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The sources of adversity in the delivery of mental healthcare in prisons

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ABSTRACT

In 2006, the National Health Service commenced with assuming responsibility for the delivery and commissioning of mental healthcare services in prisons within the UK. Previous research has indicated that some prison environments may present challenges to the delivery of mental healthcare for prison populations. The present study aimed to explore the experiences of staff working in NHS offender health teams to identify the sources of adversity that frontline staff may encounter when providing mental healthcare in prison settings. The present study also aimed to identify working conditions that may be conducive in facilitating the delivery of mental healthcare in prison settings. Mental healthcare professionals (n = 10) who worked in NHS offender health teams took part in 1:1 semi-structured interviews that were audio recorded and transcribed verbatim. The thematic analysis of the dataset indicated three themes that presented sources of adversity for NHS offender health teams in their delivery of mental health care in prisons; which were 1) location of mental healthcare delivery 2) communication links with stakeholders and 3) prison policies, procedures and legislation. The results of this study have illustrated some of the work-related factors that require attention in order to further support frontline staff in their delivery of mental healthcare in prison settings.

1. Introduction

It has been estimated that 10.74 million people are detained in a prison setting on a global basis (Walmsley, 2018). Higher rates of mental health difficulties are often observed in prison populations around the world in comparison to the general population (Fazel et al., 2016). The World Health Organisation stipulates that all prisoners have the right to receive healthcare that is of the equivalent standard to services provided in community settings (Gatherer, Jürgens, & Stöver, 2007). In 2006, the National Health Service (NHS) assumed responsibility for the commissioning and provision of mental healthcare services in prisons across England and Wales (Hayton & Boyington, 2006) with the same applying to Scotland and Northern Ireland in 2011 and 2012 respectively. As part of this reform, the Department of Health and Her Majesty's Prison Service set an initiative to ensure that the standards of NHS mental healthcare services delivered in prisons are equivalent to those provided for the general population (Department of Health, 2001). This initiative led to the development of NHS offender health services, which are multi-disciplinary teams that deliver healthcare for prisoners during incarceration. However, although mental healthcare delivery in prisons has improved under the NHS, they have been deemed as being substandard in comparison to community healthcare services (Till, Forrester, & Exworthy, 2014) and further improvements have been called for (Pepin, Beard, & Bate, 2018). Thus, there is an essential requirement to ascertain the challenges that prison environments may present for NHS offender health teams when required to provide mental healthcare services of the same standard to those provided to the general population.

Prison populations in England and Wales can comprise of people who may be vulnerable to various mental health disorders such as psychoses, neuroses, alcohol and drug dependence, bipolar disorder, deliberate self-harm, post-traumatic stress or any comorbities of these disorders (Singleton et al., 1997). The prevalence of mental health disorders, such as personality disorder, anxiety and suicidal ideation, are higher in the UK prison population in comparison to the general population (Tyler et al., 2019). Rates of suicide have also been reported as being 8.6 times more likely to occur within prison settings compared to the general population (Prison Reform Trust, 2020). In March 2019, it was reported that 53,193 people were being treated for drug and alcohol disorders within adult prison settings in England (Public Health England, 2020).

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As the prevalence of mental health difficulties are reported as being higher in prison populations than the general populace, there are also concerns that prisoners can encounter difficulties in accessing care services in a timely manner (Davies et al., 2020). Given the remit to deliver mental healthcare services in prison settings of the same standards to those provided to the general population, there is a need to ascertain the work-related factors that may influence offender health teams in their delivery of care to prison populations.

Healthcare professionals working in prison settings have acknowledged that identifying and meeting the healthcare needs of prisoners are the most important aspects of their occupation (Powell et al., 2010). However, offender health teams have the remit of providing mental healthcare within some prison settings that may be considered as non-therapeutic environments for prisoners (Jordan, 2011). For instance, the architectural design of prisons could be a factor that influences the mental healthcare practice of offender health teams. It has been argued that restrictive prison architecture that is devoid of adequate space and light can have negative consequences on the well-being of both prisoners and staff members (Moran, Turner, & Jewkes, 2016). The architectural design of prisons can also potentially influence the thoughts, interactions and behaviour that staff members have towards prisoners. For example, research conducted in the Netherlands observed that prisoners who shared a cell with another prisoner reported to have fewer positive relationships with staff members than offenders who resided in cells on an individual basis during incarceration (Beijersbergen et al., 2016). This would suggest that some prison settings may not be conducive to harnessing therapeutic or empathic interactions between staff and prisoners (Jewkes, 2018).

However, there are initiatives such as the Royal College of Psychiatrists' Enabling Environments that provides a set of standards to illustrate what prison settings require in order to facilitate therapeutic interactions between staff and prisoners (Haigh et al., 2012). Within England, Her Majesty's Prison (HMP) Grendon was the first democratic therapeutic community prison that aimed to encourage prisoners to socially integrate with others through participation in meaningful activities, such as group-based exercise, education and therapy sessions (Bennett & Shuker, 2017). HMP Grendon provides an exemplar of how prison settings can potentially foster social climates that can enable therapeutic change in prisoners through their development of trusting and supportive relationships with staff members (Dolan, 2017). There have been calls for further research to illustrate how architectural design and institutional spaces can impact staff who work within prison settings (Jewkes, 2018). Thus, there is a need to ascertain how prison settings can influence offender health teams in their delivery of mental healthcare services for prisoners.

