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Title: Negotiating Barriers: Prisoner and Staff Perspectives on Mental Wellbeing in the Open Prison Setting.

Abstract

Purpose - The purpose of this paper is to explore the perspectives of prisoners and prison staff in relation to mental wellbeing and the negotiation of barriers to accessing and providing support. This small-scale study includes the experiences of 11 prison staff and 9 prisoners within a Category D male prison.

Design/Methodology/approach - A focus group was conducted with the prisoners and interviews with prison staff. Thematic analysis identified three core themes: “context enabling factors”, “barriers to accessing support for mental wellbeing” and “peer support roles”.

Findings – Prisoners conveyed a reluctance in reporting mental health issues due to the fear of being transferred to closed conditions. All staff indicated the benefits of peer support roles.

Research limitations/implications - Further research is required on a wider scale, as it is acknowledged that the findings of this study are from one prison and may not apply to other settings. Although there are barriers that may impact the reporting of mental wellbeing issues, there may be small relational steps that can be taken to address these.

Originality/Value - Few studies exist that explore the nuances and barriers within open prisons, perhaps due to the overwhelming need within closed conditions. A context specific approach considering early prevention strategies to support a safer prison system and successful rehabilitation are explored. The combination of prisoner and staff experiences is of value to both academia and policymakers.

Keywords: Mental Health, Wellbeing, Prisoners, Suicide, Prison Staff, Peer Support, Rehabilitation

Paper Type - Research Paper

Introduction

It is widely recognised that prisoners have higher incidence of mental health conditions than those in the community (Prison Reform Trust, 2016; HMIP, 2007; Singleton et al., 1998). Further, the prison environment and experience can have a negative impact on health and wellbeing (Liebling and Maruna, 2005; South et al., 2015), as well as compounding existing mental health issues (Birmingham, 2003; HMIP, 2007). Singleton et al (1998) found that 90% of prisoners have common mental health problems, yet often their needs fall below the threshold to access community based treatment, prior to custody. The Revolving Doors Agency (2007) suggests “it is clear that the holes in the safety net of service are too large for this group, so that they fall through into the criminal justice system easily and repeatedly”. The existing literature supported by findings from the current research indicate that individuals are entering the prison estate with undiagnosed and unmanaged mental health needs.

Part 1 of the Prisons and Courts Bill (2017) sets out in law, for the first time, that prisons are a place where prisoners should be reformed as well as punished. Following the White Paper (2016) ‘Prison Safety and Reform’, the Ministry of Justice (MOJ) have been under pressure to provide strategies for improvement within the prison service, to ensure the safety of both staff and prisoners. The official statistic for self-inflicted deaths in custody for 2016 was 119 deaths; a 32% increase on the previous year and the highest on record (MOJ, 2017). The Prison and Probation Ombudsman (2016) analysed the self-inflicted deaths in custody between 2012- 2014 and highlighted that 70% of those individuals were known to have mental health diagnoses. Moreover, they recognise that due to data recording issues and a lack of inclusion of dual diagnoses (mental health issues and substance misuse), there is likely to be a gap in the reporting and diagnosis of mental health issues. The Prison Reform Trust (2008) has estimated that 72% of male sentenced prisoners suffer from two or more mental health disorders, whilst 75% of all prisoners have a dual diagnosis. The Prison Reform Trust (2016) Autumn Bromley Briefing indicates that there is currently ‘insufficient’ data detailing the current prevalence of mental health issues in custody. In terms of UK recorded suicide rates in those individuals that have been released from prison, Pratt et al (2006) indicates that the risk of suicide is eight times the national UK average. Previous research such as this emphasises that mental wellbeing is a fundamental rehabilitation need and the support individuals receive prior to their release is critical in the preparation for life outside of prison (Bradley, 2009; Edgar and Rickford, 2009).

In this context early preventative strategies are vital to support prisoner mental wellbeing and a broad multi-disciplinary approach is required. These statistics highlight the multiple and complex needs experienced by the prison population. The term multiple and complex needs is used to describe an individual has two or more of the following needs; homelessness, substance misuse, mental health

issues and a history of offending behaviour (Boobis, 2016). The World Health Organisation (WHO) definition of health from the 1948 constitution states that health is “a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity”. The term ‘mental wellbeing’ has been used to describe the dynamism of an individual’s mental state as it changes from moment to moment (Mind, 2017).

Haglund et al (2014) investigated suicide rates in a Swedish cohort-based study, examining 27,000 released prisoners over a five year period and found suicide rates to be eighteen times higher in this cohort than in the general population control group. The authors found a different pattern of need and risk factors in the released prisoners compared to the general population including substance misuse and a previous suicide attempt. They argue for the necessity of adequate resources to aid the transition back to the community, with particular attention to those individuals with those risk factors. In the UK context Byng et al (2015) explored suicide pathways and the role of agency which found a risk both in those individuals that had a history of self-harm and/or previous suicide attempt, as well as those with no previous history. They found those with no previous history gravitated towards more violent means. The authors therefore suggest that there is a cohort of high risk individuals with no previous suicide attempt that require identification and subsequent engagement.

