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Title

Mental health/illness and prisons as place: Frontline clinicians' perspectives of mental health work in a penal setting

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Title

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Abstract

This article takes mental health and prisons as its two overarching foci. Debates explore links between social and structural aspects of the penal setting, the provision of mental healthcare in the given milieu, and the notion of mental health work in the environment. These analyses utilise qualitative interview data derived from prison-based fieldwork undertaken in Her Majesty's Prison Service, England. Two main themes are discussed: 1.) The desire and practicalities of doing mental health work and 2.) Prison staff as mental health work allies. Concepts covered include: equivalence; training; ownership; informal communication; mental health knowledge; service gatekeepers; case identification; unmet need. Regarding implications for practice: 1.) The mental health knowledge and understanding of prison wing staff might be appraised and developed in order to improve mental health/illness in prisons and address unmet mental health need. The roles of observers and gatekeepers might be considered. 2.) The realities of frontline mental health work for clinicians in the penal environment could be embraced and utilised to produce and implement improved mental health policy and practice guidance, which is in better accord with the actuality of the context – both socially and structurally.

Keywords

Mental health; prison as place; social setting; professional boundaries; working environment; health work.

Introduction

Within Her Majesty's Prison Service (HMPS), prisoners are entitled to healthcare (including mental health services). This is provided by either the National Health Service (NHS) or private providers. However, 'prison settings are a challenging environment in which to manage and deliver healthcare' (Powell et al., 2010, p. 1263). Thus, research that explores the notions of health and place in this clinical setting and appraise contemporary problems in this field of healthcare provision are worthy. '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).

The mental illness profile of HMPS's prisoners as a group remains 'under-recognised, not high enough on the public health agenda and a constant daily nightmare for prison systems' (Fraser et al. 2009:410). It has been demonstrated before that context is crucial in relation to the conduct of mental healthcare in a prison setting (Jordan, 2010). Gojkovic's (2010) national study of English prisons' mental health services' organisation and provision reports tension for mental healthcare staff in relation to 'delivering care in a punitive environment' (p. 284). Indeed, 'the provision of mental healthcare and the pursuit of good mental health in the prison milieu are challenging' (Jordan, 2011, p. 1061). It is therefore appropriate to devote further attention to social and institutional structures that permeate the prison setting and affect mental health services (Jordan, 2010).

For mental health patients in a prison setting 'mental healthcare *receipt* experiences and environments are important' (Jordan, 2012, p. 722). As debated in this article, the same is the case for mental healthcare *provision* and those frontline providers/staff who undertake mental health work in penal settings. For the prison healthcare clinicians involved in this study, the nature of health and place is salient for both political and personal reasons. 'The delivery of mental healthcare within the prison system is a complex process' (Brooker and Birmingham, 2009, p. 1); reasons for this place-orientated complexity are explored in this article.

The Present Study

The analysis presented in this paper is drawn from a larger piece of work which evaluated the mental health commissioning and providing arrangements within several HMPS establishments, as well as the met and unmet mental health needs of prisoners. Part of the wider project involved using qualitative research methods to explore the experiences of frontline healthcare staff. Semi-structured interviews were conducted across three prisons. This paper uses some of that fieldwork data in order to develop the literature and debate surrounding mental healthcare provision in the prison setting. Interview participants were recruited from three HMPS sites. The study team was based at the Centre for Health and Justice at the Institute of Mental Health and included a registered mental health nurse, a medical sociologist, and a specialist in secure services provision.

The contributions of this article are fourfold. First, we address a neglected area in the literature relating to the experiences of staff providing mental healthcare within penal settings. To this end, we explore the under-discussed topics of personal desires and political practicalities when providing mental healthcare in prison establishments. Second, we highlight the barriers and facilitators to mental health work in this specific context. Third, we identify the important role played by social relationships and informal networks (rather than, for example, formal healthcare procedures) embraced and practiced within the setting to manage prisoners' mental health needs. Fourthly, the roles and responsibilities of prison wing staff are evaluated in relation to the notion of mental health work.

Method

Fieldwork and Participants

Participants were recruited from both primary and secondary healthcare services and included both mental health specialist staff, for example Registered Mental Health Nurses (RMNs), Clinical Psychologists and Psychiatrists, as well as non-specialist staff such as Registered General Nurses (RGNs) and General Practitioners (GPs). Within the prison setting (as in the wider community) a distinction is made between primary care, comprising physical healthcare input and some primary level mental health input from RMNs. As examples, this may involve a triage service for prisoners who have not previously had mental health problems, prison reception health screening, or the provision of time-limited brief interventions for prisoners with problems such as anxiety and depression. In addition to primary mental healthcare, secondary-level in-reach services provide specialist care to prisoners with severe and enduring mental health problems (examples of these include schizophrenia and bipolar disorder). Twenty-three of the participants recruited to the larger study are relevant for the analysis presented here. Table 1 summarises their professional backgrounds. Within the prison contexts for

this study, primary care services were provided by a private sector healthcare provider, while the in-reach services were NHS.