As global prison populations have increased, there has been a recognition that further work is required to ascertain how mental healthcare delivery can be improved in order to provide optimal psychiatric care for prisoners during their contact with criminal justice systems (Forrester et al., 2018). It has also been acknowledged that mental health care delivery in English and Welsh prison settings is still substandard in comparison to services that are available to the general public (House of Commons Committee of Public Accounts, 2017). It has been argued that further improvements to the occupational support of frontline staff is essential in order to facilitate improved delivery of mental healthcare in prison settings (Patel, Harvey & Forrester, 2018). However, there is limited evidence obtained directly from frontline staff in relation to the occupational factors that may influence the delivery of mental healthcare in prison settings. The present study will address this important gap in the literature. Qualitative research has been cited as a useful approach in gaining further knowledge on how social and environmental factors can influence the subjective experiences of healthcare professionals (Fossey et al., 2002). Thus, the present study used a qualitative approach to explore the lived experiences of NHS Offender Health Teams to gain an understanding of the workplace adversities that could occur in prison settings and influence the delivery of mental healthcare to prisoners. Obtaining an understanding of the factors that may influence the practice of NHS offender health teams could inform future strategies on how to further support frontline staff to deliver optimal standards of mental healthcare services in prison settings. Furthermore, the present study also aimed to illustrate strategies that could be used by offender health teams to negate their stipulated challenges and further support the delivery of mental healthcare in prison settings.

2. Method

2.1. Research Approach

A qualitative research approach was used that involved conducting a series of 1:1 semi-structured interviews, on a face-to-face basis, with the participants. The participants in this study were mental healthcare professionals who worked within National Health Service (NHS) Offender Health Teams who were responsible for providing mental healthcare in prison settings. Please refer to section 2.2 for anonymized information on the participants who took part in the present study. The 1:1 semi-structured interviews were conducted by the lead author and an interview schedule, comprising of open-ended questions, was used to guide participants to discuss their experiences of the occupational factors that influenced their delivery of mental healthcare services in prison settings. The interviews comprised of three initial questions (Table 1). Follow-up questions were provided by the interviewer to enable participants to elaborate and discuss their experiences of providing mental healthcare in prison settings. The 1:1 semi-structured interviews were transcribed verbatim and the six stages of thematic analysis (Braun & Clarke, 2006) were applied to analyze the anonymized dataset. Thematic analysis provides a structured framework for coding qualitative data as a means to identify patterns or themes across a dataset that are relevant to the aims of a study. An inductive thematic analysis was conducted for the present study, which means that themes were developed and informed by participants' experiences rather than the analysis being guided by a particular theoretical framework (Braun & Clarke, 2006). Thus, an inductive thematic analysis was utilized to explore and identify the common experiences of participants regarding the work-related factors that could influence the delivery of mental healthcare in prison settings.

2.2. Participants

A purposive sample of 10 employees who worked in NHS offender health teams were identified and recruited to take part in the study. Permission to recruit participants was approved by an NHS Foundation Trust in accordance with the ethical approval granted by the ethics committee at the Faculty of Arts, Design and Social Science, University of Northumbria at Newcastle. The 10 participants were recruited from NHS offender health teams who were responsible for the delivery of mental healthcare in 4 different prison services. The contract for mental healthcare provision within these 4 prison services were managed by the same NHS Foundation Trust. The service managers of participating offender health teams communicated details of the request to recruit participants to take part in a 1:1 semi-structured interview for the

Table 1
Details of the initial questions used to guide the 1:1 semi-structured interviews with the participants.

Interview Schedule
1) What does your role consist of in relation to the delivery of mental healthcare in the prison service?
2) What do you find challenging when delivering mental healthcare in prison settings?
3) What strategies do you find helpful to overcome the stipulated challenges to mental healthcare delivery in prison settings?

present study. Members of the offender health teams who expressed an interest in taking part in the study were then provided a participant information sheet that clearly illustrated the aims of the study. Participants who agreed to take part in the study were required to provide written informed consent prior to their participation. Recruitment of participants ceased once data saturation had been achieved and interviews were no longer yielding novel concepts that were relevant to the aims of the study. Please refer to Table 2 for a summary of participants' job titles at the time of data collection.

For the purpose of confidentiality and anonymity, the prison services where participants provided offender health services are referred to as Service 1, 2, 3 and 4.

Service 1 was a Psychologically Informed Planned Environment (PIPE) unit and provided mental health care for females with diagnosis of personality disorder in a closed female prison. Service 1 was providing care for 12 female prisoners with a personality disorder at the time of data collection. Employees within Service 1 were based and delivered interventions within a closed unit that was external from the traditional prison wing.

Service 2 provided mental health care for adult female prisoners with severe personality disorders within a closed prison for adult females.

Service 3 provided mental health care for adult male prisoners in a remand prison. Service 3 comprised of 7 wings and had an operational capacity of 1001 prisoners.

Service 4 provided mental health care for male prisoners aged 18 years and over within a prison setting that had an operational capacity of 1210. The prison comprised of prisoners who were serving long-term sentences and remand prisoners.

