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Chapter title:

"The will's there and the skill's there": Prison Mental Healthcare

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Abstract:

This discussion explores some of the data from a social science PhD whose fieldwork took place in a category B, adult male, local and remand prison in England run by Her Majesty's Prison Service (HMPS). The debate analyses National Health Service (NHS) staff experiences of mental healthcare provision in a penal context and debates achievements, problems, and implications for future improvement. To summarise using a staff member narrative: "*The will's there and the skill's there, but …"* – staff are well trained and keen to provide outstanding healthcare but there are barriers impeding this aim. Issues that affect the wholly apt provision of healthcare in the prison are narrated as structural and establishment related – and not social or cultural. The nature of penal healthcare is explored; the following themes are raised: primary task, ownership, pride, efficiency, enjoyment, communication, and multi-disciplinary teamwork.

Chapter overview:

This discussion explores some of the data from a social science PhD whose fieldwork took place in a category B, adult male, local and remand prison in England run by Her Majesty's Prison Service (HMPS). Decades ago, in 1984, Jones and Fowles stated 'the official view in British prisons is still that deprivation of liberty is the punishment — conditions in prison should not add to it. The state of the prisons does not bear this out' (p. 203); the contemporary prison system in England and Wales continues to experience issues (*e.g.* overcrowding) that affect conditions in the institution. Regarding mental health, Awofeso and Guggisberg (2011) highlight 'prison settings generally worsen the precarious health profiles of incarcerated individuals' (pp. *v–vi*) and report 'the experience of incarceration, it is widely acknowledged, is likely to exacerbate mental health problems' (p. 150). Mental healthcare is needed in prisons; nevertheless, 'the provision of healthcare services behind bars for these prisoners is not for the faint hearted, but it is uniquely rewarding' (Smith 2010:33).

This debate analyses National Health Service (NHS) staff experiences of mental healthcare provision in a penal context and debates achievements, problems, and implications for future

improvement. To summarise using a staff member narrative: "*The will's there and the skill's there, but …"* – staff are well trained and keen to provide outstanding healthcare but there are barriers impeding this aim. NHS mental healthcare in this prison is split into primary and second levels and patients/prisoners are referred to services according to severity and endurance of mental illness; generally mental health services in prisons operate according to a principle of equivalence (*i.e.* care should be equivalent to that which is available in the community). However, the suitability of this principle and the achievement of this principle are both critiqued. For example, arguably the direct application of community mental health services to the prison population is mistaken, as issues of criminality complicate the situation (Steel *et al.*, 2007).

Prison In-reach teams are intended to provide the specialist/secondary mental health services to persons in prison that are provided by community based mental health teams to the wider population. Unfortunately, In-reach teams have been affected negatively by limited resources, constraints imposed by the prison environment, difficulties in ensuring continuity of care, and wide variations in practice (SCMH, 2008). In-reach teams are now often termed Secondary Mental Health Teams; however, the label In-reach occurs often, as participants utilise this term.

Staff in the prison argue mental healthcare is an important topic for research and development because the voices of patients/prisoners themselves are not easily or often heard:

Participant: *So often with services, it's all about the people who deliver the service … especially if the people in need [i.e. the patients/prisoners] do not, or cannot, ask for change.*

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

Overall, this work argues that for the NHS staff who acted as interview participants in this study the delivery of healthcare in a prison setting can be understood as an amicable collaborative endeavour where several overarching workplace goals are shared, to good effect, throughout the healthcare centre's staff membership. Two such intersubjective workplace aphorisms are analysed: '*To prevent anyone falling through the net'* and '*The will's there and the skill's there*'. The setting's working environment is explored, including the primary–secondary mental health service boundary. The required staff attributes for prison-based psychiatric work are discussed. Issues that affect the wholly apt provision of healthcare in the prison are narrated as structural and establishment related – and not social or cultural. Experiences of working with mental health patients are presented and analysed. Prisoners are conceptualised as healthcare patients and offender elements receive little attention in transcripts. The nature of penal healthcare is explored; the following themes are

raised: primary task, ownership, pride, efficiency, enjoyment, communication, and multi-disciplinary teamwork.

