomer; it is better to talk of ‘offenders who are mentally disordered’. That places the emphasis on the *criminality* where it should belong, and where the research should be directed’ (p. 178, apostrophes in original, emphasis added).

This prioritisation of pre-offence social exclusion issues and the nature of criminality (afore mental illness) is here supported; undeniably, reasons for the occurrence of crime and the UK’s current cycle of repeat offending deserve investigation.

Lennox *et al.* (forthcoming) highlight release from prison is associated with a range of negative outcomes (including increased suicide rates) and there is need for robust discharge planning for prisoners with mental health problems. Indeed, although not covered in this thesis, links between In-reach teams and community mental health teams are pertinent for those who cease to be prisoners yet continue to be patients. This commentary is applicable in the US also, as Binswanger *et al.* (2011) report transition from prison to community can be problematic and ‘improved release planning, coordination between the medical, mental health, and criminal justice systems may reduce the risk of poor health outcomes for this population’ (p. 249). Notably, topics discussed in this thesis do not have UK relevance only.

Furthermore, myriad issues associated with the global practice of incarceration are not debated in this thesis. It is recognised that this study explores only a diminutive segment of prison-orientated literature and theory. Numerous additional topics are ripe for address and development (*e.g.* the treatment of aging and transgender prisoners). Kingston *et al.* (2011) report psychiatric morbidity amongst older prisoners is unrecognised and undertreated; HMPS is noted as not equipped for its ageing prisoner population and resultant physical frailty and dementia requirements. Fazel *et al.* (2002) highlight ethical and legal implications (*e.g.* The Human Rights Act, 1998) of managing dementia in prison custody. Additionally, McCay (2010), a Psychology Prof., argues ‘being deaf and in prison is a horror’ (p. 311); although McCay’s (2010) paper debates the situation in the US, the highlighting of deaf prisoners’ needs is relevant for HMPS also. Crucially, mental health and mental healthcare requirements are not the only concerns for HMPS, UK.

Finally, Gojkovic (2010) reports a cross-national prison mental health study that concludes ‘a number of issues emerged that are common in both countries’ (p. 284). At present, commonality of problems occurs internationally (*i.e.* across the UK and Serbia in this instance). Therefore, although this thesis exhibits data and debates that originate from one prison setting only, a global approach to considering, conceptualising, and developing prison mental health is commendable. Thus, the current WHO endeavour *Health in Prisons Project* that adopts a worldwide approach to prison health and the provision of healthy prisons is here advocated and encouraged.

Study development

Both the fieldwork undertaken for this work and the necessitated study processes for this thesis (*e.g.* analysis) have provided excellent opportunities to develop research skills required for a career in academia, whilst exploring an important and engaging issue in offender health. The intention is to continue with these two pursuits (*i.e.* to develop research competency and aptitude via future healthcare-orientated study). Therefore, in relation to a potential study that could follow on from this piece of work, a medical sociology research proposal that retains prison mental health as its foundation, yet that takes medical ontological facets as its foci (*à la* Mol, 2002) and not epistemological issues — as is the case for medical sociology theory and ongoing study more generally — is valuable.

Mol's (2002) work represents an exploration of ontology in medical practice via an examination of the ways medicine performs the disease entity atherosclerosis. How the disease entity is *done* in the clinical setting in a practical sense. Applied clinical techniques are investigated. Reality-in-practice is explored. The manipulation of knowledge, rather than the *objects* of knowledge, is observed and analysed. Mol (2002) considers her work to debate:

‘the way in which (Western, cosmopolitan, allopathic) medicine deals with the body and its diseases. The questions it raises do not concern the ways in which medicine *knows* its objects ... This is a book about the way medicine *enacts* the objects of its concern and treatment’ (p. *vii*, parentheses and italics in original, ellipsis to denote removed section).

In relation to research and development funding in this current era of austerity, higher education institutions, and their academics, are increasingly required to demonstrate the impact of their projects. This proposed prison ethnography, that

would utilise interview and observation methods to research (and then develop) how mental health is *done* in the prison context, is valid, as frontline practice is the focus of the planned work — how mental health is *enacted* in the penal milieu via involved social actors (*e.g.* prisoners, clinicians, wing staff). Therefore, resultant implications would be concrete, functional, applied, practical, and hands-on. Thus, in advance, it would be possible to demonstrate the, albeit potential, impacts in an overt, feasible, and workable sense for funding bodies and the prospective host academic institution and fieldwork site.

Thesis postscript

A newly formed academic and clinical grouping, the Centre for Health and Justice based at the Institute for Mental Health in Nottingham, represents a welcome development in relation to offender health (including mental health) in the UK. The centre intends to generate major national development in the understanding of, and provision for, offenders' health. The centre is directed by Prof. Eddie Kane and the advisory board is chaired by Lord Ramsbotham. Hopefully this centre shall fashion policy and practice research, innovation, and development in the field of criminal justice system health and illness.

As a result of the fieldwork, reading, and analysis undertaken for this thesis, it is here suggested that this new centre (and its eventual outcomes) may benefit from devoting time and attention to studying social and institutional aspects of the prison incarceration experience for both staff and prisoners — in tandem with the healthcare policy and practice topics that are expected sources of investigation for the centre.

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