TABLE 1

The overall study was commissioned by a NHS Primary Care Trust and recruitment occurred via healthcare service leads and managers who informed their staff about the study and its aims. Participant Information Sheets and Consent Forms were used to ensure all participants were fully aware of what the study involved. Participants were reminded that they could withdraw from the study at any time or ask for the audio recording equipment to be switched off. A semi-structured interview schedule was developed – with themes identified from the literature and relevant policy documents. Table 2 summarises the key topics included. Prompts were also used to encourage more detailed responses, where necessary. Interviews were completed in April 2013 and lasted between 30 and 90 minutes. All interviews were audio recorded.

TABLE 2

Data Analysis

The audio files were transcribed verbatim and thematic analysis was conducted on the data. This involved a detailed reading and preliminary coding of the transcripts. These initial codes were then extrapolated and combined to produce overarching themes. The themes explaining the data were based on the aims of the study. This analysis process is similar to the work of Grbich (2007), who considers thematic analysis to consist of two complementary data reduction techniques: block and file, and conceptual mapping (pp. 32–35). Data analysis was completed in the first instance separately by the first two authors; they then compared their coding and good agreement was found between the identified concepts and themes.

Results & Discussion

As stated previously the analysis presented here draws on work from a larger study and has four aims: (1) to explore the experiences of staff in prison settings of providing mental healthcare, (2) to discuss the barriers and facilitators to mental health work in the prison context, (3) to look at the role of social relationships and informal networks, and (4) to consider the role of wider prison staff. Two overarching themes were identified from the data which explored this enactment of mental health work in prison settings: “the desire and practicalities of doing mental health work” and “prison staff as mental health work allies”. In this section of the paper both of these themes are discussed and contextualised by relating them to the existing evidence base and using direct quotation from the interviewees where relevant.

The desire and practicalities of doing mental health work

Mental healthcare provision within the prison setting is a complex system comprising multiple actors. This in itself is not unique, as mental healthcare within the wider community can also involve many agencies and professional groups. However, the prison setting as a context has its own specific security requirements and custody personnel. For example, the roles and requirements of prison officers and prison security measures in mental healthcare is unique to the penal setting. Despite the specific

requirements prisons present, there is a need to ensure that the care provided is equivalent to what is available in the wider community. This principle of equivalence was introduced in "*Changing the Outlook: A Strategy for Modernising Mental Health Services in Prisons*" (DH and HMPS, 2001). However, Niveau (2007) states 'from a clinical point of view, the principle of equivalence is often insufficient to take account of the adaptations necessary for the organisation of care in a correctional setting' (p. 610). It is also worth noting at this juncture that it is widely considered that equivalence has not been fully achieved and continues to pose an 'enormous challenge' (SCMH 2007:2) for prisons. Providing for mental health needs in the penal milieu is a convoluted endeavour.

Data from this study suggest that although equivalence in quality of service should be aspired to, the form mental health provision actually takes must reflect the unique context of prison:

"In terms of absolute equivalence, it can't be, it's a prison, it's different, and therefore it's about: What are the important things about what we're delivering? ... What is it about the services that we're providing, and the quality of the services, that we need to have a similar, or as far as possible the same level of quality and the same level of availability, as you would get in the community" (P006).

As well as the custodial nature of the prison environment, participants identified other challenges to undertaking mental health work. First, mental healthcare in prisons can be conducted by those who are not primary experts in the field (e.g. reception screening by RGNs). Second, fragmentation in commissioning and provision can lead to a lack of clarity and/or competition regarding roles and responsibilities for staff (e.g. the gap between primary and secondary mental healthcare). Thirdly, communication in relation to mental health work is often dependent on informal social networks – rather than, or in addition to, the official written records. These three topics are now explored in-depth.

The interview narratives from healthcare staff highlight that much 'low level' mental health work is conducted by individuals who are not trained nor have expertise in this area. For example, RGNs expressed concerns about assessing mental health and psychiatric history during the prison reception interview and the dispensing of psychiatric medications on prison wings. One participant described how she felt that she let prisoners down due to her lack of detailed mental health knowledge, particularly outside of in-reach office hours when there was little alternative support available:

"I know that I can make people safe, and I know I'm a good communicator, and I will get them help, but I do feel like I let them down a bit, particularly at weekends" (P002).

