The Value of Positive Relationships for Those with Mental Health Distress in Society and Whilst Incarcerated.

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A Portfolio Submitted for the Doctorate in Counselling Psychology (DPsych)

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Acknowledgements

This thesis would not have been possible without the support and contribution of many people.

Firstly, I would like to sincerely thank the participating organisations and individuals, who generously gave their time. To the organisations, thank you for the time and effort you put into finding participants for me. To the participants, it was a privilege to be able to listen to your experiences, and I thank you for being willing to openly share your story with me. The experiences shared by you were incredibly meaningful, valuable and eye-opening. Your strength and motivation to overcome the hardships in your lives is admirable and inspiring. I dedicate this thesis to you.

I would also like to thank my supervisors as well as other teaching staff at City University, alongside classmates and placement colleagues, who positively supported me throughout my journey at City University. To my supervisors, George Berguno and Jacqui Farrants, I am incredibly grateful for the time you dedicated to supervising me. Your advice, feedback, support and overall guidance was second to none.

Finally, to my family (special shout-out to my parents), partner and friends, I thank you from the bottom of my heart. Thank you for your endless support, love, patience, understanding and encouragement throughout my journey to becoming a Counselling Psychologist. You mean the world to me and I couldn't have done this without you. I am eternally grateful for everything you all have done for me.

Declaration of Power

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Preface

This portfolio is made up of three written pieces of work, which embody key aspects of my doctoral training in counselling psychology. The first piece presents my grounded theory research, which explores what happens when incarcerated individuals experience mental health distress. The second piece is a publishable paper, which explores one of the key findings of my research. More specifically, it explores the value of positive relationships for incarcerated individuals and the impact of such relationships on the ability to access consistent and appropriate treatment whilst incarcerated and upon release. The final piece is a case study, which explores how the person-centred therapists 'way of being' encourages the development of a strong therapeutic alliance and has the ability to improve therapy outcomes. I feel that this case study appropriately and effectively conveys how I work with clients in practice.

The three pieces of work fit together as a united body of work, linked through a common theme of the importance of having and being able to develop positive relationships for those who experience mental health distress. A key focus of this theme is the importance of these positive relationships with professionals, such as therapists, other mental health professionals and support staff and the ways in which such relationships can be developed. There is also a focus on how such relationships impact an individual with mental health distress in terms of their ability to access therapeutic support as well as mental health outcomes. An additional focus consisted of reflecting on how the importance of such a relationship transfers to psychological research and impact of the researcher-participant relationship on research outcomes.

Whilst I initially did not intend for this to be the overarching theme of the portfolio, reflecting on the findings of the research and the focus of the client case study brought the importance of this concept to the forefront. This is why I ultimately chose to write the publishable paper on this topic in relation to incarcerated individuals, instead of briefly summarising the research.

My passion and interest for this topic are multifaceted and have developed through the doctoral training and work experiences. I believe that the first time I became aware of the importance of relationships between professionals and service users was when I worked within a specialised school in London. In this setting, I worked as a teaching assistant and as part of the behavioural support team, with male students with moderate to extreme social, emotional, behavioural and/or mental health difficulties. In this position I therapeutically and academically supported at-risk male youths generally coming from backgrounds of severe neglect, emotional, social, psychological, sexual and/or physical abuse. Many of the students were described as being on the 'wrong path' and as being likely to end up in the criminal justice system, due to environmental and familial factors at play. Through this role, I became aware of the fundamental role positive relationships played for those who are vulnerable, at-risk and who have experienced significant challenges in their lives. It was evident, from day one, that the outcomes for these children largely depended on staff taking their time to develop positive and trusting bonds with them. However, it was only when I began the doctorate in counselling psychology that I began to thoroughly reflect on the value of such relationships when working with vulnerable and at-risk populations. Ultimately, this work experience also ignited my passion to study further in order to be

able to work as a counselling psychologist with those deemed vulnerable as well as those who with criminal backgrounds.

The doctoral training, including the academic components and the placements I took part in, allowed me to further recognise my deep personal and professional interest in this topic area. The value that a strong therapeutic alliance holds in the lives of those with mental health distress and in therapy outcomes was consistently demonstrated and emphasised. I came to understand that the ability to offer a space in which positive relationships can develop is a fundamental aspect of working as a counselling psychologist. As stated by Knox and Cooper, the therapeutic relationship provides '"the context for the therapeutic work" and as such, it represents the basis for any therapeutic treatment taking place (Knox & Cooper, 2015, pg. 1).

My academic and professional experiences brought on a keen interest to comprehensively reflect and research the importance of the ways in which one can effectively develop positive relationships and how these relationships impact individuals with mental health distress, with a particular interest relating to working with populations who are argued to be marginalised and overlooked. Whilst I developed as a professional, through the doctoral training, to be able to work from a range of approaches, I personally was most drawn to the person-centred approach (Rogers, 1980), which acts as a basis in my therapeutic work. As such, you will notice throughout the portfolio that I specifically reflect on the ways in which this particular approach impacts the ability to develop positive relationships and outcomes, both in my practice as well as in the research study that I carried out.

Section A, which refers to the research study carried out, uses an abbreviated version of constructivist grounded theory to explore the experiences of incarcerated individuals with mental health distress and how these individuals go about seeking support (Charmaz, 2006; Charmaz, 2014). There were several aims associated to this research, which consisted of the following: offering a voice to a marginalised and overlooked group, developing a deeper understanding of their mental health experiences as well as reviewing the quality of existing mental health support services in this context. In relation to this, I was also interested in reflecting on the role counselling psychologists can play in improving the mental health experiences of those who are imprisoned. I chose to take a constructivist epistemological and critical realist ontological approach to the data analysis process, with the aim of developing a tentative theoretical model which answered the research question and addressed the objectives of the research study.

The second piece in this portfolio, Section B, is a publishable paper, to submit to The Howard Journal of Criminal Justice. The publishable paper focuses on one of the findings of the qualitative research piece carried out, which can be said to be an original contribution. This piece explores the importance of incarcerated individuals having and being able to develop positive relationships both inside and outside the prison environment. Alongside this, it explores the impact that such relationships have in the lives of incarcerated individuals, both whilst incarcerated and upon release.

I chose to write the publishable paper for The Howard Journal of Criminal Justice, which is published by Wiley-Blackwell, for several reasons. The Howard Journal of Criminal Justice is a highly recognised international journal which specifically covers

many aspects related to crime and the criminal justice system. As the research discussed in the publishable paper explores relationships within prison contexts and solely focuses on the prison population, I felt it would be most suitable to use a journal which specifically focuses on this context. The journal is also committed to offering high-quality theory and research which allows for conversation and debate around current cultures, policies and practices within criminal justice institutions such as prisons. As such, the aims of the journal are compatible with one of the key aims of my research, which was to review existing policies and structures and to encourage conversations around the suitability of these in relation to prisoners who experience mental health distress. Alongside this, it has a strong focus on social justice, which is of huge importance to the psychology field. The journal is not only read and used by counselling psychologists, but also by many who work within the criminal justice system, meaning that it has a broad reach which I felt was an essential factor to consider when choosing a journal.

Section C, the final piece of work in this portfolio, is a clinical case study, which represents the work I carried out with a male client, whilst working as a Trainee Counselling Psychologist at an NHS-IAPT service. At the start of therapy, the client was overwhelmingly suffering from a range of negative thoughts related to his life and his direct surroundings on a day-to-day basis. He was unable to understand why he had these thoughts, as he felt that his childhood and current life with his wife was ‘full of support and understanding’. As such, he referred himself to therapy, to develop a better understanding of his distress. The case study provides a thorough account of our therapeutic work together. It also offers a thorough insight into how the person-

centred approach allowed for the development of a strong therapeutic alliance and supported the client in becoming more congruent with his true self.

As part of our role as counselling psychologist, we are inherently social justice advocates. We focus on individual wellbeing as well as the wellbeing of communities, and strive to reduce the suffering of individuals we come in contact with, both in practice and in research (DeBlaere et al., 2019; Toporek, Gerstein, Fouad, Roysircar & Israel, 2006). The counselling psychology doctorate, the process I went through to complete this portfolio and the findings of my research encouraged me to critically reflect on my role as counselling psychologist, its association to the concept of social justice in different contexts alongside the approach I want to take to tackling the injustices faced by different individuals and communities. As such, the aim of this portfolio is to shed light on several topics. These consist of the challenges faced by incarcerated individuals in accessing mental health support, the positive impacts that counselling psychologists can have within the field of mental health in different settings, as well as ways in which the person-centred approach can be effectively applied in therapeutic practice as well as research. I hope that the readers can find something in this portfolio which feels relevant to them and can support them in their practice, as it did for me.