Overarching PhD:

The title for the full doctoral thesis is *Prison mental health: Context is crucial*. The study devotes attention to social and institutional arrangements that permeate the prison locale and affect mental health and mental healthcare. Myriad issues regarding prison social environment, prison institutional set-up, and specific mental health requirements of patients/prisoners are addressed. The research is characterised as a policy and practice orientated exploratory case study and the principal study question is: How could prison mental healthcare be developed? There is a paucity of prison based mental healthcare studies that assess policy implementation, policy effectiveness, the role of NHS commissioning, and the effectiveness of the provision in the prison context (Brooker *et al*., 2009), hence the justification for this work. In relation to the wider societal context, the concept of transinstitutionalization (Prins, 2011) and more general concerns about the location and treatment of those with mental illness within our society act as a guiding query for the research.

The PhD implements an inductive approach to the datum–theory relationship, a constructionist ontological position, and an interpretivist epistemological orientation. A full debate concerning the philosophical underpinnings of the study can be found in the original thesis. Regarding method, semi-structured interviews were conducted with healthcare centre staff, the secondary mental health team, prison governors, prison psychologists, primary-level mental health service users/prisoners, and secondary-level mental health service users/prisoners. Regarding numbers of transcripts, twenty-one interviews were utilised for analysis. This number of transcripts represents four patient/prisoner, twelve NHS staff, and five HMPS staff interviews.

Grbich (2007) considers the process of thematic analysis to consist of two complementary data reduction techniques: block and file, and conceptual mapping (pp. 32–35); both of these disparate yet complementary coding processes were utilised in this study. General social theory alongside medical sociology literature is used to frame study results.

The ethical and security guidance provided by the HMPS Psychology Research Ethics Committee was adhered to and all arrangements stipulated by the HMPS Research Contact at the prison were upheld, including the Security Governor's requests. Participant Information Sheets and Consent Forms were used. All participants attended interviews as volunteers, including prisoners; no coercion was deployed. Participants are assured confidentiality and anonymity. The work was labelled a service evaluation by a NHS Research Ethics Committee and the NHS Research & Development group. The overall Governor at the prison approved the project and was also keen to act as a participant.

The PhD concludes that the penal milieu, in relation to an extensive variety of social and structural issues, impacts mental health and mental healthcare; these range from the overarching ethos of imprisonment right through to individual interactions in the setting. To précis, mental healthcare provision and receipt experiences and environments are important for clinicians and patients/prisoners alike; aspects of the prison cultural environment and aspects of prison institutional existence are salient. For further reading from the same author regarding this thesis see Jordan (2012), (2012a), (2011), and (2010), plus Wright *et al*. (2014).

Service setting:

This qualitative study was conducted in one prison. This analysis utilises data from interviews conducted with prison-based NHS clinicians including registered general nurses (RGNs), registered mental health nurses (RMNs), health care assistants (HCAs), In-reach team members (psychologist, psychiatrist, community psychiatric nurse (CPN)), plus varied administration and clinical management staff — all NHS staff. Both primary and secondary mental health staff are represented. Interviews with these NHS staff were conducted in the NHS Healthcare Centre (HCC) in the host prison. Multiple clinical and non-clinical meeting rooms were utilised. Interviews lasted between thirty and ninety minutes, were audio recorded, and were then transcribed verbatim within the prison. All of the themes discussed were first considered in relation to their relevance and fit across the HCC staff transcripts as an entire body of data (*i.e.* deviant case analysis). Where complication or deviation exists, this is debated in the main body of the debate; there is not a specific section dedicated to anomalies.

Analytical themes and findings:

Across the interview transcripts, there is an agreement concerning — unacceptable — mental illness prevalence in the prison setting; this is then linked with a desire to address and resolve the issue. However, the nature of imprisonment is depicted as often detrimental to mental health by interviewees. In relation to published prevalence statistics, including substance addictions and personality disorder up to ninety per cent of prisoners have some form of mental health problem (CMH, 2009 as sourced from Singleton *et al.*, 1988). There are currently around 85,000 female and male persons housed in HMPS establishments across England and Wales and these prisons often receive people from the community with poor mental health. ‘Most prisoners with mental health problems have common conditions, such as depression or anxiety. A small number have more severe conditions such as psychosis’ (CMH 2009:2).

‘There is a high prevalence of mental health problems in prisons and insufficient provision for these problems’ (Nurse *et al.* 2003:484). Prison healthcare services are in need of development (de Viggiani, 2006). Rates of self-harm and attempted suicide in prison are high (CMH, 2009). ‘For some, being in prison will lead them to develop depression or anxiety’ (CMH 2009:2).