Dyer and Biddle (2013:531) explored resettlement pathways in relation to health and identified potential ways to overcome the problem of newly released prisoners returning to the community with mental health issues “equal to, or greater than, those that they faced when they first entered the criminal justice system”, as this could also influence their likelihood of reoffending. They suggest adopting a “whole prison approach” (HMIP, 2003) or “care management strategy” may improve the institutional health promotion which they argued could support the active engagement of prisoners in understanding their own health issues. The early identification and early prevention of mental wellbeing issues (and factors that may feed into mental wellbeing) may help to avoid the escalation towards crisis. This also connects with reducing the risk of reoffending by considering all of the factors that may link to offending behaviour and preparing prisoners fully for release with the aim of tackling the issue of the ‘revolving door’. Due to the gaps in recognised needs, a significant improvement would require a “profound culture shift” to move towards an approach that is centred on prisoner recovery, wellbeing and rehabilitation (Howard League of Penal Reform, 2017). This is not a new recommendation, as the HMIP (2007: 6) Thematic Review: *‘The mental health of prisoners’* indicated the need for a “holistic approach” in which all of those involved with the care and management of prisoners take responsibility for their mental wellbeing. The report refers back to earlier recommendations that are repeated, particularly the seminal ‘Patient or Prisoner?’ report (HMIP, 1996) which recognised the higher levels of mental health issues

in the prison population, the negative effect the prison environment can have on mental health issues, and the individual and community level long-term impact. Despite this continued drive and recognition of the issues surrounding mental wellbeing in custody, the self-inflicted deaths are the highest on record and the prison estate is recognised as being “under serious and sustained pressure” (Truss, 2016). A multi-disciplinary approach to mental wellbeing in the prison setting involves not only the mental health staff but every professional that has contact with the prisoner (HMIP, 2007). Howard League of Penal Reform (2017: 5) recognise “key partners” in the prison setting includes peer mentors and support staff and the authors argue a collaborative approach is required that incorporates the entire prison estate.

Approaches that facilitate co-production between all individuals within the prison system may be beneficial in the move towards a culture shift. Peer support initiatives may be able to mediate some of the barriers and challenges experienced by individuals within the prison system, whilst promoting prisoner wellbeing. Peer roles (including peer mentors) within the prison system offer an “expertise by experience” approach (Woodall et al., 2015). South et al (2015) conducted a systematic review investigating the efficacy of peer support and peer education interventions in the prison setting in relation to health outcomes and organisational processes. The authors found peer support services to have a practical or emotional positive impact on recipients of the services and that being in a peer support role was linked to positive effects. Five types of peer intervention were recognised within the review; peer support, peer education, health trainer, prison hospice volunteers and mentoring. Dennis (2003) conceptualises peer support roles in a health context and argues they can have an impact at multiple levels with ‘direct effects’ (facilitating access to information and services/ improving social relationships), ‘buffering effects’ (buffering the harm caused by stressful events and environment) and ‘mediating effects’ (improving self-efficacy). Some models of peer support roles in the prison setting are well established and supported by developed governance and processes, for example substance misuse Peer Mentors (generally managed by the local substance misuse provider) and Listeners through The Samaritans. Other peer support models are less well established, dealt with more informally or work in silos as connected to a specific prison department, such as gym orderlies. Although there are commonalities across the prison estate, the provision, service delivery and governance of peer support initiatives appears to be context specific (Fletcher and Batty, 2012).

There is very little extant literature examining the open prison setting or mental health provision in the open setting, despite this being a critical juncture in the prisoner’s journey through the system. Moore and Hamilton (2016) examined the resettlement provision at a male open prison in the context of the Transforming Rehabilitation agenda and discovered an ingrained silo mentality throughout the resettlement process. The authors found emotional and mental health to be a marginalised area within

their study and a lack of effective contact or joint working between the prison officers, healthcare and probation. The lack of “joined-up thinking” and therefore “joined-up doing” was found to be normalised within the open prison setting they explored and they suggest the silo mentality is “endemic” within the entire criminal justice system. Forrester et al (2013) examined 105 prisons and related institutions in England and Wales using telephone interviews to explore the mental health in-reach provision. A broad variation in services was found and the authors indicate that equivalence of provision to the community has not been reached in prison healthcare. With regards to Category D open prisons, they made up 6% of the total included in the study and of these two-thirds had no in-reach team. The authors advocate for the development of a national framework to aid the comparison of prison healthcare services across the estate to monitor and progress future developments. The author also emphasised throughout that there is a high level of unmet need and referred to the Centre for Mental Health (2011) findings which indicated that this included those who are leaving prison and those with common mental health problems such as distress and anxiety.

This review has recognised that high levels of mental health needs exist both within the prison population, as well as those individuals who have recently been released from prison. There are also potentially unrecognised mental health issues within these populations that may impact on an individual’s wellbeing and rehabilitation pathway. Although some of these issues are recognised in policy, a disjoint remains between prison health policy and the translation into practice, due to a variety of complexities that include the prison culture, lack of resources and the prison environment itself (Dixey and Woodall, 2011; De Viggiani, 2007).