References

DeBlaere, C., Singh, A. A., Wilcox, M. M., Cokley, K. O., Delgado-Romero, E. A., Scalise, D. A., & Shawahin, L. (2019). Social Justice in Counseling Psychology: Then, Now, and Looking Forward. *The Counseling Psychologist*, *47*(6), 938-962. doi: 10.1177/0011000019893283.

Charmaz, K. (2014). *Constructing Grounded Theory* (2nd ed., pp. 1-16, 225-240). London: Sage Publications Ltd.

Charmaz, K. (2006). *Constructing Grounded Theory: A Practical Guide Through Qualitative Analysis* (pp. 1-12, 177-183). London: SAGE Publications Ltd.

Knox, R., & Cooper, M. (2015). *The Therapeutic Relationship in Counselling and Psychotherapy* (pp. 1-98). London: SAGE Publications Ltd.

Rogers, C. R. (1980). *A Way of Being* (pp. 5-26, 113-126). New York: Houghton Mifflin Company.

Toporek, R., Gerstein, L., Fouad, N., Roysircar, G., & Israel, T. (2006). *Handbook for Social Justice in Counseling Psychology: Leadership, Vision, and Action* (1st ed., pp. 1-13, 251-253, 313-332). London: Sage Publications.

Section A – The Research

What happens when individuals experience mental health distress in prison? An exploration of the experiences of previously incarcerated male individuals.

An Abbreviated Constructivist Grounded Theory Study.

Abstract

Whilst there is strong evidence that mental health is negatively impacted by imprisonment, there is a lack of exploration of the individuals directly experiencing the phenomenon. There is also a lack of independent research on the topic, done from a psychological perspective. This research offers a unique and in-depth qualitative exploration of what occurs when individuals experience mental health distress when in prison.

Semi-structured interviews were carried out with five previously incarcerated male individuals, recruited from a drug and alcohol recovery service. An abbreviated version of the constructivist grounded theory method was then used to construct a tentative explanatory theory. A constructivist epistemology and critical realist ontology was taken to the data collection and analysis process.

The findings of this research were split into four categories, which consist of the environmental impact, inmate needs, access to services, as well as relationships inside and outside of prison. Through the analysis it became clear that the environment negatively affects the mental health of inmates, leading to need of consistent support from services. The ability to develop positive relationships both within the prison and outside of the prison environment was a fundamental factor which impacted the ability to receive consistent and appropriate support.

The relevance and findings of this research are then discussed in detail, in relation to relevant literature and empirical research. The findings highlight that the experiences of incarcerated individuals with mental health distress are negatively impacted by the overall structure and the make-up of mental health support services which currently exists in prisons. Based on the findings, practice recommendations are outlined which relate to both the prison environment as well as counselling psychology practice in these contexts. These practice recommendations can ensure that incarcerated individuals are more consistently and effectively supported through healthcare services in these contexts.

Chapter 1: Literature Review

1.1 Introduction

Whilst many improvements have been implemented throughout the years in regards to prison structures and mental health service accessibility in the UK, there are still many to be made (Georgiou & Townsend, 2019; RCPsych, 2018; RCPsych, 2019; Durcan, Saunders, Gadsby & Hazard, 2014; Brooker & Webster, 2017; Tyler, Miles, Karadag & Rogers, 2019; Patel, Harvey & Forrester, 2018). A significant challenge is that prison reform has always been a strongly debated topic within parliament and politics, healthcare and society as a whole, thus it has been difficult to agree on the most appropriate way to treat those who commit crimes (Roberts & Hough, 2002; McNeill, 2014: Johnstone, 2011). Whilst some believe in the rehabilitative strategy, others believe that punitive measures are more suitable (Roberts & Hough, 2002; McNeill. 2014: Johnstone, 2011). The difference in perspectives can powerfully be conveyed by comparing the American and Norwegian prison systems.

Whilst the American system is more punishment based (though rehabilitation programs do exist), the criminal justice system in Norway revolves around the principles of restorative justice, rehabilitation and re-integration into society (Sterbenz, 2014; Alper, Durose & Markman, 2018). Arguably, the Norwegian system offers more positive results as they have one of the lowest recidivism rates in the world at around twenty percent. In comparison, within the USA, the prison population has consistently increased over the years (Sterbenz, 2014; Alper, Durose & Markman, 2018). Interestingly, the British criminal justice system has strong similarities to the American

criminal justice system and the reoffending rate similarly has continued to increase throughout the years (Alper, Durose & Markman, 2018). For example, in both the UK and USA, nearly half of the those released from prison are likely to reoffend and be arrested within their first year (Prison Reform Trust, 2019; Alper, Durose & Markman, 2018). Alongside this, there appears to be a strong relationship between support offered within prison contexts to inmates and the recidivism rate. This begs the question, why hasn't the UK taken on more of a rehabilitative focus within its prisons?

There are many factors to consider when responding to this question, including cultural values, political stances, societal ideals and budgeting issues, to name a few. For instance, when looking at prison reform, one has to consider the debate on punishment versus rehabilitation, which has been ongoing for centuries (Gideon & Sung, 2011; Scott, 2013). Whilst some hold the belief that the punishment of being imprisoned functions as a deterrent to crime being committed, others believe that rehabilitation is the key to reducing reoffending rates (Gideon & Sung, 2011; Genders & Player, 2013). Although within recent years, the benefits of rehabilitation have been increasingly considered and policies have been established to support reform within prisons, funding challenges have hindered the ability to create significant change (Atkins et al., 2019). Still, the statistics reinforce the idea that more research should be carried out within UK prisons to reflect on how the UK prison healthcare system currently works and how it can be altered to better support prisoners and thus also reduce the recidivism rate.

1.2 Introduction to Chapter

This chapter aims to contextualise the present study through an exploration of available theoretical and empirical research, and offer a strong rationale for this new research to be carried out. The chapter begins by exploring mental health as a concept, and continues by considering mental health statistics amongst the UK population as well as available support services. Following this, the chapter reviews the UK prison system, demographics of prisoners, the prevalence of mental health issues and the state of support services in prison settings. Limitations of available research will also be considered in relation to these topics. Finally, the opportunity is taken to reflexively contemplate on my role as the researcher in relation to the chosen topic.

There is a debate regarding the appropriateness of conducting literature reviews prior to embarking on grounded theory research. Some argue that carrying out a critical literature review prior to carrying out the research can create researcher bias (Dunne, 2011; Giles, King & de Lacey, 2013). Whilst there are mixed views regarding the use, purpose and timing of literature reviews in relation to grounded theory methodology, I chose to carry out a literature review before completing the interviews to be able to contextualise the research and offer a rationale for the established research question. It also helped me in identifying my methodology, including the theoretical framework taken to this research, as well as the method. Further detail regarding my position on this matter can be found in the Methods Chapter.

1.3 Mental Health as a Concept

The concept of mental health can be understood in a variety of ways, depending on the philosophy of thought through which one approaches it. For instance, variations in cultures around the world impact the way mental health is perceived, understood and approached (Galdderisi, Heinz, Kastrup, Beezhold & Sartorius, 2015; World Health Organisation, 2004). The understanding of mental health has also drastically changed over time. Historically, mental health was approached with negative connotations and stigma, and those who experienced negative mental health symptoms were often institutionalised and shunned from societal groups (Manderscheid, Ryff, Freeman, McKnight-Eily, Dhingra & Strine, 2010; Dickinson, 1990). There was also been a strong emphasis on the sole use of diagnoses to treat mental health concerns.

Over time, our understanding of mental health has evolved and has become more holistic-focused, especially within the counselling psychology field (Manderscheid, Ryff, Freeman, McKnight-Eily, Dhingra & Strine, 2010). Whilst a diagnosis is still often the basis for identifying the appropriate treatment pathway, treatments now more commonly also take into account social, emotional and mental factors (Johnson, 2021, NICE, 2011). Mental health has also become less stigmatised as societal attitudes have changed over time, though there is still a long way to go, and more individuals are seeking professional help from professionals within the community (Caplan, 2013, NICE, 2011). As all of these changes have occurred over time, the definition of mental health has also transformed significantly throughout the years.