2.3. Procedure

Ethical approval for this study was obtained by the research ethics committee of the Faculty of Arts, Design and Social Sciences as the University of Northumbria at Newcastle. Participants who agreed to take part in the study were asked to meet with the lead author (DR) on a 1:1 basis in a private room located on the premises of their workplace but external to the prison setting. Participants were asked if they had read through the participant information sheet and were provided with an opportunity to ask the lead author any questions regarding the aims of the study. Participants were also informed that the interview would be semi-structured and that some questions would be informed by their responses in order to explore their experience of delivering mental healthcare in prison settings. Written informed consent was obtained from participants prior to commencing with the semi-structured interviews, which were audio recorded using a digital Dictaphone. Participants were notified that they also had the right to decline answering any questions that they did not want to answer during the interview and the option to withdraw their data up to 30 days following their interview without consequence. The lead author verbally presented questions to enable participants to discuss the work-related factors that influenced their delivery of mental healthcare services in prison settings. The lead author provided follow-up questions, as informed by the responses of participants, to further explore their experiences of delivering mental healthcare services in prison settings. Once the interviews had ceased, participants were notified that the Dictaphone would be switched off. Interviews lasted for a duration of 60–90 min. Participants were then provided with a debrief sheet and thanked for their participation.

Table 2
Details concerning participants' job title, gender and anonymised service in which they were providing mental healthcare at the time of data collection.

Participant	Job Title	Gender	Anonymised Institutional Code
Participant A	Forensic Psychologist	Female	Service 1
Participant B	Higher Assistant Psychologist	Female	Service 1
Participant C	Trainee Forensic Psychologist	Female	Service 2
Participant D	Forensic Psychologist	Female	Service 2
Participant E	Higher Assistant Psychologist	Female	Service 2
Participant F	Mental Health Nurse Practitioner	Female	Service 3
Participant G	Registered Mental Health Nurse & Clinical Lead	Female	Service 3
Participant H	Registered Mental Health Nurse	Female	Service 4
Participant I	Registered Mental Health Nurse	Female	Service 4
Participant J	Clinical Lead	Male	Services 1 & 2

2.4. Procedure for analysis

The six stages of thematic analysis (Braun & Clarke, 2006) were applied when analyzing the anonymized dataset. In accordance with this approach, the lead author first read through the interview transcripts and coded passages of the dataset that were relevant to the aims of the study. Codes of similar meaning were then collapsed together into overarching themes. Each theme was provided a definition to represent participants' experiences of how prison environments could impact NHS offender health teams in their delivery of mental healthcare, which are illustrated in the Results and Discussion section of this manuscript. When reporting a thematic analysis, it is necessary to utilize extracts from the transcripts that support themes and interpretations in relation to the aims of a study (Braun & Clarke, 2006). It is recommended that extracts from the transcripts are large enough to provide sufficient context of participants' experiences that are relevant to the research question (Braun & Clarke, 2012). Thus, the results of the present study comprise of extracts from the transcripts that provide sufficient context of participants' experiences of the work-related factors that influenced their delivery of mental healthcare in prison settings.

3. Results and Discussion

The aim of the present study was to ascertain the work-related factors that may influence NHS offender health teams in their delivery of mental healthcare in prison settings. Three themes were identified as presenting potential sources of adversity for NHS offender health teams in their delivery of mental healthcare for prisoners, which were 1) location of mental healthcare delivery; 2) communication links with stakeholders; and 3) prison policies, procedures and legislation. This section will provide quotes from the dataset to illustrate how participants' experiences informed the development of themes and interpretations in accordance with relevant literature.

3.1. Location of mental healthcare delivery

This theme was defined by participants' experiences of how the location of mental healthcare delivery in prison settings could influence offender health teams in their capacity to provide care for prisoners. Participants stated the potential difficulties in being able to engage with prison populations when the waiting areas for offender health services were deemed as being aesthetically unpleasing, devoid of natural light and could also leave prisoners vulnerable to bullying.

> *"[Service 4] is 200 years old. The environment doesn't lend itself to a lot of change. In [Service 4], there is a huge waiting area [for mental healthcare] with major issues about bullying in the holding area. It isn't a great place to be in [Service 4]. There is no natural light, it's like a huge goldfish bowl. It's dark, it's dirty and I can understand why people don't want to go in it. I wouldn't want to sit in there for two or three hours. If*