The Offender Health Research Network (2011) provides updated mental health prevalence statistics from 2009: Severe and enduring Mental Illness (SMI) is present in 23% of the prison population; major depression is present in 19% of the prison population; psychosis is present in 4% of the prison population; dual diagnosis is present in 18% of the prison population; substance misuse is present in 66% of the prison population. Overall, 71% of the prison population has a SMI, substance misuse problem, or both. Evidently, 'prison settings are a challenging environment in which to manage and deliver healthcare' (Powell 2010:1263).

The following discussions of achievements and challenges are split into eight sub-sections:

- Working with patients/prisoners at the Healthcare Centre;
- Working with patients/prisoners with mental illness;
- The working environment at the Healthcare Centre;
- Communication and co-operation amongst NHS staff;
- Overarching goal for the NHS staff;
- Enacting NHS change in the prison setting;
- 'Did Not Attend' as an issue for NHS services;
- Old Guard *versus* New Guard.

Working with patients/prisoners at the Healthcare Centre

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

The NHS Healthcare Centre (HCC) staff involved in this study narrate a working life in the prison establishment that is permeated with the notion of security — in a positive sense. Security/safety concerns and incidences are accepted to occur in the prison as an institution — and staff are trained well for these occurrences — however these incidences are narrated as somewhat distanced from the HCC and its day-to-day work with individual patients.

Participant: *Prior to working here, [it was] eleven years working in mental health on a community secure unit, and it's much more secure here.*

Smith (2010), a prison-based RGN, conceptualises prisons as 'self-contained communities, with a transient problematic population' (p. 34) and an unpredictable working environment. Congruently, the transitory nature of this HCC's patient base is acknowledged by its NHS staff. Patient turn-over is high. Also, in relation to the unpredictable working environment narrated by Smith (2010), this is echoed in the interview transcripts too.

However, it is aspects of the institutional working environment that are recounted as unpredictable, and not the behaviour of, or the nature of work with, the individual prisoners (*i.e.* their patients) in the HCC. This distinction sets the tone, as some structural aspects of the workplace are considered problematic whereas social aspects are narrated positively.

Structural aspects often refer to prison regime, timetable, physical layout, resources, time to deliver healthcare, *etc*.; whereas, social aspects often refer to elements of social interaction and cultural norms, values, and practices in the HCC.

HCC staff depict their work in the prison establishment and their work with prisoners as comfortable, safe, and secure. Enjoyment is also expressed in relation to clinician–patient/prisoner interactions:

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

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

Working with patients/prisoners with mental illness

Participant: *What I've always said is, half the prisoners in here shouldn't be in prison, it's not the correct place for them, as many have huge mental health problems. You don't realise until you work in a prison how many prisoners there are with massive mental health problems, and it's not the right environment for them, it's just not, and it's of no use locking them up here.*

'Prison nursing is demanding as it involves dealing with people who have multiple, complex needs' (Smith 2010:35). Poignantly, where issues that influence mental health in a negative sense are raised, these are often framed as prison regime problems:

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

However, in relation to NHS mental healthcare provision, HCC employees consider service provision to be excellent:

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

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

Interviewer: *So, to discuss the primary mental healthcare that you deliver, which aspects do you think are working particularly well?*
Participant: *All of it ... Yesterday I had a clinic of three, they were all brought on time, they all had their allotted time each, it was just ideal.*

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

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

The working environment at the Healthcare Centre

Participant: There is always a good feeling here.

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

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

In relation to service delivery, capability at work is professed by the healthcare clinicians involved in this study. NHS staff are content and sufficiently skilled to fulfil their ascribed roles. Proficient service provision is narrated in tandem with good safety nets:

Interviewer: Prison reception screening has a few mental health questions, yes? Do you feel that aspect is working well?
Participant: I think it's fine. It seems to be working well. It kind of, you know, anyone who's already on psychiatric medication automatically gets referred to the mental health team anyway [In-reach], so it's quite, there's a good safety net there, especially for a general nurse like me [a RGN]. I feel quite safe with that whole process.

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

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

Efficient and concise work is required swiftly in this healthcare environment. When considered as a whole body of data, the interview transcripts for the study echo this labelling of important HCC staff characteristics. Moreover, and encouragingly, the narratives profess personal fulfilment of these abilities. Therefore, these notions of effectiveness, conciseness, and swiftness do not represent idealistic work goals; they are instead aspects of working lives participants consider themselves to fulfil appropriately. These service delivery characteristics are not restricted to clinical staff, they apply also to HCC staff who do not interact with patients practically in a healthcare sense (*e.g.* NHS administration staff).