For this research, the definition by the Mental Health Foundation will be used to define mental health. This particular definition states that mental health refers to how people

perceive themselves and their life, and how this impacts how one copes with distress (Mental Health Foundation, 2008; Bhugra, Till & Sartorius, 2013). The description suggests that “mental, physical and social functioning” are interconnected, as it focuses on an individual’s thoughts, feelings and associated behaviours, in relation to themselves, others, their immediate environment, society and the world (World Health Organisation, 2004). The causal and consequential factors of mental health can also be said to be interrelated. Research shows that here are many factors that can impact one’s mental health, including but not constricted to sexual orientation and identification, biological make-up, self-esteem, trauma, well-being, age, social inequalities, employment status, substance use, stability of the home environment, relationships and physical health (Zhang, Zou & Kwan, 2019; Pineles & Borba, 2018; Cooper, 2011; Behan, Doyle, Masterson, Shiers & Clarke, 2015; Gupta, 2016; Hwang, Kim, Yang & Yang, 2016; Cygan-Rehm, Kuehnle & Oberfichter, 2017; Siegel, 2019). These factors can also impact the deterioration or improvement of mental health distress.

There are many existing mental health concerns, however as it would not be feasible to cover all, this research exclusively explores more commonly experienced mental health concerns. A decision to focus specifically on commonly experienced mental health disorders (over for instance, co-morbid disorders) was also made to ensure that the results of the study are not too generalised and that findings are emphasized. The types of mental health concerns which are considered common differs per organisation and country. To avoid confusion, the National Institute for Health and Care Excellence (NICE) guidelines were solely considered for this research. Within the UK, clinicians use the NICE guidelines as a pathway to identifying mental health

concerns, which considers both the tenth revision of the Classification of Diseases (ICD-10) and the most recent version of the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) definitions, to establish formal diagnoses of mental health problems, alongside biological, psychological and social factors (NICE, 2011). The NICE guidelines identifies more commonly experienced mental health problems as "depression, generalised anxiety disorder (including social anxiety disorder), panic disorder, obsessive compulsive disorder and post-traumatic stress disorder" (NICE, 2011, pg. 5). These are all characterised by particular symptoms which can range from mild to severe, and can exist independently or co-morbidly.

Arguably, it can be said that mental health distress is a very personal experience and that it impacts individuals in different ways. I found it challenging to decide which definition to use for the purpose of this research, as I did not want potential participants feeling confused and excluded if their distress did not meet particular criteria. I decided to use the Mental Health Foundation definition as it is commonly used and can be used alongside NICE guidelines. I also feel that this particular definition offers a comprehensive insight into different aspects associated to mental health, which is why I chose to use this specific ones.

1.4 Mental Health Amongst the UK Population

According to NICE, commonly experienced mental health concerns affect up to fifteen percent of the population at any given time, with generalised anxiety disorder being the most prevalent in England overall (Baker, 2018). Alongside this, the 2014 Adult Psychiatric Morbidity Survey (APMS), which is carried out every seven years, established that typically one in six adults is diagnosed with a common mental health

concerns every week, with prevalence generally more common in women than men (McManus, Bebbington, Jenkins, Brugha & Cooper, 2016; Baker, 2018, Mental Health Foundation. 2016). The APMS also discovered that since 2007, the incidence rate of all commonly experienced mental health problems has increased over time, with the exception of panic disorder for individuals above the age of sixteen (McManus, et al., 2016, in Mental Health Foundation, 2016). Furthermore, it's been evidenced that those diagnosed with common mental health problems and/or interacting with mental health services are a higher risk of attempting and/or committing suicide (Hawton, Houston, Haw, Townsend & Harriss, 2003; Mental Health Foundation, 2016; Department of Health, 2012). The frequency of common mental health concerns and associated acts of self-harm have generally increased amongst young people as well as adults aged between fifty-five and sixty since 2007 (McManus et al., 2016).

The prevalence of the common mental health concerns differs per ethnicity. Research has identified that individuals identifying within ethnic minority groups, such as black and Asian ethnicities, appear to be more likely to experience common mental health concerns (Baker, 2018; The Mental Health Taskforce, 2016). The APMS also found that individuals who are living by themselves, in poor physical health, homeless, unemployed, being offered employment support and/or associated with the criminal justice system are at a significantly higher risk of developing mental health concerns (McManus et al., 2016; The Mental Health Taskforce, 2016). Groups considered to be at a higher-risk of suicide are suggested to be young and middle-aged men, individuals in contact with mental health services including inpatients, those with previous incidents of self-harm, people associated to the criminal justice system as well as specific occupational groups, for instance veterinary physicians (Hewlett & Horner,

2015). These findings coincide as common mental health problems are considered more prevalent amongst groups that are also evidenced to be at a higher-risk of self-harm or suicide.

It is challenging to provide a fully accurate presentation of the prevalence of mental health concerns amongst the UK population due to irregularities in descriptions of mental health, and because distress can be unreported and un-diagnosed by professionals (Mental Health Foundation, 2016). There is also general disagreement within the field regarding which populations are considered most vulnerable to common mental health concerns, self-harm and suicide. Still, the statistics provided here offer a general overview of the prevalence of mental health amongst the UK population.

1.4.1 Mental Health Support in the UK

Within the UK, NICE guidelines are also used in regard to treatment options for mental health concerns. Treatment options for common mental health problems include evidence-based pharmacological treatments and psychological interventions, which can be offered separately or in combination with each other. Pharmacological treatments for common mental health concerns often consist of prescribing selective serotonin reuptake inhibitors (SSRI's), as they have been evidenced to work effectively for all of the common mental health problems (NICE, 2011; NICE, 2009; NICE, 2018; NICE, 2019; NICE, 2005; NICE, 2013). It is important to mention though that no conclusive validation exists for the use of drug interventions for symptoms associated to Post-Traumatic Stress Disorder (National Collaborating Centre for Mental Health, 2005; NICE, 2018). Psychological interventions for common mental

health concerns largely refer to the use of Cognitive Behavioural Therapy, a short-term talk-therapy, which has a significant evidence base in relation to many mental health concerns (NICE, 2011). Other types of therapy advised in the clinical guidelines depend on the specific symptoms present under the different diagnoses. For instance, interpersonal therapy and mindfulness-based cognitive therapy (MBCT) are also identified as effective for individuals experiencing symptoms of depression. Interpersonal therapy refers to a structured and time-limited approach which focuses on improving an individual's interpersonal relationships and social functioning skills (Wilfley & Shore, 2015). MBCT supports individuals in developing the ability to be more conscious of their thoughts and feelings, and be able to manage these through mindfulness-based exercises (MacKenzie & Kocovski, 2016). Eye movement desensitisation and reprocessing therapy (EMDR) has been identified as applicable for Post-Traumatic Stress Disorder (NICE, 2011; NICE, 2009; NICE, 2018). EMDR aims to help individuals in processing traumas with the use of external stimuli, such as sounds, images and eye moments (Shapiro, 2018).

Many individuals in the UK access psychological treatments through the NHS Improving Access to Psychological Therapies programme (IAPT), which aims to make such support services more available to those who experience common mental health concerns (NHS, 2018). Out of the one in six that are identified as having a common mental health problem within UK society, half are considered to have symptoms that merits treatment by a mental health professional (NICE, 2011). The APMS established that, one in eight adults accessed treatment for mental health concerns in 2014 in England and that approximately thirty-five percent of those with common mental health problems received treatment (McManus, et al., 2016). The majority of those seeking

support gained access through primary care services (The Mental Health Taskforce, 2016).

Whilst medication tends to be the most common form of treatment, many appear to prefer psychological treatment (Gyani, Shafran, Layard & Clark, 2013; Kwan, Dimidjian & Rizvi, 2010). It has been found that despite these preferences, the use of therapeutic interventions such as talk-therapy has only increased more recently, and medication is still prescribed significantly more than therapy. The APMS indicates that by 2007, many experiencing common mental health issues were not offered therapy, however by 2014, an increase had been evidenced (Gyani, Shafran, Layard & Clark, 2013; McManus, Meltzer, Brugha, Bebbington & Jenkins, 2009; McManus, et al., 2016). Overall, the most common talk-therapy offered is cognitive-behavioural therapy, followed by counselling and psychotherapy (McManus, et al., 2016; Health and Social Care Information Centre, 2015).