Prisoners are held within the prison setting twenty-four hours a day seven days a week, yet mental illness, like general illness, does not confine itself to office hours. However, the specialist in-reach mental health services were only available between the hours of approximately 9am and 5pm Monday to Friday. This led to anxiety regarding out-of-hours psychiatric crises. Thus, there was the perception that other professionals and services were 'picking up after mental health'; this narrative was particularly specific to primary care staff:

"I feel like I've moaned massively but that's because there is a bit of an issue in here regarding how much we do for everybody else I guess" (P001).

In-reach staff also highlighted problems with their prescribed working hours and the timings and regime of the prison (e.g. the administration of psychiatric night-time sedation as it had to be given early, often at six o'clock in the evening, which was not ideal for the individual prisoners/patients).

To summarise, primary care staff stated that it was not a lack of desire to do mental health work which was difficult for them, but a concern about operating outside their sphere of practice with little supervision. Many primary care staff stated that they would be willing to complete training to become dual registered nurses in both adult general and mental healthcare:

"Yeah we are not mentally health trained, I would like to be dual trained, I think it would be really beneficial, but they are not going to train me to do that. So we just kind of have to keep asking questions – Is this the right thing to do? Am I approaching this the right way?" (P001).

Further, interviewees narrated structural and political divisions and gaps between the various health and prison services in relation to mental healthcare:

"The inter-play between provider organisations is not always seamless" (P010).

Disagreements between services about who should see a particular prisoner/patient and at what point in the process were felt to hinder early intervention and swift action for the patient's benefit. The referral route to secondary-level mental healthcare is an example here. In-reach staff described being approached directly by prison staff and prisoners for help and having to explain the referral pathway and the need to be seen by primary care first:

"Sometimes there maybe needs to be some clearer, erm, what's the word I'm looking for, direction for the [prison] staff about who they're referring to ... I get an awful lot of requests ... to in-reach directly from prisoners, ... The minute I walk down a wing I get, 'I need to be seen by you', I say, 'Well it actually needs to go through, you know, primary first', with which the prisoner is fine but the [wing] staff seem to be a bit unclear generally ... I suppose nobody's really sat them down and explained what the difference is [between primary and secondary] ... When they think of mental health they directly, especially if something's going wrong, they directly seem to think of the in-reach team rather than primary, and I think they struggle to differentiate between the two" (P008).

It was also felt that the expectations of prison staff were unrealistic in relation to what mental health services could provide. In-reach staff described an assumption that they would be involved with all prisoners who self-harmed whether or not they had a mental health problem. Although policy drivers such as the Care Programme Approach (CPA) were seen to provide a possible structure for interagency collaboration and joint working, its implementation in practice did not fully support or generate this ideal multi-stakeholder model. For example, there were contradictory understandings of who should or should not be on CPA. In addition, the completion of documentation was occasionally prioritised over and above the actual practical use of CPA as a means of bringing people together in the spirit of collaborative working.

Ironically, fragmentation and a lack of ownership over mental health work in the prison setting also led to a duplication of provision. One in-reach CPN stated that she had been

unaware that as well as seeing her, an individual on her caseload was also seeing a counsellor from the prison counselling service:

"To find out that he'd been referred to counselling, and he'd been seeing the counselling woman for three or four weeks ... and it was only by accident that I found out, because I went over to see him and she was in with him" (P007).

Similarly, in those establishments where there was an expectation to engage in therapeutic group work with psychologists, the boundaries with NHS psychiatry services and mental health work at the healthcare centre were not always clear.

Despite the difficulties with determining ownership of mental health work in the prison settings there were examples of good collaborative practice and joint working. This was often described as being *in spite* of the structures in place rather than being *facilitated* by them. Collaborative working was instead dependent on informal, verbal, and social contact between individual colleagues who opted to communicate well together.

Difficult working relationships were identified throughout the prison setting; for example at a service management level between primary care and in-reach services, and between frontline clinicians who work in the same service. In relation to these problematic workplace relationships and the notion of informal communication networks in the setting, the aforementioned poor relations were perceived to hinder knowledge sharing and amicable collaborative working.

Although the informal routes of communication worked well for individuals, this could result in a lack of structured and written documentation in relation to intended pathways and processes. The issue of risk management was frequently cited as an area where this was particularly complex. Healthcare staff wanted information relating to the risk an individual may present to them, for example hostage taking behaviour. Interestingly, gaining access to the formal databases which held this information was not perceived to be the solution. Instead verbal communication was preferred amongst colleagues who worked well together.