Aims and objectives

The key aims of this article are to explore prisoner and staff perspectives in the area of mental wellbeing in the open prison setting. This paper brings together findings from two wider research studies which will be reported elsewhere. The aim of the wider studies were to explore the prisoner and staff perceptions around health more broadly; the first in relation to the feasibility of a health promotion peer support role and the second in relation to the prison staff experiences of working with prisoners who have multiple and complex needs. Both studies found mental wellbeing to be a theme that emerged from the data. Therefore, this paper highlights the areas that emerged from data collected within a Category D Open male prison and provides insight into a setting that is under researched. This paper aims to draw attention to the pertinent issue of mental wellbeing in the open prison estate and the findings highlight key areas of concern with relevance for policymakers, practitioners and academia.

Method

Design

A qualitative approach was taken using thematic analysis (Braun & Clarke, 2006; Ritchie and Spencer, 2002) to analyse the interview and focus group data with the intention of exploring attitudes, perceptions and uncovering data that may be 'hidden' using quantitative approaches.

Participants

A purposive sampling technique (Palys, 2008) was employed, enabling a range of staff members to be approached for participation in the study. The same sampling technique was then used for the prisoners, who were approached by way of negotiation with a gatekeeper. All prisoners were currently engaged in a peer support role within the open prison setting. In total, across the two time points, 11 staff participants were approached and agreed to take part in the study. The staff participant sample included prison staff at different levels and across departments (5 women and 6 men). A total of nine prisoners agreed to take part, ten were approached. Written and verbal participant information was provided, with written consent obtained prior to the focus group or interviews.

Focus Group

The focus group was held in the visiting room within the prison, verbal and written information provided and consent forms signed with an opportunity to ask questions. It was made clear that participation in the research was voluntary and one man decided not to continue after the information was provided. The prisoners were asked to discuss their health concerns, experiences in a peer support role in the open prison setting and their attitudes towards a peer support role related to health promotion. The focus group was recorded using a Dictaphone with encryption technology and took place in July 2015 (time point one). The focus group was used for the prisoners to enable the group dynamic and interaction between the men to generate discussion around health and peer roles (Kitzinger, 1994).

Interviews

Staff interviews lasted 45 minutes and were recorded using a Dictaphone with encryption technology. All interviews took place at the open prison location with the exception of one (during time point one, July 2015) which was held at another prison location; this interview was not recorded as the recording device could not be taken into that prison for security reasons. Instead contemporaneous notes were made and written up afterwards. For the research at the first time point (July 2015), staff were asked to discuss health concerns and health promotion within the prison setting including potential challenges

and positive factors for implementing a peer support role linked to health promotion. For the purposes of the research at the second time point (September 2016) staff were asked to discuss the ways that they supported prisoners with multiple and complex needs within the open prison setting. All staff participants were interviewed in contrast to the prisoner focus group to ensure anonymity and to enable different perspectives to be expressed because the staff worked in different departments or had different roles within the prison. Interviews were also more practical for the staff, to accommodate alternating shift patterns.

Analysis

The interviews (with the exception of one as described above) and the focus group were transcribed verbatim. Analysis at the first time point was undertaken using the 'framework' analysis method as described by Ritchie and Spencer (2002), which comes under the umbrella of thematic analysis and is often used for policy related research. The data was coded, managed and analysed using the qualitative analysis software NVivo 10 which enabled transparency between the original source and the systematic analysis process. Data analysis at the second time point was conducted in line with the approach suggested by Braun and Spencer (2006), again using the analysis software NVivo 10. Mental wellbeing emerged separately from both data sets, the data linking to mental wellbeing was then pooled together and further analysed to identify the themes for the purposes of this study, as reported in the results section.

Strengths and limitations

The exploratory nature of this study allowed for an in-depth consideration of the potential barriers within the context of a Category D Open male prison. The qualitative design enabled the experiences of both the prisoner and prison staff to capture the barriers they faced, in order to address current and context specific issues that may have otherwise been overlooked. A potential limitation of the study is the combination of two datasets collected at two different time points, however this allowed for a more in-depth exploration of the same setting and although the primary aim of both studies was not linked to mental wellbeing this emerged from the data. It is acknowledged the study is small scale and explorative, therefore not intended to be generalizable, however the key points and themes may be transferrable to other prison settings.

Results

The findings of this research highlight potential barriers as to why there may be unrecognised and unreported mental health issues within the Category D open prison setting. Yet the findings also provide cost-effective scope, to overcome some of the key barriers associated. Within the scope of mental wellbeing, three overall themes were identified: ‘Context enabling factors’, ‘Potential barriers to accessing support for mental wellbeing’ and ‘Peer support roles’ shown in table 1 with accompanying subthemes. To illustrate the connection to the original data source, quotes are provided to support each theme.

Table 1: Overarching themes and subthemes

Context enabling factors	Time Expectations in the open prison setting
Barriers to accessing support for mental wellbeing	Fragility of the open prison position Fear of reporting health concerns Masculinity Information sharing
Peer support roles	Staff perspective on peer support roles Challenges in the open setting Support: prisoner or staff?