Evidence suggests that approximately twenty-two percent (of people surveyed for the 2015 Community Mental Health Survey) feel they don't have sufficient communication with mental health services (Mental Health Foundation, 2016). Additionally, available research implies that a reported seventy-five percent of the public may not access treatment needed to support their individual mental health concerns (Davies, 2014). Alongside this, significant inequalities have been uncovered within the existing healthcare service, as those diagnosed with common mental health concerns are female, White British or in midlife are considered more likely to be given access to treatment than any other group (McManus, et al., 2016). In contrast to this, the Black/Black British individuals had considerably lower treatment rates, and those who

were young, living alone and within a low income household were especially likely to not be offered suitable treatment options (McManus, et al., 2016).

Significant changes have taken place within government legislation throughout the years to encourage better practice in the management and support of mental health distress (Hewlett & Horner, 2015; McManus, et al., 2016). Future ambitions for mental health service improvements have also been published by NHS England, which outline aims of increasing access to mental health facilities seven days a week and providing more community-based services, promoting equality within existing services and expanding mental health prevention schemes (The Mental Health Taskforce, 2016). Still, increased access to mental health support services are required to more adequately support the current mental health needs of UK society.

1.5 The Prison System in England

In the UK, the prison system functions differently depending on the country, with England and Wales using the same system, and Scotland and Northern Ireland using a different one. As this research is taking part in England, the focus of this description will be based on their incarceration system. Within England, both public and private prisons exist. Whereas most of the public prisons are managed by Her Majesty's (HM) Prison and Probation Service, supported by the Ministry of Justice, private prisons are run by third-party companies or funded through private contracts (Grimwood, 2015). It is important to note that public and private prisons follow the same legislation regarding the categorisation of prisons, and both are inspected through the Her Majesty Inspectorate of Prisons and the Independent Monitoring Board.

Different types of prison settings exist for adults, based on gender, age, the level of security the offender requires, as well as the crime committed and sentence given (Grimwood, 2015). For adult offenders, there are open and closed prisons. Open prisons refer to settings where incarcerated individuals have more freedom of movement, whereas closed prisons refer to fully secure settings (Grimwood, 2015). Alongside this, there are separate security categories which identify the type prisoner in more detail, and the categories differ for males, females and young adults. The security categories are based on risk assessments associated to the probability of escaping, the level of risk the individual presents regarding potential harm to the public, as well as potential factors that can affect the security of the prison, including those within security grounds (Ministry of Justice - MoJ, 2011a; MoJ, 2011b; MoJ, 2011c). Individuals are allocated a category once sentenced.

For male offenders, there are four security categories. When a male offender is considered to be a category A or B prisoner, the individual is allocated to a High Security Prison. Category A refers to prisoners who are considered a significant danger to the public, police force or safety of the country, and potential to escape from the setting must be unfeasible (Grimwood, 2015, MoJ, 2011a). Category B refers to individuals who do not require the “highest conditions” but still should not be given the opportunity to escape (Grimwood, 2015, MoJ, 2011a). Category C offenders are also allocated to a closed prison setting, but are not considered likely to escape (Grimwood, 2015, MoJ, 2011a). Finally, individuals classified as Category D prisoners are designated to open prisons (Grimwood, 2015; MoJ, 2011a).

The security categorisation of all female offenders and young adult male offenders is different to that of males, though the factors included in the risk assessment are the same (MoJ, 2011b; MoJ, 2011c; Grimwood, 2015). The Category A security classification refers to individuals that are considered highly dangerous to the public, police force and safety of the country, and escape from the prison setting must be unachievable (Grimwood, 2015; MoJ, 2011b; MoJ, 2011c). Restricted Status consists of individuals who are considered a serious risk and thus must be held within secure settings, and the Closed Conditions category are for those who do not require the highest conditions of safety measures but are not deemed appropriate for open settings (Grimwood, 2015; MoJ, 2011b; MoJ, 2011c). Lastly, the Open Conditions category consist of offenders who do not present a high level of risk (Grimwood, 2015; MoJ, 2011b; MoJ, 2011c).

1.5.1 The State of Prisons in England

The state of performance of prisons in England are inspected consistently, with some aspects monitored quarterly and others monitored annually. Performance assessments consider many factors, which can all be considered to be part of the following main categories: safety, security, rehabilitation and release planning, respect, purposeful activity and organisational effectiveness (MoJ, 2019a). These areas of investigation were newly identified in 2018.

The most recent annual performance analysis carried out by the MoJ identified a positive increase in performance levels from 2018 to 2019 in the annual investigations from the previous two years. Thirteen percent of prison contexts in England were rated as performing with exceptional performance and around fifty percent were

acknowledged as performing at an adequate level (MoJ, 2019a; MoJ, 2019b). Fourteen percent were considered to perform in a way that signified substantial concern, all of which were incarceration settings for male offenders (MoJ, 2019a; MoJ, 2019b). It is important to note that this last statistic identifies the highest number of prisons performing at a level of significant concern since these annual ratings began. Overall, open prisons performed better on the performance ratings than closed prisons (MoJ, 2019a; MoJ, 2019b).

Regarding levels of security in prison settings, a large majority were recognised as having adequate or exceptional performance (MoJ, 2019a; MoJ, 2019b). Still, eighty-six percent of prisons were identified with performance levels of concern or serious concern in regard to incidents of self-harm and prisoner-on-prisoner violence (MoJ, 2019c). Incidents of self-harm increased by twenty-four percent in the year leading up to March 2019, and there was a twenty-three percent increase in self-inflicted deaths, with a significant portion of these taking place in male prisons (MoJ, 2019c; Prisons and Probation Ombudsman, 2019). Deaths in prison associated to drug use also remain high, and the use of psychoactive substances remains a significant issue within prison settings (Prisons and Probation Ombudsman, 2019). Male prisons which accommodated individuals on remand or with short-term sentences appeared to have the highest rating of positive substance use testing (MoJ, 2019c). Reports also stated that prisoner-on-prisoner assaults continue to increase, however it appears that official complaints are rarely made against other prisoners (Prisons and Probation Ombudsman, 2019). Associated to this, not many prisoners appear to formally complain about feeling unsafe within prison settings (Prisons and Probation Ombudsman, 2019). Regarding this statistic, there are numerous reasons to consider

which may stop an individual from reporting such incidents, such as the prisoner's potential worry of retaliation.

Reports show that there has been an increase of complaints around the living conditions of prisons in England in recent years (Prisons and Probation Ombudsman, 2019). A strongly linking cause is prison overcrowding (MacDonald, 2018). Despite the prison population having decreased slightly in the two years coming up to March 2019, the prison population has significantly increased over the years (MoJ, 2019b; Sturge, 2020). Statistics show that the complaints have quadrupled between 1900 and 2018, and it has been suggested that this number will increase as has been the trend (Sturge, 2020). As of July of 2020, there were 79,531 prisoners in England and Wales, with 76,269 male prisoners and 3,262 female prisoners, and sixty-two percent of prisons have been evidenced to be overcrowded (Sturge, 2020; MoJ, 2020).

1.5.2 Demographics of the UK Prison Population

When researching the demographics of the UK prison population, research not only discusses the identification of prisoners, such as gender, age, ethnicity, and sentence time, but also potential pathways to being incarcerated.

Analyses done shows that as of 2019, only five percent of the prison population was female, with the majority of the population being male (Sturge, 2020). Data on the ages of all prisoners indicates that the amount of prisoners aged twenty-one to twenty-nine has decreased since 2014, whilst the quantity of prisoners aged above fifty has increased (Sturge, 2020). Alongside this, in 2018 it was found that foreign nationals made up fifty-four percent of the prison population, of which forty-three percent were

from Europe (Sturge, 2020). The majority of offenders are white, however, people of minority ethnicities made up twenty-seven percent of the prison population in comparison with thirteen percent of the general population (Sturge, 2020). Unfortunately, this statistic can be linked to the evidenced biased treatment against those identified as being part of the ethnic minority populace (Uhrig, 2016).

Regarding sentence length, around one quarter of the prison population is serving a sentence between one and four years, and the majority of sentences were determinate sentences, which is when the prisoner serves a sentence of a fixed time period (Sturge, 2020). The majority of the adult prison population at the end of March 2019 were serving a sentence for violence based offenses on another individual, followed by sexual offenses, drug offenses, theft and robbery (Sturge, 2020). Many of those incarcerated also have previous convictions, which is in line with evidence proving that re-offending rates are increasing within England and the UK (MoJ, 2019d).