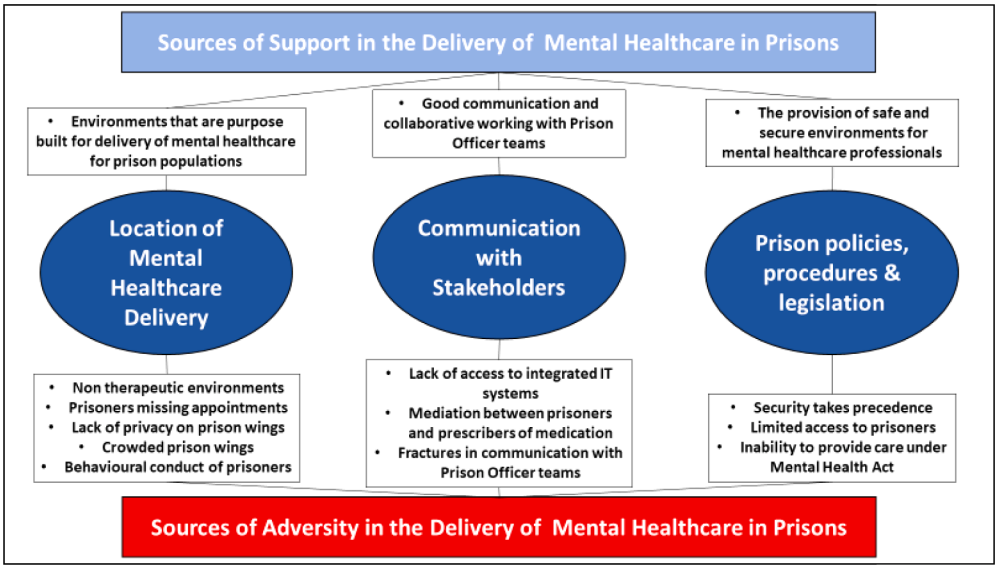

Fig. 1. A thematic map that illustrates the work-related factors that may influence offender health teams in their delivery of mental healthcare in prison settings.

you have a clinic booked you will have a massive DNA [Did Not Attend] rate. So, they [prisoners] don't attend and that puts pressure on the [offender health] team to go to the wings". (Participant J, Clinical Lead)

The quote above suggested that the waiting areas for offender health services could leave prisoners who require mental healthcare vulnerable to prisoner bullying. Prisoners with mental health difficulties have a higher risk of physical (Blitz, Wolff, & Shi, 2008) and sexual victimization (Wolff, Blitz, & Shi, 2007) than prisoners with no psychiatric diagnosis. Prisoners can also experience fear of bullying in certain locations within prison settings that are associated with risks of being bullied (Allison & Ireland, 2010). Thus, if the waiting area for offender health services are associated with threats of bullying, then this may inhibit prisoners from attending their appointments with offender health teams. It has been argued that prisons should include 'intermediate zones' that are non-carceral, such as educational and chaplaincy settings, where prisoners can be acknowledged as students and worshippers respectively (Crewe et al., 2014). It has been recognized that some locations, such as visit rooms in which prisoners meet with loved ones, can also be immune to any oppressive prison cultures and replaced with a sense of love and compassion (Crewe et al., 2014). HMP Grendon' therapeutic community has also illustrated how it is possible to harness social climates where fellow prisoners can provide peer support that contributes to the facilitation of therapeutic change (Dolan, 2017). In order to encourage attendance to mental healthcare appointments, some prison settings may need to cultivate cultures where the waiting areas for mental healthcare services are deemed as 'intermediate zones' in which prisoners are acknowledged as patients who require care.

Participants also discussed how having offender health team services based in locations that were aesthetically unappealing and devoid of natural light may also deter prisoners from attending their appointments. It has been posited that prison environments that comprise of oppressive architecture and devoid of natural light can have negative consequences on the quality of interactions between frontline staff and prisoners (Moran, Turner, & Jewkes, 2016) Spending prolonged periods of time in buildings without exposure to natural light can also have negative consequences on mood, sleep quality and elicit biological stress responses through increases in cortisol activity (Harb, Hidalgo, & Martau, 2015). Thus, offender health teams may have further difficulties in engaging with prisoners who perceive that the designated locations of prison mental healthcare services are non-therapeutic. It would be necessary for future research to gain prisoners' perspectives as to whether the designated locations of mental healthcare services, within prison settings, can determine as to whether they attend their scheduled appointments or not.

Participants discussed the requirement of going onto the prison wings to deliver mental healthcare when prisoners did not attend their appointments. Participants stated the difficulties that can occur when there was limited or no access to interview rooms on the prison wings in order to deliver mental healthcare in a safe, private and confidential manner.

"The interview rooms on the wing are not the best. There are some wings where there are no appropriate rooms. You can go on the wing and have a chat with the patient but it is not appropriate for further discussions when others are around. There are discussions with our manager and governor to obtain more appropriate interview rooms as it can cause stressful situations, as you need to see someone. But there are no rooms available. So that puts a barrier of providing care for someone". (Participant G, Registered Mental Health Nurse & Clinical Lead)

It has been acknowledged that female prisoners may be hesitant to engage with mental healthcare services when there are concerns around breaches in privacy, anonymity and confidentiality (Plugge, Douglas, & Fitzpatrick, 2008). The present study also suggests that not having access to private rooms on prison wings can be problematic for mental healthcare professionals in terms of finding suitable spaces to hold clinical appointments with prisoners. This illustrates the necessity for mental healthcare professionals to have access to private rooms that facilitate the delivery of care in a private and confidential manner within prison wing settings.

Participants stated how prison wings can also be unpredictable and chaotic, particularly at times when large numbers of prisoners were out of their cells, which could potentially inhibit frontline staff in their delivery of mental healthcare.

"It is not a good environment being out on the wings and walking into the unknown at times and it can be chaotic…We do everything to safeguard ourselves when on the wings, we make sure the officers know where we are if we are seeing people. But when a lot of prisoners are out on the wing, it can be worrying". (Participant F, Mental Health Nurse Practitioner)

The process of providing care in environments that are perceived as being unpredictable has been identified as a risk factor of occupational burnout for registered nurses (Garrett & McDaniel, 2001). Furthermore, it has been argued that prison officers who work within overcrowded prison wings can be vulnerable to work related stress and be fearful of

prisoners (Martin et al., 2012). The views expressed in the present study would suggest that the occupational practice and wellbeing of mental healthcare professionals can also affected when required to work within prison wing settings that are deemed to be overcrowded and chaotic environments.