Context enabling factors

An open Category D male establishment is built upon mutual trust and there is a high level of behavioural expectations for prisoners. An individual’s risk must be considered both low to the public as well as to absconding from the establishment, to be able to secure a place in this setting (MOJ, 2011). The individuals housed within this setting are approaching the end of their prison sentences, have usually worked their way down through the security categories and are ready to take part in a resettlement programme (external employment or training) to aid their reintegration back into society (Ministry of Justice 2013). The staff interviewed reflected upon their experiences of closed prison, despite not being asked to do so. During interviews all staff compared the two experiences of working in open to that of working in closed, to signify the differences in service. The review of the literature found no specific reference to the rates of mental health concerns in the open prison setting with the exception of Singleton (1998) who found that the lowest rates of neurosis in those prisoners in the open settings. The environmental conditions of the open prison setting are different to that of closed conditions including the often smaller population size and therefore accommodation, increased

movement and freedom, access to the outdoors, ability to leave the prison on Release On Temporary Licence (ROTL) for work and other ‘approved appointments’ including family visits and increased access to telephones. These conditions may be considered to be more ‘psychologically survivable’ (Liebling, 2012) than closed conditions however this would also be dependent on individual differences as the open setting may be more difficult for some to cope with such as those serving IPP sentences because of the added ‘pains of freedom’ (Pennington, 2015).

The open prison setting involves more than the described physical or practical elements (as does any other institution) and an examination of the entangled emotional aspect is valuable, particularly when considering mental wellbeing. To apply the emotional geography work by Crewe et al (2014), the less constrained open prison setting may provide more opportunities than in closed conditions in which it is more acceptable to remove the ‘mask’ of masculine bravado and express emotions. Increased access to the outside world through ROTL for employment or family visits may provide increased access to ‘emotion zones’, although on the most part private for the individual, still controlled by the institution. Liebling (2007) emphasises the importance of the prison environment in prison research, particularly in the area of prison suicide because of the negative impact it can have on wellbeing. The author argues that much of the previous literature avoids distinguishing between prisons or prisoners and indicates that some prison environments are more ‘survivable’ than others.

Time

The notion and importance of time was discussed by all of the staff interviewed (Ludlow et al, 2015). Staff felt that they had more time to spend with prisoners in the open prison than they did within closed settings, and that this was in their experience a beneficial outcome. The differences in the prison environment including prison and emotional climate (Liebling, 2012; Crewe, 2014) associated with the increased freedoms and less restrictive regime in the open setting may also influence staff perspectives. The open environment is acknowledged in the quote below:

“I can spend as much or as little time as I want with those on my caseload, when I was in closed you were restricted to time you have and when you went on a wing everyone wanted to talk to you, the environment here helps”.

(Prisoner Officer 3 – time point two)

Staff at the second time point identified how time could impact the success of prisoner-staff relationships and also indicated the influence this had on their autonomy, as illustrated in the above quote.

Similarly, another officer remarked:

“We have the time, to spend that little bit more quality time as personal officers, I know in closed you’re lucky to get one seen a month, we can build up that relationship with the lads here”.

(Prisoner Officer 1 – time point two)

Another officer directly linked time to the recognition of prisoner’s mental health needs, whilst contrasting their previous experiences of closed conditions to the open prison setting:

“Sometimes the amount of time we can spend getting to know someone, can really help us as staff recognise their mental health needs, say for example if their behaviour changes, we have the time to question that; whereas you can’t do that in closed”.

(Prison Officer 4 – time point two)

Ludlow et al (2015) in their submission to the Harris Review (Harris, 2015) explored staff experiences in closed conditions in relation to self-inflicted deaths in custody in 18 to 24 year olds. They found that time was associated with making meaningful connections with prisoners and being able to work in a “relational” way. This was often linked to staff shortages and staff feeling they did not have time to do their jobs properly. Therefore being pushed into a “transactional” way of working, which centred on a mechanistic approach to providing the basics. Contrasting this research with the experiences of staff in the current study highlights the differences between the open and closed settings, specifically linked to time. Whilst having more time is a positive aspect of the open setting, staff in closed conditions have reported feeling frustrated that they do not have enough time to provide integrated and personalised care (Ludlow et al, 2015) which could negatively impact on prisoner wellbeing if they were transferred from open to closed conditions because of a mental health issue.

The staff specified that time was central to support their ability to build rapport with the prisoners in their care and that time also aided their potential to recognise changes in behaviour that may provide insight into the prisoner’s wellbeing (Ludlow et al, 2015; Howard league for Penal Reform, 2017). However the comparisons made between the open and closed setting could prove problematic as this may generate a “false expectancy”, whereby it is assumed to be “more effective, efficient and economical than it really is” (Moore and Hamilton 2016:130). Therefore, the comparison between experiences in open and closed conditions may hinder future developments and innovation within the open setting if the standard is already assumed to be high.

Expectations in the open prison setting

The prisoners and staff identified an attitude of respect that the prisoner had for their place in the open prison setting because of the resettlement focus and the appreciation that it is the step before release into the community:

“Plus because they are preparing for release, their behaviour is completely different because they have a lot to lose here”.

(Prison Officer, time point two)

In the prisoner focus group this attitude was also expressed, particularly around the effort that had been exerted to gain the open prison position:

“Some of us have like waited years to get here and we’ve jumped through every hoop going”.

(Prisoner participant focus group)

“I was trying to get here and I had to appeal again, six months over”.