When researching more into potential determinants in getting involved with the criminal justice system, several potential causal factors arose. A significant amount of research has linked the impact of negative childhood experiences with the likelihood of committing crimes later in life, alongside issues surrounding substance misuse and homelessness, and deteriorating mental health, to name a few (Williams, Papadopoulou & Booth, 2012; Altintas & Bilici, 2018; Cronley, Jeong, Davis & Madden, 2015; Fischer, Shinn, Shrout & Tsemberis, 2008; MoJ, 2012). For instance, individuals from low-income households, those who have suffered from poverty, or are from single-parent families may be more likely to end up within prison later in life (Williams, Papadopoulou & Booth, 2012; Mok, Astrup, Carr, Antonsen, Webb & Pedersen, 2018;

Antecol & Bedard, 2007). Those who have suffered from childhood abuse or were raised amongst family associated to criminality were also evidenced to be more likely to commit a crime (Williams, Papadopoulou & Booth, 2012; Cronley, Jeong, Davis & Madden, 2015; Widom & College, 2017; Besemer, Farrington & Bijleveld, 2017). Individuals with substance misuse or who were brought up with parents with substance use problems were again seen as more likely (Williams, Papadopoulou & Booth, 2012). Alongside this, individuals who displayed delinquent behaviour during their childhood, such as aggression, recurrent violence towards animals or persistently skipping school, was also related to a higher probability of committing crimes in adulthood (Kassing, Godwin, Lochman & Coie, 2019; Hensley & Ketron, 2018). Whilst these factors are not considered to guarantee that one commits a crime, research indicates that they can however increase the likelihood. These studies generally consist of small sample sizes, indicating that they cannot be considered representative of the prison population.

Another casual factor to consider regarding the pathway to incarceration is the structural racism that exists within society. Long-standing systemic racism has resulted in social inequalities and inequities for ethnic minority individuals, and has led to Black, Asian and ethnic minority (BAME) individuals being unjustly targeted and discriminated against (Fekete, 2017; Lammy, 2017; Miller, 2021). Within the criminal justice system, the biased impact of structural racism is clearly evidenced. For example, within police initiatives like the stop and search, young BAME male individuals were more likely to be stopped and arrested than white males (Bridges, 2018, Uhrig, 2016). Another example which highlights the disproportionality is within the court system, with BAME individuals being significantly more likely to receive a

sentence than their white counterparts (Bridges, 2018). The results of structural racism is also clearly evidenced within prisons, with BAME individuals being hugely overrepresented within the prison population (Fekete, 2017; Sturge, 2020).

1.6 Mental Health Amongst the Prison Population

It has been consistently evidenced that mental health is negatively impacted by imprisonment, with mental health concerns significantly more prevalent within the prison population than in the general population (Senior, 2015; Bradley, 2009; Prisons & Probations Ombudsman, 2016; World Health Organisation, 2005; Nagel 1976; Gee & Bertrand-Godfrey, 2014; Nurse, Woodcock & Ormsby, 2003; Bowler, Phillips & Rees, 2018). Research indicates that currently ninety percent of incarcerated individuals are considered to have a mental health, drug or alcohol problem, with prevalence higher amongst female prisoners than male prisoners (The Mental Health Taskforce, 2016; Senior, 2015; Fraser, 2009; Tyler, Miles, Karadag & Rogers, 2019). Alongside this, it's been established that between approximately forty-five and seventy-five percent of prisoners have a minimum of one of the more commonly experienced mental health problems, with co-morbidity common (Gunn, Maden & Swinton, 1991; Harty, Jarrett, Thornicroft & Shaw, 2012; Tyler, Miles, Karadag & Rogers, 2019). In regard to the more commonly experienced mental health concerns, a recent study identified that the prevalence of incarcerated individuals suffering from anxiety, depression, and post-traumatic stress disorder symptoms is around five times higher than in the general population in the UK (Tyler, Miles, Karadag & Rogers, 2019). Research does not seem to identify the predominance of panic disorder and obsessive compulsive disorder related symptoms. It is important to emphasise that

many mental health concerns can go unnoticed and untreated, so exact numbers are unknown (Tyler, Miles, Karadag & Rogers, 2019).

Worryingly, mental health distress is strongly correlated with high rates of suicide and self-harm in prison, alongside violence and victimisation (Prisons and Probation Ombudsman, 2019; Dean & Korobanova, 2018). The most recent Prisons and Probations Ombudsman investigation into prison custody deaths found not only that prisoners are at a higher risk of attempting to commit suicide and self-harming, but also that those who died from self-harm or suicide whilst incarcerated were more likely to be diagnosed with a common mental health problem (Prisons and Probation Ombudsman, 2016; Prison Reform Trust, 2016). Reports of events of self-harm and suicide have never been so high, with the proportion of suicides in incarcerated contexts being ten times higher than in the public (Georgiou & Townsend, 2019; MoJ, 2019c; Patel, Harvey & Forrester, 2018). Suicide risk is higher in male prisoner and self-farm rates are higher amongst females (Patel, Harvey & Forrester, 2018). As mental health distress is strongly associated to increased risk of self-harm and suicide, it is important to research and reflect on the potential causes of mental health deterioration as well as ways to support prisoners vulnerable to mental health deterioration.

There are several causes which are associated to the deterioration of mental health within prison settings, relating to both the environment and the administration. Reports indicate that overcrowding is a dilemma strongly associated to mental health distress, alongside violence, lack of meaningful activity, isolation, lack of privacy and forced separation from family members (Harding, Morenoff & Wyse, 2019; Goomany &

Dickinson, 2015; Bowler, Phillips & Rees, 2018). Qualitative studies carried out with prisoners identified similar findings, with additional detail. Two environmental factors mentioned by prisoners are the isolating environment, as many of those incarcerated are within their cells for the majority of the day, and a lack of activities available, such as physical activity, work or education (Nurse, Woodcock & Ormsby, 2003; Goomany & Dickinson, 2015). Other factors to consider include relationship between staff and those incarcerated, which the participants described as “a cycle of negative attitudes”, as well as an atmosphere of bullying and worries of personal safety (Nurse, Woodcock & Ormsby, 2003; Goomany & Dickinson, 2015). Concern of personal safety generally appears to be strongest in those considered more vulnerable, such as those with poor health or mental health (Goomany & Dickinson, 2015). An organisational factor such as a reduction of funding provided throughout the years is strongly associated to the worsening of the prison environment, as they have led to a decrease in the amount of staff available as well as reduced resources (Nurse, Woodcock & Ormsby, 2003; Goomany & Dickinson, 2015). All of these factors are inter-related and associate to feelings of loss of independence and autonomy, as well as increased levels of frustration, anxiety, and substance use (Tyler, Miles, Karadag & Rogers, 2019; Harty, Jarrett, Thornicroft & Shaw, 2012; Bowler, Phillips & Rees, 2018).

Whilst it is clear that the prison environment negatively impacts mental health, it is challenging to identify specifically how significant the impact is. A recent study carried out with male and female UK prisoners was able to establish that nearly half of the participating individuals had previously accessed mental health services, suggesting that they experienced symptoms of mental health deterioration prior to entering prison (Tyler, Miles, Karadag & Rogers, 2019). Similar findings were identified by another

recent study, which identified that individuals with backgrounds such as childhood trauma, previous use of illegal substances, educational difficulties during school years and having an uninhibited nature are more likely to experience mental health distress in prison (Bowler, Phillips & Rees, 2018). Still, in comparison to the research evidencing the current state of mental health in England overall, the findings specifically on the current state of mental health within prisons are alarming, emphasising why more needs to be done to support mental health needs of incarcerated individuals.

1.6.1 Mental Health Support in UK Prisons

The inadequacy of prison mental health support services has been a significant concern for a long time. With the poor mental health of prisoners gaining increased attention in recent years, there have been significant changes in legislation and service structures to better support incarcerated individuals. For instance, IAPT programmes were introduced in 2007 to combat common mental health disorders in prison, based on the NHS approach aimed at supporting mental health needs of the general public (Reed, 2003; Adamson, Gibbs, McLaughlin, 2014; Senior, 2015; NHS England, 2013). Additionally, based on the 2009 Bradley Report findings signifying need for early identification, prevention strategies and a clear model for prison healthcare services, the government and Ministry of Justice established specific prison guidelines and programmes (Prisons and Probation Ombudsman, 2016: Bradley, 2009; MoJ, 2013). NICE has since also developed specific clinical guidelines for services supporting incarcerated individuals with their mental health (NHS England, 2018). Alongside this, the Royal College of Psychiatrists' Quality Network for Prison Mental Health Services (QNPMHS) have also began delivering annual reports since 2015 based on

investigations into the quality of mental health services in prison contexts (Georgiou & Townsend, 2019). These reports provide in depth detail on improvements made to the prison mental health support services and also identifies areas for improvement.