> *"I have been ill when working on wings where prisoners have used spice [synthetic cannabis]. It is easily accessible for prisoners and unfortunately drug tests do not show when prisoners are using spice. I had unknowingly inhaled spice and became unwell and had to be taken to hospital. Now, I am very wary when I go onto the wings"*. (Participant I, Registered Mental Health Nurse)

The quote above illustrates how prisoners' use of synthetic cannabis (colloquially known as spice) can influence offender health teams in their ability to deliver mental healthcare on prison wings. Spice can elicit mind-altering effects (Ralphs et al., 2017) and the misuse of synthetic cannabinoids can also trigger acute psychotic episodes or exacerbate symptoms of psychosis (Papanti et al., 2013). The inhalation of second-hand fumes from synthetic cannabinoids can potentially leave frontline staff vulnerable to harmful side effects, such as nausea and loss of consciousness (Norton, 2019). Thus, the current study has indicated that members of offender health teams who had experienced the side effects of inhaling second-hand fumes from prisoners' drug misuse may subsequently be apprehensive about delivering mental healthcare on prison wing settings.

However, some participants discussed how providing care on Psychologically Informed Planned Environments (PIPE) was beneficial in enabling offender health teams to successfully deliver mental healthcare for prisoners.

> *"[Service 1] is fairly unique and the nature of [Service 1] means it has to be placed on a discreet unit. So already that allows the opportunity for relationships to flourish in perhaps ways they wouldn't ordinarily. The female estate is generally more settled and with [Service 1] and [Service 2], we have a higher ratio to staff to prisoners than we do on any other wing."* (Participant A, Forensic Psychologist).

Psychologically Informed Planned Environments were introduced in 2011 as part of a strategy to ensure that prisoners who have a personality disorder diagnosis are able to access mental healthcare within designated areas of a prison setting (Haigh et al., 2012). PIPE units are designed to provide calm environments and have shown to be conducive in harnessing therapeutic alliances between staff and prisoners, as well as in the successful delivery of mental healthcare (Turley, Payne, & Webster, 2013). The quality of therapeutic alliance between healthcare professionals and care recipients has been identified as an integral component to the successful delivery of non-pharmacological and pharmacological mental healthcare interventions (Krupnick et al., 2006). Therefore, offender health teams working on PIPE units are able to deliver mental healthcare in locations that allow therapeutic relationships with prisoners to flourish and enable the successful delivery of care. However, not all prisoners are eligible to access services on PIPE units. Thus, it must be acknowledged that there will also be frontline healthcare staff who do not have opportunities to deliver mental healthcare in such enabling environments. It is therefore necessary for future research to investigate if there are differences in occupational wellbeing between offender health teams who provide care for prisoners in PIPE units and those professionals who deliver mental healthcare on non-PIPE settings.

This theme has provided some illustrations on how the location and environments in which offender health teams are situated in when delivering mental healthcare in prisons could determine the extent to which frontline staff are able to provide care effectively for prisoners. It appeared that prisoners may fail to attend mental healthcare appointments if offender health services were situated in settings that were deemed as being non-therapeutic and associated with a perceived threat of bullying. Participants also suggested that some prison wings can be devoid of easily accessible rooms where mental healthcare delivery can be delivered in confidence. However, when offender health teams are working in settings that are specifically designed for the delivery of mental healthcare, such as PIPE units, this was conducive in facilitating therapeutic interactions with prison populations.

3.2. Communication Links with Stakeholders

This theme illustrates how communication with relevant stakeholders could influence offender health teams in their delivery of mental healthcare in prisons. Participants discussed how not having access to the integrated IT system of their NHS Trust could inhibit effective communication between offender health teams and external primary/secondary healthcare services.

> *"We don't have access to the Trust's IT system, so we don't know anyone's background unless it's on SystmOne [SystmOne is an IT system where prison staff can access prisoners' health records]. We have to call community teams, which can be horrendous. You could have someone acutely psychotic…You are chasing information and it can be quite stressful…It takes time away, and you don't have a lot of time as it is… Having access [to the Trust's IT system], even if it was read only, would be ideal"*. (Participant F, Mental Health Nurse Practitioner)

IT systems that do not support the adequate transfer of patient specific information between prison services and external healthcare services has shown to potentially disrupt the delivery of healthcare prisoners with chronic physical ailments, such as asthma, diabetes and hepatitis (Cornford et al., 2007). The present study suggests that not having access to the IT systems of external NHS services may also delay prison services to obtain patient specific information that can be necessary to ensure the delivery of appropriate mental healthcare to prison populations in a timely manner. Thus, the development of IT strategies that ensure the safe transfer of patient information and integration of offender health teams with external healthcare services could further support the effective delivery of mental healthcare in prison settings.

Participants also discussed the difficulties of mediating between prisoners who request medication and General Practitioners/Psychiatrists who are apprehensive about prescribing pharmacological interventions due to concerns of them being misused or used as currency within the prison setting.