In relation to the recording of information on databases, interviewees described a process where only the minimum required was documented. Two main reasons were proposed for this. The first centred around concerns that the computer system would fail (and had done so in the past) and so hard copies were required as a 'back up' and second that it was not in the prisoners' best interests to have all information related to mental health widely recorded:

"So there are issues about data, I think; there are big problems with, with the fact that I'm not always convinced that confidentiality is properly maintained. I think that we sort of lost sight of patient confidentiality" (P009).

There was also some evidence of a hierarchal inter- and intra-professional desire to not share data and retain ownership of it whilst at the same time expecting other professional disciplines in the prison to communicate with them. In essence, some healthcare staff expected to be given access to others' data but not at the expense of sharing their own information.

Prison staff as mental health work allies

This section explores prison staff and how this professional group might assist with prison-based mental health work. Prison staff as mental health work allies is proposed.

Clinicians' interview narratives are analysed in relation to 1.) problems with the identification of those prisoners with mental illness and unmet mental health need, plus 2.) clinicians' working relationships with prison staff. As a result, suggestions are offered for how these two facets of mental health work in the prison might be developed in tandem. The figure below acts as an introduction to these debates. (*N.B.* MH = mental health).

PICTURE

The interview narratives from prison healthcare staff suggest that case identification for mental illness requires development. The argument is made that unmet mental health need can exist in the prison because insufficient opportunities for identification are built into healthcare work at the establishment. The overreliance on reception screening is raised as a concern. Reception screening alone is considered not sufficient in terms of case identification for mental health need and other options and points within the prison system should be considered in addition. It's worth mentioning here that the reception screening tool used was designed only as an immediate risk assessment tool and not for profiling mental health. Thus, other options and points for identifying those with mental health need – within the penal setting – are sought. Here is where prison wing staff might have an increased role – by becoming intentional observers and more frequent usage gatekeepers to the referral process.

This issue is linked with concerns regarding a relative absence of proactive mental health work in the prison milieu; the services are considered to be mainly reactive in nature and lacking a preventative care pathway. To summarise, there is a desire to increasingly search for, then pick-up and address, unmet mental health need in the prison.

"Interviewer: What about any potential missing diagnoses or unmet need? Do you feel that all mental health issues are being detected? For example, what about personality disorder, learning disability, or intellectual disability?"

Participant: There's quite a lot, to be honest" (P011).

Thus, prison staff on the wing might be usefully recruited to play a more active role in case identification and referral. This makes common-sense due to the amount of time this professional group spends with the prisoner population in comparison to the primary and secondary healthcare staff – who are often located on a separate healthcare centre wing/area.

'As detailed in the Bradley Review, staff working in the criminal justice system ... require at least a 'basic' level of mental health awareness in order to both identify and effectively work with the high proportion of offenders with mental health disorders' (Sirdifield et al. 2010:39). However, concern was raised by interviewees about the adequacy of prison staff mental health knowledge in order to support the identification and referral of prisoners who are quiet on the prison wings and do not display problematic behaviour or overt signs of mental illness, yet have covert mental health problems.

"Education for officers regarding mental health issues is inconsistently provided" (P010).

Gojkovic (2010) explores the delivery of mental healthcare in prisons and debates the care–custody balance experienced by wing staff. 'Tension of care and security is perhaps best evident in the case of prison officers who are in daily direct contact with offenders' (Gojkovic 2010:285) and who 'may not always recognize the symptoms of a mental health problem' (Gojkovic 2010:285). Thus, the possibility of prisoners suffering mental ill health in (albeit well-behaved) silence on the wings is raised as a potential concern by healthcare staff. Thus, an additional strand of prison-based proactive mental health work could be implemented to address this problem. Arguably, prison staff could play a pivotal role in this new mental health work – as observers and gatekeepers to the mental health services.

According to the clinicians interviewed, relations between frontline prison staff and healthcare staff are often good. This workplace rapport is based on the understanding that prison staff spend far more time with prisoners than healthcare staff, and are accordingly placed well to assist with the clinicians' mental health work – even though this form of work usually occurs via informal communication channels only at present.

There exists a requirement to further acknowledge and make use of the fact that prison staff spend significant time with prisoners; for example, developed mental health knowledge of this occupational group could be supported to consequently improve mental health case identification and in turn reduce unmet mental health need in prison.

A development in mental illness understanding of this professional group would also begin to address stigma in the penal setting attached the mental illness and accessing mental healthcare:

"Interviewer: In terms of prison staff then, so not clinical staff, just other staff, how would you describe their mental health knowledge, plus any ramifications of this?"