Despite the positive advancements made, findings from these reports of the last two years show significant improvements still need to be made in order for practice to match legislative visions (Georgiou & Townsend, 2019; RCPsych, 2018; RCPsych, 2019). The 2014 review of progress of the 2009 Bradley Report proposals also found there were some improvements, however that most recommendations still needed to be addressed (Durcan, Saunders, Gadsby & Hazard, 2014; Brooker & Webster, 2017). Whilst prisoners are entitled to the same healthcare services as the general public under the HMPS, evidence suggests that many prisoners are not receiving the appropriate support for their needs (Georgiou & Townsend, 2019; RCPsych, 2018; RCPsych, 2019; Tyler, Miles, Karadag & Rogers, 2019; Patel, Harvey & Forrester, 2018). One study looking into the “prisoner perspective” of mental health support services identified that of those participating in the study, less than half reported positive feedback (Patel, Harvey & Forrester, 2018). Alongside this, it has been demonstrated that if an individual’s mental health needs are not identified when first entering prison, often his or her symptoms will continue to be overlooked through the remainder of their time in prison, as generally, no further screenings are carried out (Wright, Jordan & Kane, 2014; Dean & Korobanova, 2018). Unfortunately, despite the important purpose of screening measures, the identification of symptoms appears through available screening procedures also appears to be poor (Dean & Korobanova, 2018; Brown, Cullen, Kooyman & Forrester, 2015). Though not excusable, there are numerous factors that must be considered in relation to these facts.

Delivering mental health support in prison contexts is seen as “challenging” (Wright, Jordan & Kane, 2014; Powell, Harris, Condon & Kemple, 2010; Georgiou & Townsend, 2019). Alongside there being limited types of interventions available within prison contexts, reports have found that there continues to be a lack of support for healthcare professionals (Prisons and Probation Ombudsman, 2016; Georgiou & Townsend, 2019; RCPsych, 2018; RCPsych, 2019). This including a lack of guidance for use of assessment tools for diagnosis, and that overall staff awareness of mental health is limited (Prisons and Probation Ombudsman, 2016; Georgiou & Townsend, 2019; RCPsych, 2018; RCPsych, 2019; Patel, Harvey & Forrester, 2018). There also is a “lack of coordinated care between different healthcare professionals and teams”, potentially due to the culture clashes between the punitive criminal justice system and rehabilitation-focused support services (Prisons and Probation Ombudsman, 2016; Georgiou & Townsend, 2019; RCPsych, 2018; RCPsych, 2019). These factors are considered a dangerous cocktail when considering the complex mental health needs presented within prison contexts. For instance, some of the mental health issues presented in prisons can cause individuals to behave in difficult manners, which service staff might treat as a behavioural issue instead of a mental health concern, which can lead to further deterioration of the individuals state of mental health (Prisons and Probation Ombudsman, 2019).

Additional key issues in prison mental health support services are the demand and burden it places on staff, especially with reduced funding, a lack of resources and a shortage of staff (Georgiou & Townsend, 2019; RCPsych, 2018; RCPsych, 2019; Ajji & Huges, 2019). Alongside this, worries around safety and increased misuse of new

psychoactive substances by many inmates create further demand on the health services available in prison and cause the services to function less effectively and efficiently (Brooker & Webster, 2017). Overall, it seems that staff are insufficiently qualified for the environment they are working in and the need of vulnerable prisoners, and that they do not have access to resources required to appropriately support mental health needs which present themselves (Senior, 2015; Forrester et al., 2013).

Regarding the use of therapeutic interventions, the most recent Prisons and Probation Ombudsman investigation also reported that talk-therapies are now the most common types of treatments offered to those suffering from mental health distress (aside from medication (Prisons and Probation Ombudsman, 2016). Cognitive-behavioural therapy specifically is used most often due to brief nature and the evidenced effectiveness of the therapy (Vennard, Sugg & Hedderman, 1997; Friendship, Blud, Erikson & Travers, 2002; Adamson, Gibbs, McLaughlin, 2014). Counselling is also offered through in-reach teams. Unfortunately, despite the evidenced effectiveness and additional implementation of therapeutic interventions, availability is limited due to long waiting lists. This is as mental health support services seem to still be a focus on emergency management and risk prevention, despite legislation guiding professionals to work towards early identification and prevention strategies (Gee & Bertrand-Godfrey, 2014; Towl, 2003). Alongside this, there is still debate on whether such interventions contribute specifically to reduced re-offending rates, which is the main priority of prison officials, leading to a lack of focus on the benefits of therapy for prisoners (Ajji & Huges, 2019). Fortunately, more research and mental health professionals are beginning to emphasise the value of providing therapeutic

interventions in prison contexts, and the government continues to strive to better support mental health needs within the criminal justice system.

1.7 Review of the Literature and Research

Despite mental health not being a new phenomenon, variations exist amongst the descriptions used by the government, organisations as well as individual practitioners and researchers to define mental health and associated disorders. Such discrepancies make it more challenging to study the phenomenon, and negatively impact the significance of findings of overall research on topics surrounding mental health.

1.7.1 Mental Health and Mental Health Support in the UK

Statistics used to guide mental health research largely refer to APMS findings as its considered to offer the most accurate and well-grounded description of mental health in England by many (McManus, et al., 2016). This statement is justified by the fact that the survey has been carried out every seven years since 1993, it covers a range of disorders and associated behaviours (i.e. self-harm) and as its comprised of a large sample group, including individuals who do and don't attend health services (McManus, et al., 2016). Furthermore, by using the Clinical Interview Schedule-Revised (CIS-R) survey to diagnose CMHD, a cross-culturally validated instrument (Das-Munshi, Castro-Costa, Dewey, Nazroo & Prince, 2014), additional validity and reliability of findings was ensured. Finally, as the research was commissioned by government associations and carried out by a university as well as an independent research institute, a multi-disciplinary approach was taken to reviewing mental health and available support services in England.

It's important to note that those living in institutional settings (i.e. prisons) were not included in the sample of the APMS, indicating that overall findings are not representative of all sub-groups within the overall population. This is essential to state as most other existing research uses APMS findings to guide their research. Furthermore, it needs to be acknowledged that APMS findings solely provide an estimate of the current state of mental health and associated support services in England. This is especially important when reviewing findings of smaller sub-participant groups used within the review, as these findings can't be considered as broadly representative, such as the finding that young women are considered a higher risk – though this finding has been backed by others (i.e. Knudsen, 2016). Additionally, whilst APMS findings provide a comprehensive overview of the current state of mental health and support services, it's imperative to bear in mind that the findings are solely quantitative, thus there is a lack of in-depth detail on service user experiences. The most recent AMPS was also carried out in 2014, meaning that the current prevalence of mental health and available support services may have changed since the publication of this report.

Alongside the APMS, there are very few studies which directly investigate mental health in England, and rarely any which consist of qualitative methods. It would be vital for future research to consider the value of qualitatively exploring the experience of service users, with the aim of developing and improving the supportive service structure for those experiencing mental health distress.

1.7.2 Mental Health and Mental Health Support in UK Prisons

Researching and analysing the prevalence of mental health in the prison population, the impact of incarceration on mental health and how associated support services assist in reducing these influences is challenging due to several reasons. A key playing factor is that there is a lack of funding in the area, making it tough to carry out further in-depth research. Furthermore, as the prison population is considered to be highly vulnerable, many ethical considerations have to be considered, including for instance, how to obtain adequate informed consent and how to appropriately recruit participants. Whilst the ethical standards are justified, they may play a role in deterring extensive amounts of research being done on the topic and prison population.

Whilst this review concentrates on examining existing research representative of England, it was found that most existing research on this topic (especially qualitative) has been carried out in the USA. It was incredibly challenging to find qualitative research that specifically focused on prison population within England. Although results of research carried out in other countries can be considered in general terms, they aren't specifically representative of England's population and needs. Minimal qualitative research has been carried out specifically on the British prison population, suggesting that there is not an in-depth understanding of how support services in prisons in England can be restructured to better support presented mental health needs. Finally, as the majority of existing research in England is provided by the government through surveys and questionnaires, there is a clear lack of detail on subject experiences. Although there are advantages to quantitative research as they often include larger samples and provide more representative findings, it's known to not revel in the importance of investigating subjective experiences, which is where the

importance of qualitative research comes in – as it regards experience to be an essential source of knowledge (Racher & Robinson, 2003, in Gee & Bertrand-Godfrey, 2014).