(Prisoner participant focus group)

The exclusivity and advantage of being within an open prison was seen as a positive factor when working towards their rehabilitation and release, however, this could also lead to anxiety in relation to the fragility of their position within open conditions. This may suggest the importance of managing expectations and providing clear guidance to both prisoners and staff when dealing with this issue.

Barriers to Accessing Support for Mental Wellbeing

Prisoners and staff acknowledged potential barriers that may link to the effective management of mental wellbeing in the open prison setting and the reporting of concerns with mental wellbeing.

Fragility of the open prison position

A key finding of the research was that the prisoners associated the risk of being transferred from open conditions back to closed conditions with health issues and specifically depression. The prisoners often described this transfer as being ‘shipped out’. The quotes below indicate both an expectation that they would be transferred to closed conditions for having depression and also a lack of clear information, both of which are barriers to accessing support for mental wellbeing.

Participant 1: *“Also there’s certain issues in this prison, where you have certain health issues and they, they, they...bully you, the establishment will send you to [Local Category B prison] then and get looked at this health matter there”.*

Participant 2: *“yeah”.*

All participants: *“yeah, yeah”.* (multiple agreement within the group)

Researcher: What sort of health issues?

Participant 1: *“I don’t know what it is but there are certain things that this prison doesn’t deal with...”*

Participant 2: *“Depression”.*

Participant 3: *“Depression”.*

Participant 4: *“Depression”.*

A potential ramification of the above prisoner understanding and the expectation they will get shipped out if they report mental health issues, is that mental health issues do not get reported at all, or that they do not seek support which could prevent a crisis. This could be particularly problematic in relation to depression, as depression has been identified as a key motive for suicide (Rickford and Edgar 2003; Towl and Crighton, 2000). Furthermore, this understanding around mental health issues creating a problem for others (i.e. staff/professionals), or a perception that reporting such issues creates a burden onto the prison, may lead prisoners not to seek support either formally or informally on release which is a concern because of the increased risk of suicide in those who have recently been released from prison (Pratt, 2006). In addition, Edgar and Rickford (2009) highlighted that one of the biggest issues with releasing prisoners who have unmet mental health issues is the revolving door, due to the link between mental wellbeing and offending behaviour. Liebling (1999) also emphasises that a quick return to prison may be indicative of poor coping, rather than a disregard of the consequences, and those individuals are particularly vulnerable at re-entry. Harvey (2011) argues policymakers, practitioners and researchers should be aware of the complexities involved in providing mental health provision in the prison setting, particularly three aspects; the broader psychosocial issues prisoners import into the prison, the deprivations caused by the prison experience and the interaction between the prison environment and the individual. All of these factors can be applied with relevance to the fragility of the open prison position and fear of reporting as this is a consequence of the first two factors combined with the third aspect of the prisoner interacting with the prison environment. This suggests more nuanced ways of measuring and monitoring services and environments are required in order to improve services (Forrester et al, 2013).

Fear of reporting health concerns

Prisoners recognised the fragility of their position within the open prison setting and this appeared to link to a fear of reporting health concerns in case they were shipped out. This is illustrated in the excerpt of focus group discussion below:

Participant 1: *I was saying that you need to find out what are them situations of health what this prison does not, you know, deal with... [Researcher: where you would get shipped out?] yeah and where they kind of threaten to ship you out even if that person has got a genuine health issue, he'll just keep quiet 'cause...*

Researcher: do you think that puts people off talking about it?

Participant 1: *Yeah! Course!*

Participant 2: *Definitely!*

Participant 3: *100% it does.*

Participant 4: *Course it does.*

Participant 5: *I mean would you rather be in [local Category B prison] or here?!*

This highlighted the prisoner perception around the consequences of reporting (and therefore potentially seeking support with) common mental health issues and potentially the lack of awareness of different types of mental health issues, i.e. the difference between common mental health issues such as depression or anxiety and an acute crisis. The Prison Service Instruction (PSI) 3050; 'Continuity of Healthcare for Prisoners' (HM Prison Service 2006:12) stipulates that the transfer of a prisoner occurs where a "significant health issue requiring the transfer of a prisoner and local resolution has not been possible". This lack of specificity raises questions around what may be deemed a significant health issue and what specific factors may result in the transfer of individuals with mental health. Birmingham (2003) discuss the discrimination and stigmatisation of mental health issues within the prison setting by prisoners and prison staff and how this may lead individuals to be cautious in who they chose to disclose concerns to. This existing concern present in prison culture, along with the fear of being transferred to closed conditions for reporting common mental health issues further contributes to the barriers in accessing support for mental wellbeing in the open prison setting. Crewe (2009) found that prisoners were deprived of 'neutral forms of intervention and explanation' and that they struggled to find non-judgemental avenues to discuss and explore emotion and gain psychological insight because of the encompassing institutional power. This risk discourse can also be seen here, with individual needs

(depression) turned into risk therefore associated with the transfer to closed conditions to benefit the institution.

Additionally a staff quote from the second time point appears to confirm that the prisoners fear about the risk of being shipped out was reasonable and shows that there may have been a change over time in the way in which reported depression (or specifically feeling suicidal or indicating the intention to self-harm) was dealt with rather than transferring the individual to the local Category B prison with which the healthcare resource is shared.