> *"It's probably some of the greatest conflict that we have is that they (prisoners) say they must be on certain meds, we find no history. They'll threaten to do all sorts to themselves unless we prescribe. If they are mentally unwell, they can just stop [prescribing] the anti-psychotic because they have been seen palming it, not taking it when they should be and then we are then caught in that conflict. We know they need the meds, the GP says they won't re-prescribe and we have to try and mediate or get our psychiatrist to prescribe and it can be frustrating"*. (Participant I, Registered Mental Health Nurse)

Reviews have shown incidences where prisoners have diverted, traded or abused medication as prescribed by GPs (Choudhry & Evans, 2014). Given the potential for prescribed medication to be misused in prison settings, the quote above illustrates how offender health teams may encounter difficulties when communicating the needs of prisoners to colleagues who are prescribing practitioners. This illustrates a challenging conundrum for offender health teams in being able to identify genuine cases where prisoners require pharmacological interventions and then liaising with qualified practitioners in ensuring that medication is prescribed as necessary. These difficulties can be further compounded in situations when prisoners present as a risk of self-harm when requesting medication or communicating their unmet needs.

"There is a lot of incidents of self-harm which are purely because they [prisoners] want to gain something. Unfortunately, they've learned that by self-harming they will be put on an ACCT ['Assessment, Care in Custody, and Teamwork'], *which automatically will get reviewed so staff are involved. So, there is a lot of prisoners that do cut themselves purely for manipulation to get control of the situation".* (Participant F, Registered Mental Health Practitioner)

The above quote converges with previous studies that have observed healthcare professionals' and prison officers' perceptions of being manipulated or blackmailed into responding to the requests of prisoners who repeatedly self-harm (Marzano, Adler, & Ciclitira, 2015; Ramluggun, 2011). In England, self-harm has been defined as the process of self-injuring and/or self-poisoning (Hawton et al., 2007). It has been posited that self-harm can be used as a form of communicating unmet needs in order to gain a sense of control and exert interpersonal influence to seek help from others (Edmondson, Brennan, & House, 2016). The quote above suggested that there can be a perception among some offender health teams that prisoners self-harm in order to be placed on an ACCT, a multidisciplinary care plan that aims to reduce the risk of self-harm and suicide in English and Welsh prisons (Humber et al., 2011). When placed on an ACCT, the additional support that is provided by multiple members of staff has shown to provide prisoners with reassurances that strategies will be implemented to negate further incidences of self-harm (Pike & George, 2019).

It has been argued that notions of low self-efficacy and inadequate training could go some way to explaining why frontline prison staff may perceive as having their practice being manipulated by prisoners who self-harm (Ramluggun, 2011). Thus, there may be a need to provide the necessary training and support for some members of offender health teams in identifying the function of self-harm in prison populations. In 2019, there were 63,328 recorded incidents of self-harm, which is the highest rate of self-harming behaviours observed over a 12-month period in prisons within England and Wales (Ministry of Justice, 2020b). There are various risk factors associated with self-harm in prison populations within England and Wales, such as suicidal ideation, having a psychiatric diagnosis, experience of solitary confinement and victimization (Favril et al., 2020). Repeated incidents of self-harm have also been identified as a risk factor of suicide (Hawton et al., 2014). It has been argued that the provision of training programs that aim to increase understanding of self-harming behaviors could be beneficial in harnessing professional relationships between prison officer teams and female prisoners who self-harm (Kenning et al., 2010). Furthermore, it is necessary for mental health care professionals to have the required skills to screen and identify any unmet needs of prisoners that may manifest into self-harming behaviors (Marzano et al., 2010).

The quality of communication and collaboration with prison officer teams was also discussed as being influential for offender health teams in their delivery of mental healthcare and interactions with prisoners. Participants discussed the difficulties of providing mental healthcare effectively when their communication links with prison officer teams were fractured.

"There's at times a spilt between clinical [offender health teams] and discipline staff [prison officers]. I think the fact that we are located in two separated buildings probably does not help that. The disciplines of people [staff] can create separations…I think you can communicate more easily when you're more present and you can have those five-minute chats about what's going on… I know we do quite different jobs but I think it would help so much more if we were a bit more connected". (Participant D, Forensic Psychologist)

Prison officers often have more direct contact with prisoners than offender health teams and are predominantly led by security protocol that can potentially conflict with the aims of healthcare workers in prison settings (Foster, Bell, & Jayasinghe, 2013). It has been purported that prison officers do not perceive that ensuring the mental wellbeing of prisoners is a clear and explicit objective of their role, which could be due to a lack of training or expertise in the area (Tait, 2011). The current study indicated that the divide between the remit of prison officers (secure detainment of prisoners) and offender health teams (the delivery of mental healthcare) can further diverge when both occupational groups were based in separate locations. However, some participants stated that being based in the same location as prison officer teams could enable the two occupational groups to work in tandem and support the delivery of mental healthcare in safe/secure settings for prisoners.

"The group [prisoners] is more controlled if they know there is a prison officer in there. But sometimes we do it [group therapy] in the group room in the main corridor and it's more beneficial for the prison officer being there as they are able to move them [prisoners] and manage them [prisoners]…I think that is massively important to build relationships with staff [in prison officer teams] and work together as a team rather than separate entities. (Participant B, Higher Assistant Psychologist)

It has been shown that having mental healthcare professionals and primary care practitioners co-located in the same setting can encourage face-to- face discussions and cohesion between colleagues; all of which enhances collaborative working and service delivery for patients (Wener & Woodgate, 2016). Prison officers are likely to have more contact with prisoners than other occupational groups and can therefore be an integral facet to the successful delivery of mental healthcare in prison settings (Jordan, 2011). This would suggest that working practices that facilitate collaborative working between offender health teams and prison officers could be beneficial in harnessing safe environments to deliver mental healthcare in prison settings. The quote below also illustrates how the successful delivery of mental healthcare can be informed by holding designated meetings with prison officer teams to discuss the needs of prisoners who were at risk of self-harming.