There has been more emphasis in recent years on researching the impact of imprisonment on mental health. As a result, there has been an increase in the use of independent investigations, which generally consist of large samples, such as the 2009 Bradley Report, Prisons and Probation Ombudsman investigations and QNPMHS reports. The Bradley Report, which is considered to offer an illustrious overview of prison healthcare, has encouraged positive changes in legislation throughout the years (Prisons and Probation Ombudsman, 2016). Whilst there is little research evidencing the impact of incarceration on mental health, the Bradley Report and its 2014 review provide the most comprehensive overview of healthcare services in prisons. This is as its findings come from a range of sources, such as other reviews, meetings with organisations or groups, as well as service user focus groups. Thus its findings are considered representative of all individuals suffering from mental health, as well as those at-risk or involved with the criminal justice system. However, as it is a quantitative source, it lacks in details and essentially solely functions as a brief overview. The Prisons and Probations Ombudsman investigation is similar in methodology to the Bradley Report (and its review), however this time with a specific focus on exploring deaths which occurred whilst incarcerated. The review is deemed to be the most recent in-depth analysis of how lack of mental health services played a part in the deaths, and results evidenced are backed by a broad range of sources. Finally, the QNPMHS reports offer longitudinal findings of prison mental health services through a peer-review process (Georgiou & Townsend, 2019). Whilst their

findings allow a more in-depth perspective of the current state of prison mental health services, the findings cannot be generalised to the entire prison service as not all prison take part in the investigation. Still, all of these reports together have been able to provide a balanced and impartial picture of the mental health support system, despite their limitations.

Alongside independent reviews, more research using qualitative and mixed methods have been carried out in recent years. More current research has also highlighted the importance of interviewing service-users and staff. Such research has been fundamental to gaining a better insight of the current state of mental health and support services within prison contexts. Increased knowledge, a key goal of qualitative research, offers the prospect of prompting important social change (Gough & Lyons, 2016). Additionally, the amount of qualitative research does not compare to the amount of quantitative research, and it is minimal considering the prison population. Significantly more qualitative research needs to be carried out on the phenomena, especially the perspective of service-users, to develop a more accurate view of mental health and support services within prisons.

1.8 Rationale for the Research

Positive changes in legislation have taken place within England (and Wales) in recent years, with the government, independent organisations, researchers and professionals working more closely than ever before to provide better quality healthcare services. However, despite these advancements, research and reports evidence that progress has been slower than expected when it comes to providing better healthcare services. As a whole, research suggests mental health is still a

significant concern within prisons in England (and Wales). The current healthcare system is not adequately supporting presented mental health needs, and the legislations in place do not match the current quality of care received. Regarding therapeutic interventions, whilst evidence largely implies positive short and long-term impacts of using talk-therapies to support mental health concerns, there is still a lack of use of these types of psychological treatments in prison contexts. Although the lack of progress is due to a broad range of reasons, these factors should not be used to justify or overshadow the significance of findings of existing research and the need for further research.

When reading about the lack of quality care available to prisoners, I thought back on my experience of working therapeutically in a forensic hospital with prisoners detained under the Mental Health Act. There were many instances where it was clear that the patient had needed appropriate mental health support at an earlier point in their lives. There were many occasions where patients described not having access to appropriate mental health support in prison, and I often found myself thinking that such support in prison could have made a difference. I felt inclined to want to research more into this and look into the impact of the lack of support for incarcerated individuals who experience mental health distress.. Although I initially felt anxious regarding the potential challenges I could face in carrying out research in this area, the clear need for additional and more meaningful knowledge motivated me to carry out my research.

Substantial quantitative research evidences the negative impact of incarceration on mental health and ways in which prison healthcare has reformed to support mental health needs. Whilst there has been an increase in the use of therapy services, such

as talk-therapy, within prisons in England, little research has investigated whether this has assisted in reducing the negative impacts of incarceration on mental health. Alongside this, minimal research evidences how individuals suffering from mental health distress access mental health services, or how those accessing such services in prison settings experience the facilities available. The lack of qualitative exploration of the voices of those directly experiencing the phenomenon indicates we only have an overview and a minimal understanding of how to appropriately support the needs of incarcerated individuals suffering from mental health concerns. Substantially more qualitative research needs to be carried out on the current status of mental health and the experiences of therapies in prisons to produce more meaningful knowledge. Noticing the lack of qualitative research which focuses on exploring the voice of service users, I felt it was imperative that my research focused specifically on exploring their experiences. Understandably, recent implementation of service structure changes makes it impossible to explore long-term impacts of the current mental health support system, however this should not act as a deterrent as it's just as important to explore how service users feel existing treatments impact their mental health.

A key focus of this qualitative research piece is to provide in-depth and clear data with a focus to fill the gap observed in existing research and knowledge. Qualitative methods not only offer an opportunity to gather comprehensive data, but they also coincide with paradigms associated to the counselling psychology practice (Ponterotto, Kuriakose & Granovskaya, 2008). For instance, they both are a creative process, include consideration of individual's perspective and consist of having relational and meaningful communication with others (Ponterotto, Kuriakose & Granovskaya, 2008; Ponterotto, 2005). Another aim of this research is to offer a

marginalised and overlooked group a chance to share their views and beliefs. Carrying out this research will also allow for a better understanding amongst the public and health professionals. A final and critical aim of this research is to investigate the mental health support structure in prisons and consider whether current policies and protocols allows for mental health needs to be effectively addressed. As counselling psychologists are concerned with the health and wellbeing (including mental health) of the people, it feels appropriate to emphasise the importance of how this research can have the potential to improve how the counselling practice functions within specific settings such as prisons (British Psychological Society, 2017). Creating awareness could potentially ensure that in the future, more of those serving custodial sentences are provided with mental health support which is not only highly appropriate but also vastly effective.

1.9 Personal Reflexivity

There are mixed views on whether reflexivity has a place within the grounded theory methodology. There are some who argue that the method is based on mirroring the participants' realities and provides a reproduction of their realities, thus the researcher's perspective doesn't enter the realm of analysis (Thompson & Russo, 2012). Others argue that reflexivity is a crucial aspect of providing 'ethical maturity' and can increase the quality and validity of the research (Hall & Callery, 2001; Carroll & Shaw, 2012; Thompson & Russo, 2012). The constructivist grounded theory methodology version chosen for carrying out this research argues for the importance of reflexivity, which is in-line with my personal beliefs. In my opinion, personal, epistemological and methodological reflexivity is a highly important aspect of carrying out high-quality research. It can provide a solid basis for ethical practice, transparency

and conversation, can convey and rebalance power dynamics between the researcher and participants, and it allows for "researcher vulnerability" (Etherington, 2007; Carroll & Shaw, 2012; Guillemin & Gillam, 2004). Additionally, having the ability, as the researcher and interviewer, to influence participant responses and analysis both verbally and non-verbally, a constant reflective, non-judgemental, sensitive and open stance must be maintained throughout (Willig, 2013; Gearing, 2004; Finlay, 2002; Haverkamp, 2005). As such, it is important to consider my reasons for choosing the topic, including personal experiences and emotions, as well as my existing knowledge of the topic, and how they may influence the research process (Finlay, 2002).

My interest in researching how mental health distress in prison is experienced and supported is grounded in both personal and professional experiences. From having had the opportunity to travel to developing countries for voluntary work experiences from a young age, I have witnessed to a range of lifestyles and individuals. Seeing the potential happiness but also the potential trauma which people's lives can possess brought on a keen interest in me to better understand individual's experiences and work with marginalised populations. This lead to my interest to study psychology, more specifically, child development psychology.

My interest in the topic of mental health support services in prisons specifically developed from a work opportunity, which I did upon completing my undergraduate and master's degrees. Within this role, I supported adolescents who conveyed significant behavioural difficulties alongside mental health distress. Many of the students I worked with had carers who were in and out of prison, and I became aware over time that the recidivism rate amongst these caregivers was high. It was also

apparent that many experienced mental health distress. In witnessing the negative impacts on the wellbeing of the children of having carers with mental health disorders and spending time incarcerated, I became increasingly frustrated, and an interest grew about exploring the use of psychological support within prison settings. I also became increasingly aware that in order to work with children within a psychological role, one has to not only work with the child but also many other aspects of the child's life, such as the environment they have been brought up in as well as their family. This encouraged me to look into doctorates which had a broader focus, leading me to City University. In my application to City University, I identified my wish and plan to carry out prison-focused research within the submitted research proposal.