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

> 'Treating patients in forensic mental health services is a team effort with various professionals contributing in different ways according to their areas of expertise ... Everyone working with a patient communicates with other members of the team to ensure a consistency of approach with any one individual patient. Working as a member of an effective and collaborative multidisciplinary clinical team can by very satisfying' (p. 104).

As McMurran *et al.* (2009) note, the following three features aid development of effective and satisfying team environments in forensic mental health settings: healthcare conceptualised as a team effort; diverse professional contributions valued; effective team communication embraced. As the next sub-section exemplifies, this study's interviewees do narrate working lives that feature these three facets.

Communication and co-operation amongst NHS staff

Gojkovic (2010) explores both Serbian and English prisons and the mental health services provided therein. An important aspect of prison mental healthcare provision is the nature of collaboration: 'interviewees emphasized the importance of communication and collaboration when dealing with a demanding and complex caseload' (Gojkovic 2010:176). Congruently, informal yet frequent and amicable incidences of co-operation and communication amongst HCC staff are narrated by the NHS participants in this study. The notion of an amenable collaborative working environment in the prison's HCC is depicted:

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

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

> 'Working in organizations, whatever their size or task, has an emotional impact on those within them and few organizations are more emotionally challenging than those tasked with the care of highly traumatized and traumatizing environments' (p. 43).

Thus, in relation to this study's healthcare locale, what are the complex working dynamics that Tuck (2009) argues present themselves in such clinical settings? To summarise, although the clinical working environment in the prison establishment appears eventful, dynamic, and convoluted (in a clinical sense), these complexities do not appear to be experienced as

negative via HCC staff. A multitude of HCC-based experiences, interactions, goals, roles, and responsibilities are narrated by study participants, however these are not experienced as occurring in a complex, traumatic, or disconcerting fashion.

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

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

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

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

Moreover, the nature of co-operation between the primary-level and secondary-level mental healthcare clinicians is reported as amicable and trustworthy. This relationship appears to be a requirement for apt provision of prison-based mental healthcare. The prison setting requires this form or collaborative working between the two mental health occupational groups. Teamwork is conceptualised as each clinician possessing a body of knowledge that they implement in the workplace; however, this is not considered to be a knowledge base with distinct impermeable boundaries, as sharing is discussed positively:

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

McMurran *et al.* (2009) state the field of forensic mental health is affected negatively by previous high-profile incidents concerning mentally disordered offenders such as Michael Stone and Christopher Clunis; furthermore, 'what appears to underlie many of these failings is the common factor of poor communication between the differing agencies and the professionals within them' (p. *xi*). Conversely, in relation to this study, communication appears to occur frequently and effectively in this particular NHS healthcare setting.

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

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

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

This interviewee links the notions of successful multiparty clinical endeavour with the existence of enthusiasm in the workplace; this links this sub-section concerning collaborative working practice with the following sub-section regarding the workplace overarching goal.

Overarching goal for the NHS staff

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

Overall, the NHS HCC in the prison appears to be geared towards excellent patient care first-and-foremost; patient welfare is the primary focus of the HCC and this ethos permeates the everyday working lives of its staff.

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

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

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

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

intersubjective work goal (*i.e*. the concept of primary task exists): *to prevent anyone falling through the net.* This phrase is repeated often in the transcripts.

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

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

This workplace goal is laboured here. It may seem unusual that the NHS HCC's group desire to prioritise ***patient*** care is highlighted as important. After all, NHS staff are usually expected to consider patients' welfare indispensable. Interestingly and conversely, therefore, it is actually the ***absence*** of custodial, punishment, ***prisoner***, crime, punitive, or security orientated answers, narratives, experiences, ideas, roles, and responsibilities in the transcripts that is thought-provoking. It is the paucity of criminality-related terms to conceptualise patients — and their relationships with patients — that is crucial for analysis here. The language utilised by HCC-based participants prioritises the notion of patient as social role, and not prisoner as social role — although this is actually the reason for these patients' current social location (*i.e.* in prison). Thus, the overarching work goal for these NHS staff is not surprising *per se*; however, when the treatment locale is considered, this dominant and powerful healthcare delivery goal gains increased significance.