"If we have a complex case, every day we have a meeting on a lunch time and if an officer is concerned, they can come down, bring a referral, voice their concerns to us and we will listen. Before we see the patient, will ask the officers 'how the patient has been, is there any concerns or risk?'. We have complex case panels [known as an Integrated Management Panel], so if we have a really complex individual self-harming, anyone can call that in the jail. So, it is a multi-disciplinary team and we will share information based on risk". (Participant J, Clinical Lead)

The Prison Service Instruction 64/11 (PSI 64/11) is a document that illustrates the necessity for collaborative working between multiple disciplines to identify and meet the mental healthcare needs of prisoners who are at risk of self-harm or death (Ministry of Justice, 2020a). The PSI 64/11 states that healthcare professionals have a duty of care to share patient specific knowledge with relevant colleagues when there is a need to communicate prisoners' risk of harming themselves or others. The PSI 64/11 also stipulates that relevant members of prison officer and healthcare teams should attend review meetings in order to discuss, identify and plan strategies to meet the needs of prisoners who are at risk of self-harm. Prison settings that harness a culture of shared responsibility between mental healthcare professionals and prison officer teams could be beneficial in ensuring that the healthcare needs of prisoners are effectively identified and treated (Hean, Willumsen, & Ødegård, 2017). Thus, in accordance with the quote above, collaboration with prison officer teams could be beneficial in supporting offender health teams in identifying and treating the mental healthcare needs of prisoners.

This theme has provided illustrations of how poor communication links with relevant stakeholders could present as a source of adversity for offender health teams in their delivery of mental healthcare in prison settings. It was suggested that when communication links with stakeholders were enabled, such as having offender health teams based in the same location as prison officers, this was beneficial in facilitating the delivery of mental healthcare in prison settings.

3.3. Prison policies, procedures and legislation

Participants discussed how prison regimes could influence offender health teams in their capacity to provide mental healthcare to prisoners. Participants stated that some prison procedures could limit their access to prisoners, which could impact the achievement of service delivery targets.

> *"We were told that 90% of our time should be spent having clinical contact, which is really difficult to do. That isn't possible anyway with the prison regime when they [prisoners] are behind the door [in the cell], and we can't see them [prisoners] on Friday afternoons. I don't know how other people feel, but me personally, I feel there is quite a pressure on clinical contact and seeing people".* (Participant F, Registered Mental Health Practitioner)

The quote above indicated that prison procedures that inhibit the achievement of service objectives could also be perceived as a work-related stressor for some members of offender health teams. In the field of nursing, occupational constraints that hinder the delivery of care can contribute to the onset of work pressure, negatively affect self-efficacy and negate the ability to flourish in the profession (Bakker & Sanz-Vergel, 2013). Furthermore, participants discussed how the difficulties of not being able to provide care under the Mental Health Act 2007 in prison settings could impact their care practice.

> *"I think the frustrating thing is that they are in prison and we cannot enforce the Mental Health Act for treatment as the rules and legislation is different. We are seeing a more serious end of psychotic illness due to drug induced psychosis and there not being beds on the PICUs (Primary Intensive Care Units) service and seeing the same issues within the prison service too".* (Participant G, Registered Mental Health Practitioner & Clinical Lead)

Prisoners cannot be 'sectioned' under the Mental Health Act 2007 as prisons settings are not classified as a healthcare setting (HM Inspectorate of Prisons, 2007). This means that offender health teams are unable to provide mental health care, when deemed necessary, for adult prisoners who do not have the capacity to consent to treatment. The only sections of the Mental Health Act 2007 that can be applied in prison settings are sections 47/49, which stipulates that prisoners can be transferred to hospital to receive psychiatric treatment when deemed necessary. However, the current study illustrated that there can be bed shortages in Primary Intensive Care Units, which means that it is not always possible for offender health teams to transfer prisoners to hospitals in a timely manner. Therefore, consideration needs to be given to how the occupational wellbeing of offender health teams can be impacted in situations where the delivery of mental healthcare services is curtailed by particular legislation within prison services.

However, participants also stated that adherence to prison procedures was necessary in ensuring safe environments for the delivery of mental healthcare services.

> *"It's the environment we work in. The client group we work with, yes there are threats. Safety is absolutely paramount within the teams and the message is, 'if you don't feel safe, then don't deliver it'…We provide team members personal protective training which is prison prescribed…We risk assess rooms, the environment we are going to work in and make sure it is safe".* (Participant J, Clinical Lead)

While some aspects of prison regimes may limit offender health teams in their access to prisoners, participants in the current study recognized the essential requirement for prison protocol that aimed to maintain secure/safe environments and reduce risk of harm to staff/prisoners. Healthcare professionals who perceive that their working environments are unsafe to deliver care effectively can be vulnerable to the onset of occupational burnout and emotional exhaustion (Salyers et al., 2017). It has also been acknowledged that safe working environments are essential in ensuring the occupational wellbeing of frontline healthcare staff and patient safety (Hall et al., 2016). This would suggest that secure environments, as enabled by prison security procedures, are essential for the safe delivery of mental healthcare for prisoners and the occupational wellbeing of offender health team.