“There has been quite a change here since I came, if guys were down or depressed, if they spoke to a member of staff and said I feel suicidal or I am going to self-harm, it was a case of we don’t have full time healthcare here pack your bags, you’re off to [local Category B prison] because they’ve got full time care. Now we have changed that and we sort of manage the guys here, the only guys we actually send back are the ones who have self-harmed to a point where they now need full time healthcare because we can’t offer them that here, but that’s few and far between if I’m honest”.

(Prison Officer, time point two)

This suggests a positive change over time, however in the absence of collecting data from prisoners at the second time point, it is unknown whether this perception has changed or what the prisoner perspective is on this issue.

Masculinity

The impact of masculinity within the context of the adult male prison setting has been explored and it is described as ‘institutionally masculine’ (Sloan 2016). However, the nature of ‘what it is to be a man’ as well as the masculine identities of prisoners, are often overlooked within the analyses of the prison experience; rather than being acknowledged as key factors in this (Wykes and Welsh 2009).

One staff member raised masculinity as a barrier to ‘good work’ in the male prison setting:

“Sometimes the macho bullshit stops some of the good work happening in male prisons”.

(Prisoner Officer, time point two)

The notion of “toxic masculinity” has been outlined as an obstacle to mental health treatment within male prisons due to the exaggerated levels of masculinity caused by the environment, which make therapeutic relationships challenging (Kupers, 2005). The Samaritans (2015) suggest that masculinity - specifically in relation to societal expectations placed on men - contributes to suicide rates. Men can

feel a sense of loss of control when depressed or in crisis, and under these circumstances suicide can be envisaged as a way of regaining that control. A key finding of the current study acknowledges that the existing masculinity combined with the fragility of the open prison position equates to a toxic mix that can result in the underreporting of mental health concerns within the male open prison context. Prison staff in previous research (Howard League, 2017) identified an underlying machismo culture amongst staff and how this environment leads to staff feeling they cannot show weakness or fully acknowledge the impact of dealing with the mental distress of prisoners on a daily basis. One of the recommendations of the report is the requirement for increased staff support, as well as training (Walker et al, 2016) to enable staff to better connect to their own wellbeing in order to be able to support others.

Information sharing

The importance of effective information sharing in the management of multiple and complex needs (Rosengard et al 2007) and for suicide prevention, is widely recognised both inside and outside of the prison setting (Ludlow et al 2015; HM Government 2017). A member of staff discussed their experience of utilising the ‘Assessment, Care in Custody and Teamwork’ (ACCT) procedure in the setting:

“If they are on an ACCT, here the ACCT doesn’t follow the prisoner here, here it stays in the gate so someone has to put an entry in for that person and I worry about that because it might to be a designated person, so sometimes I go out of my way to do the observation and find that prisoner because then I know he is ok and it’s been done properly.”

(Prison Officer, time point two)

This may suggest that the current level of information sharing and management when a prisoner has an ACCT open relies on the particular approach of an individual member of staff, rather than any universally established processes. Effective information sharing between staff members and a multi-disciplinary approach is identified as being crucial to the management of the ACCT process (MOJ, 2011) and this may highlight a need for staff training or a refresher in this area to ensure all staff are approaching this in the same way. Following the required processes with ACCT has been highlighted as a weakness across the prison setting previously and a staff bulletin was released that aimed to address this (MOJ, 2011) which may suggest a disjoint between policy and local delivery or a lack of consistency with individual staff approaches (Moore and Hamilton, 2016). Information sharing is an integral part of effectively negotiating the barriers to providing and accessing support for mental wellbeing across the prison estate and in offender health more broadly (Byng et al, 2012)

Peer Support Roles

The data collected at time point one was directly in relation to the feasibility of a health-related peer role in the prison setting; therefore existing peer roles were discussed and this was evident in the data. The data collected at the second time point, as specified, was in relation to how staff may manage the multiple and complex needs of prisoners and peer support roles emerged from this data. A member of staff below comments on the peer support roles they are aware of in the setting, including the Drug and Alcohol Recovery Team (DART) peer mentors:

“We have the information orderlies who work in the information room so they give prisoners a knowledge of the jail and go through it with them, we’ve got the DART peers and we’ve got a safer custody group of lads that’ll deal with safer custody.”

(Prisoner Officer – time point one).

This reflects Fletcher and Batty’s (2012) findings surrounding the importance of the multi-faceted peer support roles within the prison setting as well as South et al (2015) findings that indicated a wide range of peer support roles are present in the custodial environment.

Staff perspectives on peer support roles

Staff at the second time point discussed the importance of the peer support roles in the setting, particularly the Listeners role (Jaffe, 2012). The quote from a staff member below illustrates that some prisoners may prefer to discuss issues with another prisoner in a peer support role, rather than with a staff member:

“The listener scheme is great here because they can come and go in their rooms, we don’t even know it’s happening. One of the bigger benefits of the peer roles here is that sometimes I think that some prisoners will not speak to an officer no matter what even in a Cat D prison; they just have that mentality from closed settings.”