The work of Le Grand (1997) is useful for inclusion here. Le Grand (1997) discusses welfare provision and policy-makers' differing models of human motivation and behaviour in social policy-relevant situations. Notions of state largesse, public philanthropy, and social actors' self-interest and passivity are raised. Le Grand (1997) utilises three terms to categorise citizens: knights (*i.e.* altruists), pawns (*i.e.* inactive recipients of state charity), and knaves (*i.e.* egocentrics). In relation to preceding post-World War Two UK welfare strategies, alterations have now occurred, 'from policies designed to be financed, and staffed by knights and used by pawns, to ones financed, staffed and used by knaves' (Le Grand 1997:160); individuals are considered to be more likely self-interested than public-spirited. However, 'our society regards altruistic or public-spirited behaviour as morally superior to self-interested behaviour' (Le Grand 1997:162). In relation to this study, the HCC's team character and underlying approach to healthcare — as narrated by its employees — exemplifies an aura of altruism that is directed towards individual and distinct worthy social actors in need of, and deserving, healthcare. Moreover, these persons in need of healthcare are conceptualised as patients — their criminal justice system labels and offending behaviours receive very little, if any, attention from these HCC-based workers.

How patients are conceptualised by the staff members in the NHS HCC is of relevance here as, if we utilise the work of Taylor-Gooby *et al.* (2000) (that stems from the aforementioned Le Grand work), a link can be made between the HCC's overarching goal and the notion of patient need. Taylor-Gooby *et al.* (2010) argue professional cultures (in this instance it is the professional values of dentists that are explored) 'influence how practitioners understand their own interests and those of their clients' (p. 375). There is a relationship between the professional culture of a healthcare setting and clinicians' understandings of patients' requirements. Arguably, therefore, the overarching goal of this HCC is related to the healthcare setting's conceptualisation of its patients. Thus, that the security and custodial aspects of a patient's existence in the setting do not feature is important, as these prisoners are, instead, defined as patients with numerous and valid health needs who should be identified and offered healthcare: *to prevent anyone falling through the net.* To summarise, it appears there is a relationship between a shared overarching goal for a setting, its conceptualisation of involved social actors (*e.g.* patients, or consumers, or criminals), and then a setting's outputs — in terms of service provision (whether this be healthcare, or consumable items, or punitive action). Positively, this relationship in the host prison's HCC seems to be generating a workplace milieu beneficial for patients/prisoners and their healthcare.

To finish this sub-section, a reflection regarding pride, community ethos, and the notion *the will's there and the skill's there* is fitting.

The HCC is understood by study participants to be a physical site of appropriate healthcare expertise and apt healthcare delivery desire. *The will's there and the skill's there* appears to represent a shared attitude at this prison's HCC. This approach permeates both the social nature of the working environment and the approach to healthcare delivery adopted in this specific clinical setting.

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

Interviewer: *Sounds like you take quite a lot of pride in your work?*
Participant: *I do, yeah.*

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

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

Enacting NHS change in the prison setting

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

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

The interview quote below represents a team level development example:

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

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

Participant: *I've been doing it for probably two years now, me being in charge of it, and I've developed it my own way to make it easier to follow, so that nobody falls through the net.*
Interviewer: *So that's really interesting that you've, in a way, been able to develop your own regime, your own ways of doing the jobs that you need to do. So do you feel that you have enough personal freedom, as it were?*
Participant: *Oh, yes.*
Interviewer: *So if you felt there was a better way of doing something you'd be allowed to do it?*
Participant: *I'd be allowed to do it … X knows she/he can trust me.*
Interviewer: *So you're given a task and then you can work out your own ways to complete it?*
Participant: *Yes.*
Interviewer: *So you don't feel like you experience any overt prison guidelines or constraints upon how you choose to operate?*
Participant: *No.*

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

Autonomy in relation to professional roles is professed:

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

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

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

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

In terms of the theoretical level of this understanding that is shared by staff in the HCC, this approach to the working environment does not occur at individual social actor level; instead, this working practice conceptualises HCC staff as professional and social groupings with clinical group titles (*e.g.* In-reach team, RMNs) with associated roles, responsibilities, and knowledge. De Dreu and West (2001) argue individual creativity and innovative ideas, alongside participation in team decisions, are positive aspects of organisations. Encouragingly, novel working methods and experiences of team inclusion are depicted via this study's participants.