This theme has illustrated that although prison policies, procedures and legislation may limit offender health teams in their access to prisoners, they are essential in ensuring safe and secure settings to enable the effective delivery of mental healthcare. However, it was suggested that limiting offender health teams in their access to prisoners may prevent the achievement of service delivery targets and could negatively impact the occupational wellbeing of frontline mental healthcare staff. Furthermore, the inability to provide care under the Mental Health Act 2007 in prison settings and make referrals to hospital settings can also present challenges for offender health teams in ensuring that prisoners receive prompt mental healthcare when necessary.

4. Conclusion

It has been acknowledged that there is a dearth of research that has investigated how prison design and architecture can impact the working practices of frontline staff (Jewkes, 2018). The present study has provided novel insights, as provided by frontline staff, to illustrate how prison environments, social climates and regimes can influence offender health teams in their delivery of mental healthcare to prison populations. It has previously been argued that frontline staff are often not included in the process of designing prison settings, and this can serve as a missed opportunty to ensure the development of prison architecture that is conducive to the rehabilitation of prisoners (Jewkes & Moran, 2017). The present study has provided detailed perspectives of frontline staff to illustrate how prison environments can have a direct influence on the capacity for frontline mental healthcare professionals to deliver their services for prison populations. Therefore, it may be beneficial for prison architects and geographers to engage with frontline staff when designing or restoring prison settings to ensure carceral spaces that faciliate the delivery of mental healthcare to prison populations.

It is also important to acknowledge that offender health teams in prison settings are part of a wider mental healthcare system and an essential component to public health (McLeod, et al., 2020). For some prisoners, their first contact with mental healthcare services is upon incarceration, and it is essential that prison populations receive the necessary care to facilitate rehabilitation and re-integration into communtity settings (Forrester et al., 2018). Furthermore, there is also an essential requirement to ensure that there is no disruption to mental healthcare for prisoners who access community services prior to incarceration. In order to support prison populations with mental health difficulties to re-integrate into society, it is integral that offender health teams have excellent links with external community services in order to support successful discharges from prison services. The present study has identified that optimal use of technology to faciliate effective communication is one way of supporting the integration of offender health teams into the wider network of mental health services and public health.

However, some aspects of the methodology require consideration when interpreting the results of the present study. The majority of the participants that took part in the present study were female, with only one participant identifying as male. It is unknown as to whether having 90% of the participant group being female is indicative of the demographics for NHS Offender Health Teams in England and Wales. However, it has been purported that female prison officers may have greater concerns regarding their safety than male members of staff when interacting with prisoners (Taxman & Gordon, 2009). It has also been suggested that male prison officers are at a higher risk of being assaulted by prisoners and that female staff members are less likely to trigger overt acts of aggression from prisoners (Steiner & Wooldredge, 2017). This would suggest that there may be gender differences in how staff perceive

prison environments and their interactions with prisoners. Therefore, it may be necessary to further investigate how the identified gender of healthcare professionals may influence the delivery of mental healthcare services to prison populations.

It could also be argued that 10 participants is a small sample, and therefore, the findings may not be generalized to a wider population of frontline staff who provide mental healthcare services in prison settings. However, it has been acknowledged that the findings of qualitative studies with sample sizes as small as n=1 can provide informative results in healthcare and inform subsequent positivist research designs that employ inferential statistical analyses (Boddy, 2016). The findings of the present study have illustrated some key factors on how prison settings can influence frontline mental healthcare staff in their delivery of care for prison populations that could be investigated using quantitative research designs and inferential statistical analyses. For example, a subsequent study could use quantitative measures to assess how the environment, social interactions and regulations attached to prison settings can influence frontline staff in their delivery of mental healthcare to prison populations.

For the purpose of reflexivity, it must also be acknowledged that the researcher's prior experiences may have influenced responses of participants. Author DR conducted the 1:1 semi-structured interviews and had prior experience of working in clinical settings within community and inpatient mental healthcare services. Thus, the researcher's experience may have influenced the type of probing questions that were asked within the interview. However, 1:1 semi-structured interviews allow the responses of participants to inform the content of follow-up questions and facilitate further exploration of participants' experiences (McIntosh & Morse, 2015). Furthermore, the related experiences of researchers can also be useful in yielding data and responses during qualitative interviews that are relevant to the aims of a research project (Gough & Madill, 2012). Thus, 1:1 semi-structured interviews were used in the present study to enable participants to speak about their personal experiences of providing mental healthcare in prison settings as reported.

In summary, there has been acknowledgement on a global basis that there is an essential need for continued research to assess, evaluate and implement strategies to improve mental healthcare delivery for prison populations (McLeod, et al., 2020). In order to facilitate improvements and equivalent standards of care in prisons, it is essential that healthcare initiatives and policies focus on strategies to further support frontline staff who provide mental healthcare in carceral settings. The findings of the present study indicate, from the novel perspective of frontline offender health staff, that prison environments, social dynamics and regimes require evaluation to ensure that they are conducive to facilitating mental healthcare professionals in the provision of care within prison settings.

Declaration of Competing Interest

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

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