(Prison Officer – time point two)

Another member of staff remarks on the governance surrounding the Listener role, the positive impact the Listeners appear to have in relation to self-harm and how prisoners may prefer to speak with a peer:

“As we are such a small establishment we don’t have any training put in place for listeners so we rely on prisoners coming here with the skills having been a listener in the previous jail...They have meetings with the Samaritans every month and we don’t attend but if there are any issues, the staff will email me and I will try to offset a lot of the problems that arise if I can, but then between those meetings, a few of my colleagues will attend another meeting with listeners and

have a general chit chat to try and iron out any issues. They offset a lot of issues with self-harm because maybe they don't want to talk to staff, the Samaritans and listeners see all of that I believe."

(Prison Officer – time point two)

Howard League for Penal Reform (2017) conducted research including perspectives of staff across eight prison sites, considering the prevention of suicide in custody. Within their suggestions for improvement, they indicate four key aspects to a “stepped care model” with the second step recognising “key partners” including peer mentors as crucial to improving wellbeing in the prison setting. The findings indicate that the acknowledgement of the role peer supporters play in the prison setting is important, as is this level of respect for peer support roles; however it is important to acknowledge that providing adequate training, support and supervision is essential, particularly in the effort to mitigate the risk of this vulnerable group being used solely to benefit the institution. This is particularly pertinent in the context of a wider prison system that is under pressure and in the open prison setting that does not have adequate funding to provide effective training for prisoner peer supporters, and with low levels of staff. These issues around effectively supporting individuals in a peer support role have clear policy and practice implications. Ludlow et al (2015:xii) found staff identified peer support as important in identifying and managing self-inflicted deaths, and that staff are required to ‘facilitate effective prisoner work in these roles’ as part of a better practice model.

Considerations for the open prison setting

Both the prisoners and staff highlighted challenges with managing peer support roles, specifically in the open prison setting in relation to the focus on employment in the community and Release on Temporary Licence (ROTL) for other purposes, including home leave. These aspects of preparing for release and resettlement are essential. However, it means providing and sustaining peer support roles in this setting can be challenging, particularly in relation to providing training to prisoners who then move into employment or alternative training. Features of the open prison setting such as low population numbers, lower staff numbers and the ethos (in relation to low risk and increased trust levels) may be seen as an ideal setting for peer support roles to thrive, but challenges can conflict with this and a more flexible, context specific approach may be required:

“I think you're always gonna have this, situation where people leave aren't you? And then, are you looking then, how they then get replaced because if you're talking about the same people that are here now, me personally I've probably got about five months left, what happens when I leave...I mean who will replace me?”

(Prisoner focus group participant)

A Prison Officer commented on the feasibility of a new health-related peer role in the open setting:

“In an open prison that could form difficulties regarding the pay because our budget is so, it’s so low of what we can pay prisoners, that’s why we get them out to work as soon as possible and then they’re being paid by the outside agency”.

(Prison Officer – time point one)

The primary focus in the open prison setting towards employment is important but the concern is that other aspects that may link to offending behaviour or resettlement such as mental and physical health, drugs and alcohol and maintaining relationships (HMIP, 2014) may not be addressed, or an assumption made that these other aspects have already been addressed in the closed setting, rather than an appreciation of the dynamic nature of these interplaying factors (Moore and Hamilton 2016; Moore 2012; Hedderman 2007). HMIP (2007) indicated that two factors, as identified by prisoners, were essential to help with emotional and mental health issues; 1) activity, and 2) support from staff and other prisoners. A deficiency of these vital elements was thought to further compound these issues. The current findings suggest that these two elements may be at odds with each other in the open prison setting; activity being employment, and support from other prisoners being peer support roles but it is suggested a flexible and innovative approach may be required to incorporate both.

Support: prisoner or staff?

As the prisoner focus group was exploring the potential of a health-related peer role in the prison setting, the prisoners were asked whether they would prefer to access support from a peer or a member of staff:

Participant 1: *“miles better, the staff in here really aren’t really approachable they don’t help or give you, they’ll tell you what you want to hear and they go away and you never hear from them again you know so they’d rather talk to one of us but...”*

Participant 2: *“talking to another prisoner is always better isn’t it”.*

Participant 3: *“it’s always better to talk to a prisoner anyway”.*

It was also acknowledged that the prisoners had more access to each other, particularly in the open prisons setting where there were no restrictions on movement on an evening or weekend, perhaps creating more space for ‘emotion zones’ (Crewe et al, 2012) The support gained from peers may be seen as a form of neutral intervention (Crewe, 2009) that is lacking in the wider prison setting,

however this is at risk of being absorbed into the institution if used as a substitution for staff roles or resources.

The perception from staff regarding who prisoners may prefer to speak to contrasted with the prisoner view:

“...sometimes I think that prisoners are quite open to come and talk to female Officers about what’s going on and everything and they still would talk to us more than talk to another, talk to a prisoner about what’s going on.”