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

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

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

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

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

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

Participant: *You do, to a certain extent, as you're very governed by prison rules. I mean, for instance, when I have visitors come in, or locum GPs, erm, you have to really follow the strict guidelines, and the problem we're having at the minute, although I know it's nothing to do with mental healthcare, we're having trouble with hospital appointments and escorts ... we have to liaise with the prison to check there're enough staff, and they cancel, like they have today, erm, and then, it's just, we also have emergencies going out in-between. So, yes, I would say you can alter procedures in the NHS, but not if it involves the prison, as that's very restricted, many boundaries.*

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

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

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

'Did Not Attend' as an issue for NHS services

Participant: *Sometimes they come to the hatch on the wing and say they had a doctor's appointment yesterday but no one came to unlock them, so it's not necessarily their fault, but, you do often see on the system where it says 'refused' [i.e. a patient choice DNA].*

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

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

know, it has been a problem, but it's been worked on, and there is a real improvement.

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

Irritation is displayed where prisoners choose to not attend their HCC appointments:

Interviewer: *You mentioned DNAs. Why do you think these occur?*
Participant: *There are legitimate DNAs where they're at court or similar, but the ones that don't come for whatever reason, I don't know why, it really is annoying, and an absolute waste, and I hate it. There's enough people waiting, on the mental health side, for help and support and input, and then you've got some lackadaisical patient who's like, I'm off to the gym instead. It's infuriating.*

Gym sessions appear linked with patient choice DNAs:

Participant: *I think that if we're offering the service it's up to them whether they choose to take it up or not, but we're doing our best.*
Interviewer: *What are the general reasons for booking clinic time and then not arriving?*
Participant: *They might just go to the gym instead.*

The gym represents a highly desired and valued prison activity and locale, for the prisoners interviewed in the overall study.

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

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

Interviewer: *DNAs, why do these occur, do you think?*
Participant: *I think they prefer the gym and going for exercise, plus visits, and things like that. We do re-book for visits and court, and the like. We don't re-book for gym.*
Interviewer: *Do you think anything can be done about DNAs?*
Participant: *I suppose we could be more flexible. I don't know how we could be more flexible. We could offer, I don't know, ask them what their preferred time would be, but I don't know, what if they all want the same time, to avoid missing exercise. Unless we altered our clinic times, but that wouldn't work with the prison regime.*

This RGN suggests increased flexibility may be an option to reduce DNAs. This displays a desire to decrease DNAs via a route that benefits prisoners first-and-foremost. This general approach to the delivery of healthcare is exemplified via the transcripts from the HCC staff as a professional grouping. The prisoners' health needs — and their more general needs, desires, and problems in the penal milieu — are important and influential for the HCC staff in this study. The excerpt also stresses, once again, the importance of gym usage for prisoners. However, the professed potential change to clinic times is then problematised, as it is believed that the HMPS regime may not allow for this proposed alteration.

Old Guard versus New Guard

At the beginning of this sub-section it should be noted that these two terms, Old Guard and New Guard, are not the interviewer's creation. Instead, these two age-related concepts — that pertain to HMPS staff — are introduced by study participants. (To add credence to this definition dichotomy, HMPS staff ***themselves*** discuss a distinction between traditionalist guards and newer recruits. It is not just NHS staff and prisoners who use these terms).

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

Some officers are understood to be more empathic regarding mental illness and distress than others and the dividing line is often argued to be officer type – Old Guard or New Guard.

2009 work published in 2011 by the Offender Health Research Network highlights that In-reach staff working with HMPS staff in terms of suicide/self-harm prevention and management (*i.e.* Assessment, Care in Custody and Teamwork) is variable, plus involvement and responsibilities are confused.

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

Participant: *It is the case [there is an age disparity]. They remember the old times, you know, way before methadone [often used in prisons as a heroin substitute/detox. medication]. They are not interested in healthcare whatsoever. They don't think they [the prisoners] should be entitled to it.*
Interviewer: *Is that problematic in your opinion?*
Participant: *Well, it's not right, as anyone could make a mistake and end up in prison, and they will need healthcare. But they've been here years, and that's what they've*

been told, and always done. That's how they had to be, before [the introduction of NHS healthcare to the prison system]. They were trained like that, and now we're telling them they need to change.