Participant: Nine out, well no, say seven out of ten [it] is quite poor.

Interviewer: Does that matter?"

Participant: Yeah I think it does. You know, at the end of the day each person should be treated individually, whether they've got mental illness or not. They should be treated on their individual merits, unfortunately you've got some officers who'll treat everyone the same ... Their whole attitude changes when you're there: 'Oh, this is a mental health nurse, she's come to see you, she's come to cart you off'. They have a laugh and a joke, and sometimes the prisoners will laugh with it, but you've got those odd prisoners that are thinking: 'Well I can't see her because I'm going to be classed as a nutter' " (P012).

If prison staff are to be provided improved mental health awareness training, what should this staff development course comprise? Similar to psychiatric nursing training? How are prison staff to be prompted to engage in training?

Forrest and Masters (2005) debate the difference between the user/carer informed approach and the traditional approach to mental health nursing education. The user/carer informed approach emphasises teaching mental health qualities and attitudes – not traditional mental health theories or diagnostic labels. Moreover, this user/carer approach to knowledge and education intends to challenge and inspire change in mental

health practice and service provision via highlighting patients'/users' agendas. Therefore, prison-based mental health awareness training for wing staff should, arguably, be delivered in reference to prisoners' mental health agendas, needs, problems, and desires. Norman (2005) argues: 'The debate is between those nurses who are concerned primarily with understanding the *process* of nursing as a discrete activity based on the *relationship* between the nurse and individual *person* in *distress*, and those who are concerned primarily with *interventions* or *treatments* for *patients* with diagnosed mental *illness*' (p. 174, italics in original). In relation to prison staff, it is the first of these two forms of knowledge that is relevant for mental health awareness training. It is the nature of the relationship between landing staff and mentally distressed prisoners (both overtly and covertly) that is of importance — and not the clinical treatment of illness *per se*. Clinical names, phrases, and aetiology are cited as not important or relevant knowledge for prison staff; instead, it is an understanding of the behavioural aspects of mental illness that are warranted.

Lester and Glasby (2010) note 'the culture of an organisation is also important in implementing change' (p. 49) in the field of mental health policy and practice. Therefore, it is important to consider the cultural nature of prison officers' work in the prison setting. The possibility of cultural resistance to any mental health awareness training is to be considered. Maltman and Hamilton (2011) evaluate personality disorder awareness workshops for prison staff and conclude professional attitudes are crucial. 'Positive professional attitudes towards personality disordered clients have been linked with extensive clinical and strategic benefits. The largest influences on such attitudes are associated with staff training, supervision and support' (Maltman and Hamilton 2011:244). Maltman and Hamilton (2011) discuss practical implications: 'The findings indicate that personality disorder awareness training should initially engage with trainees' perceptions of their personal security and vulnerability when working with this client group, rather than aiming to increase liking, enjoyment and acceptance of such offenders' (p. 244). Therefore, perhaps mental health awareness training for prison landing staff should commence by addressing wing officers' concerns, queries, understandings, and beliefs in relation to mental illness and mental healthcare in prisons, before attention is devoted to the training's intended knowledge, outcomes, and implications (*i.e.* make the *trainees* the focus of the training via concentrating on any prison officers' anxieties, stigma, disquiet, or questions first and foremost).

Finally, Ramluggun *et al.* (2010) report 'the conflation of knowledge and experience of staff working in prison places them in a favourable position to contribute to the current reform of offender health' (p. 70). Certainly, the experiential knowledge of prison staff is remarkably valuable. This article supports the involvement of wing staff in the development of future mental health policy and practice in prisons; after all, this professional group spends far more time with the prisoner group than the healthcare staff.

Conclusion

The prison as a setting for mental healthcare presents a number of distinct challenges for those involved in the provision of services. This paper has focused on the experiences of both specialist mental health and primary care clinicians. It has also explored the notion that prison staff are important allies in mental health work and how their roles as observers and gatekeepers might be developed. The structural divisions and fragmentation of services were highlighted as particular barriers to collaborative care pathways. Conversely, what played a crucial role in mental healthcare provision were the informal networks and social relationships between differing personnel — and thus

services. However, this amicable joint-working was not standard practice and is personnel and personality dependent.

Implications

- 1.) The mental health knowledge and understanding of prison wing staff might be appraised and developed in order to improve mental health/illness in prisons and address unmet mental health need. The roles of observers and gatekeepers might be considered.
- 2.) The realities of frontline mental health work for clinicians in the penal environment could be embraced and utilised to produce and implement improved mental health policy and practice guidance, which is in better accord with the actuality of the context – both socially and structurally.

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