(Prisoner Officer –time point one)

Liebling et al (2011) outlined that assumptions have emerged US studies that suggested female staff within male prisons can create a ‘calming effect’. Further, Liebling and Price (1999) identified that prisoners were often positive about the presence of female officers. This was due to the ‘human touch’ and the fact that they were easier to talk to (Liebling et al., 2011). Although this perception was not expressed by the prisoners, this could fit with how the Prison Officer sees themselves and contrasted to the high levels of masculinity discussed. The difference in staff perception about who prisoners prefer to talk to, although perhaps expected in the prison environment, may also reinforce the assumption that the prisoners in the open prison setting do not require support, because they do not ask for it. This could also influence staff attitudes over the importance of peer roles in the prison setting, if it is felt that prisoners would prefer to talk to a staff member anyway which may be reinforced by the lack of institutional capacity and resources. It is also possible that the staff member is expressing this view because there is no institutional resource available to develop peer support initiatives.

Discussion

Staff were optimistic about the service the open prison provides in creating a facilitating environment conducive to developing relational interactions between staff and prisoners. They cited time as a productive attribute in the creation and quality of the prisoner-staff relationships. With regards to healthcare, however, staff outlined the lack of presence and part time provision due to the shared healthcare service with the local Category B establishment. The lack of information sharing within the prison, regarding the continuity of the ACCT process, highlights the need for further training surrounding effective communication between departments within the prison. The breakdown in communication, co-operation and coordination has been associated with the development of silos within organisations, that can be “detrimental to the resilience of organisations and communities” (Fenwick, Seville and Brunsdon 2009, p.ii). As noted by Moore and Hamilton (2016), policy makers are becoming concerned about the impact that silos may have on resettlement and the authors suggest a silos mentality is “endemic” across the criminal justice system. The barriers surrounding masculinity will also be

challenging to overcome due to the pervasive nature of the issues. It should be noted that the prisoners did not discuss the issue of masculinity during the focus group, however this omission could be indicative of the underlying masculinity.

The barriers identified by prisoners highlighted a reluctance to share issues relating to mental wellbeing with staff, due to the fragility of their position within open prison setting and the associated fear of being shipped out to the local Category B prison. This (among other issues) could result in prisoners being released with the same or more severe mental wellbeing issues than when they first entered custody. This is particularly problematic for both their risk of reoffending and potential suicidality (Pratt 2006; Dyer and Biddle 2013). Further, The UK National Suicide Prevention Strategy (HM Government 2012:6) specifies that men (outside of the prison context) are at a three times higher risk of suicide than women and “depression is one of the most important risk factors for suicide”. Therefore, early identification and multi-disciplinary preventative strategies are essential, as the effective treatment of depression plays a major role in the active prevention of suicide. More specifically, the report noted that untreated and undiagnosed depression was a key area associated with male suicide. As depression was noted by the prisoners in the focus group, this suggests it is an issue that they see as significant within the open prisoner cohort. To attempt to overcome this issue, better communication and awareness around mental health issues and establishment specific processes may be required with both staff and prisoners. The impact of this unknown information was suggested by the prisoners’ reluctance to share mental health and wellbeing information with staff and as such, they may not receive the support they need. However with effective communication, clarity and information sharing, the fear of being shipped out may dissipate. Findings indicate the importance of information sharing as an effective way to negotiate some of the barriers identified by participants.

The prisoners indicated they preferred to talk to peers about any issues they have within the prison, whilst prison staff feel access to peer support workers is a powerful tool towards supporting prisoner’s mental health needs. Moreover, the open environment is ideal to facilitate the freedom and confidentiality required for prisoners when discussing their mental health and wellbeing but delivering this service is not without organisational challenges. Peer support roles can be utilised to attempt to overcome some of the barriers including information sharing and communication issues highlighted and could further decrease a prisoner’s sense of fragility of position in the open setting and the fear of reporting mental health concerns. However, the organisational lack of recognition of the peer support role is evident in the lack of allocated resource and this may undermine the potential benefits and importance of peer support roles within the open prison setting. There is also a fundamental concern in the reliance on peer support roles in the absence of adequate provision. These issues reinforce the

employment and training outcomes, without an appreciation of other factors that can link to the mental wellbeing of prisoners within an open prison and beyond. The differential behaviours and experiences of prisoners within varying locations across the prison estate indicates the need for a more robust “spatial analysis of prison culture” considering the social as well as physical architecture (Crewe, 2014:71). The current research has highlighted the need for further attention to be paid to the open estate and an exploration of a nuanced institutional power including the ‘fragility of the open prison position’ and what impact this has on the rehabilitative ambition of this type of establishment.

Conclusion

This study has highlighted that there is a lack of communication and shared information which may be creating a reluctance in prisoners to share their mental health needs with prison staff. This may be resulting in the lack of reporting of mental health concerns within open prison setting and crucially, the support provided to prisoners in need. This highlights the importance of integrated approaches not only between prison departments and prison staff, but also effective communication between prisoners and staff and vice versa. Our findings suggest that although peer support roles are an effective way to negotiate some of the barriers outlined; clarity and the sharing of information could effectively reduce the feeling of fragility of the position within the open prison, as well as reducing the fear of reporting mental wellbeing. For the future development within the context of the open prison setting, a comparison between open and closed establishments may hinder any innovation and progression. Therefore, the findings suggest the need for wider scale independent research to be translated into policy and practice that can attempt to negotiate the barriers across the prison context.

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Research ethics

The two studies required ethical approval from three organisations. Firstly the university where the authors are based. Secondly, the Health Research Authority and finally the NOMS. Local level approvals were also gained from the prison site where the data was collected.

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