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

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

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

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

Here, seniority in the prison and hierarchical working roles are outlined as distinguishing features between prison service staff and their approach to prison mental health, and not age, as discussed previously.

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

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

But why are these interactions between staff and prisoners so important? Help-seeking for mental illness is one good example. Mitchell and Latchford (2010) utilise a personal construct psychology approach and question adult male prisoners regarding mental health problems and help-seeking routes; their work highlights 'the importance of both formal and informal sources of help for mental health problems in prison' (p. 773). RMNs and In-reach clinicians provide the formal mental healthcare; however, prison wing staff could embody excellent informal sources of care for mental health service users in the prison context. However, decisions regarding prisoners' selected help sources are dependent on anticipated

response, existence/absence of trust, and perceived skill level (Mitchell and Latchford, 2011) – hence the salience of the Old Guard and New Guard labels / understandings.

Winkelman (2009) addresses cultural competence in healthcare setting and lists thirty components of 'interpersonal difference in social interaction rules' (p. 97) (*e.g.* paralinguistic cues, kinesics (touch), negotiation approaches, metalinguistic messages, proxemics (space), conflict management). It is evident that sensitivity and responsiveness — in relation to interactions between patients and their carers (whether this be a NHS In-reach team member or a member of HMPS wing staff) — are beneficial in terms of therapeutic outcomes for patients. Moreover, Lester and Glasby (2010) note 'mental health is more than simply an absence of symptoms of mental illness or distress. Mental health refers to a positive sense of well-being' (p. 2). Here is where prison officers can further assist patients/prisoners. The nature of their relations and interactions with prisoners are influential and impact the imprisonment experiences of prisoners.

Conclusions:

Overall, interviewees depict their working lives as an effective team pursuit that is conducted in a passionate manner. A shared notion of optimum health service provision exists. In relation to service delivery, capability at work is professed by healthcare clinicians.

The working environment is narrated as both effective and affable. The delivery of healthcare is conceptualised as a team effort necessitating diverse professional contributions and effectual team communication. Informal yet frequent and amicable incidences of co-operation and communication amongst staff subsist.

Efficient and concise work is required swiftly in this clinical milieu. Teamwork is conceptualised as each clinician possessing a body of knowledge that they implement in the workplace; however, this is not considered to be a knowledge base with distinct impermeable boundaries, as sharing is discussed positively.

The NHS HCC in the prison is orientated towards excellent and altruistic patient care; patients' welfare occupies the primary purpose of the setting and this aura permeates the everyday working lives of its staff. The absence of punitive, security, or offender-based comments in interviews is noteworthy.

A three-way relationship appears to exist between ownership, autonomy, and trust. HCC staff are given ownership of their roles, provided with a suitable degree of developmental autonomy, and are trusted to implement these changes.

Where issues that influence mental healthcare delivery are raised, these are habitually framed as structural (not social) problems; developments in the NHS HCC appear dependent on the HMPS situation (*e.g.* resources) plus the co-operation (and mental health knowledge and understanding) of the prison establishment and its staff.

Implications for understanding mental health services:

- Unmet mental health need continues to exist in prisons and this warrants mental healthcare (although some prisoners' severe and/or enduring mental illnesses render the penal setting inappropriate).

- Prison mental health services represent excellent healthcare opportunities for those prisoners who have lacked access to services in the community.
- Prison mental healthcare requires a staff body capable of concise, effective, and swift work.
- It is important that mental health staff consider themselves appropriately skilled for their post.
- Amicable communication and cooperation amongst differing types and groups of clinical and non-clinical NHS staff is beneficial for effective teamwork and care delivery.
- Healthcare communication can occur affably when differing clinicians are respected as possessing dissimilar bodies of knowledge but where this is not boundaried (*i.e.* staff can ask other colleagues informally for advice but also have an influence on others' understandings).
- An overarching intersubjective workplace goal benefits staff (and patients, providing this primary task is positive in ethos).
- Effective team and individual changes within NHS settings can occur where permission, trust, ownership, and autonomy are granted and accepted.
- Service safety nets are required at several points in the prison mental healthcare system to prevent mental health needs being missed or dropped.
- Structural and resource barriers can impede developments to health services, even those that have cultural and managerial support.
- Where few activities are provided for patients in secure settings, it is worthwhile attempting to marry regime and healthcare timetables in order to reduce incidences of clinical 'Did Not Attend' recording.

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