During my time at City University, I specifically looked into placements which had a focus of working with incarcerated individuals. Fortunately, an opportunity came through at the end of my second year. I decided to take up a trainee counselling psychologist position in a forensic setting during my doctorate. My placement within a forensic psychiatric hospital allowed me to experience and work with mental health distress directly associated to the prison population, as part of a multidisciplinary team. The majority of patients had been transferred from prisons to the hospital under the Mental Health Act, and described their mental health as worsening in prison due to the lack of therapeutic support and provisions available. Whilst I had already begun my research, working with patients with such significant mental health distress further ignited my passion to work with and carry out research with those directly impacted by mental health distress in prison contexts.

Throughout the research process, it was important for me, as the researcher, to participate in the process of personal reflexivity. Supportive and protected contexts such as research supervision sessions, peer discussions as well as conversations with family and friends, were used to ensure reflective practice was maintained. This also ensured that a high quality of professional and ethical practice was sustained throughout. A research journal was also kept for reflective practice purposes, and memo-taking, a common procedure in the grounded theory methodology, was also carried out (Charmaz, 2006; Glaser & Strauss, 1967). As a whole, I found that putting reflexivity into practice was incredibly helpful and beneficial, as it allowed me to become more aware of the process I was going through whilst carrying out this research and during the write-up of my thesis. Whilst personal reflexivity is a very subjective process, I have strived to offer a thorough insight into this process throughout the thesis.

Chapter 2: Methodology

2.1 Introduction

The previous chapter focused on contextualising the research topic as well as rationalising the importance of the topic being investigated, by reviewing existing theoretical and empirical research. Following the literature review, this chapter carefully examines the chosen research paradigm and methodology for this research, and how that impacts the knowledge produced. The chapter continues by reviewing standards to ensure quality of the research and associated ethical considerations.

2.2 Research Question

Keeping in mind the rationale of the chosen topic, this research explores the experience of those living with mental health distress whilst in prison, in order to develop an explanatory theory of this phenomenon. As such, the research question is as follows:

What happens when individuals experience mental health distress in prison?

I spent a lot of time deciding what the question should be and the research question changed throughout this research. Whilst the overarching question remained the same, it was the wording which changed. Initially the research question was, 'How do individuals with mental health concerns feel they were therapeutically supported whilst serving time in prison?', but I felt it did not fully embody the aims, the methodology and findings of the research. I did not feel that the initial research question clearly represented the aim of exploring a social process, with the underlying aim of looking

at whether existing prison policies and protocols effectively address mental health needs. Whilst I was initially worried about the impact of altering the research question, I felt a feeling of relief when I became aware that this is a common occurrence within qualitative research, and more specifically, within grounded theory research (Willig, 2013).

2.3 Research Paradigms

A research paradigm identifies the underpinning researcher's assumptions of the nature of knowledge and acquisition of knowledge, and it establishes the context of the methodology and methods used for the study (Ponterotto, 2005). It fundamentally works as a viewpoint through which the research is approached, and consists of the philosophical anchors of epistemology, ontology and methodology (Ward, Hoare & Gott, 2015; Ponterotto, 2005). Epistemology depicts the researcher's position on how knowledge is gathered, and identifies the relationship between the researcher and study participants (Ponterotto, 2005). Ontology refers to the ways in which the researcher believes meaningful realities are constructed (Redman-MacLaren & Mills, 2015; Ponterotto, 2005). Finally, the methodology defines the process and strategies used to carry out the research (Ponterotto, 2005). The methodology tends to be guided by the epistemology and ontology.

A range of paradigmatic schemes exist, such as positivism, critical realism, post-positivism, constructionism, amongst others. It took some time and a lot of reflection for me to identify my philosophical beliefs. Once I was able to do this, I was able to establish which methodology felt most suitable in relation to my philosophical underpinnings as well as my research aims. The following section will identify the

research paradigm and associated philosophical underpinnings for this specific study. Following this, I identify and describe the chosen methodology.

2.3.1 Identifying the Research Paradigm for this Study

Grounded theory is a methodology which focuses on building an explanatory theory of a social process which is grounded in the research data (Glaser & Strauss, 1967; Willig, 2008; Urquhart, 2013; Hense & McFerran, 2016; Starks & Brown-Trinidad, 2007). It can be used with a broad range of epistemological underpinnings, depending on the type of grounded theory methodology used. For this research, a constructivist and critical-realist theoretical framework was used to explore the research question, which works in harmony with the methodology chosen.

The constructivist and critical realist positions were established more recently within the grounded theory methodology, though they are becoming increasingly used (Charmaz, 2017a; Roberts, 2014; Collier, 1994; Glaser & Strauss, 1967; Charmaz, 2006; Charmaz, 2014). The constructivist epistemological stance argues that the data found is highly dependent on the language used, is co-constructed with participants, and is embedded in relations as well as the social, cultural, historical, and situational circumstances of its creation (Charmaz, 2017a; Willig & Stainton-Rogers, 2017). Whilst the other variants of grounded theory emphasise researcher objectivity, the constructivist approach argues that it is impossible for the researcher to take a fully objective stance (Charmaz, 2017a; Bryant, 2017; Henwood & Pidgeon, 2003). As such, the constructivist approach accepts that the researcher influences the knowledge produced from the data collection and analysis process (Willig, 2008; Willig

& Stainton-Rogers, 2017; Charmaz, 2017a; Hense & McFerran, 2016; Charmaz, 2006).

I strongly agree with the idea that the researcher influences the knowledge gathered and that subjectivity plays a vital role, and I felt it was necessary to vocalise this through my epistemological position. My view on the researchers influence relates to the insider/outsider debate, which discusses 'the degree to which a researcher is located' within the research (Gair, 2012, pg. 137). As I have no direct experience of being incarcerated and as the focus of my research was to bring the participant's voices to the forefront, I am clearly researching the topic from the perspective of an outsider. However, I cannot deny that my experiences of working within forensic settings, as well as my beliefs, could have had an impact on the research, as I do have an emotional attachment to this topic. Due to this, there may have been moments where I shifted closer to the insider position (Gair, 2021; Dwyer & Buckle, 2009). For example, my preconceptions may mean that I placed emphasis on particular questions or responses in the interviews. There were also times when I felt closer to their experiences due to the emotional content in their responses. As such, it was important that throughout the research, I remained conscious of the influence I could have and thus take steps to bracket my personal feelings as much as possible (Berger, 2015).

The critical realist ontology works alongside the constructivist epistemology, as it uses aspects of the constructivist position, however it is important to note that critical realism also leans towards a positivist position (Fletcher, 2017). Critical realism argues that there can be different realities, however that our individual realities are partially based on our experiences, beliefs, expectations (Roberts, 2014; Collier, 1994). It argues that

realities are personally constructed, and that they can change over time as experiences, beliefs and expectations change (Roberts, 2014; Collier, 1994). This ontology identifies reality as being multi-layered, interactive and subjective, suggesting that knowledge is imperfect and tentative (Fletcher, 2017; Oliver, 2012). Critical realism is not aligned with a specific methodology, in fact, it can be used for a range of methodologies, including constructivist grounded theory (Fletcher, 2017; Oliver, 2012).

The constructivist epistemology and critical realist ontology strongly resonated with me. Taking a constructivist and critical realist approach, there was assumption throughout the data collection and analysis processes that experiences provided by participants are accurate, however that our perceptions of reality depends partially on our personal views and expectations (Willig, 2013; Bunge, 1993). Taking such a stance, there is also a specific focus in the analysis on the meaning of language of produced data (Willig, 2008; Willig, 2013). Findings were perceived from these philosophies only, and it is important to note that other philosophical frameworks could potentially construct an alternative theory (Charmaz, 2017b).

The research paradigm identified above is in line with the researcher's key aims of the study, which are to explain a social process, reflect on current prison mental health support procedures and encourage policy change. It is also in agreement with the other main objective of this research, which is to provide an opportunity to marginalised individuals to voice their experiences (Redman-MacLaren & Mills, 2015; Fletcher, 2017; Roberts, 2014).

2.4 Research Design Rationales

2.4.1 Rationale for Choosing Qualitative Methodology

Reviewing the existing literature, it was observed that the majority are based on quantitative studies. Whilst this type of research offers valuable information, it lacks the opportunity of gaining an in-depth understanding of the subjective meanings of experience (Willig & Stainton-Rogers, 2017). This was a key deciding factor when reflecting on whether to carry out a quantitative or qualitative research piece. Another central factor was that rather than testing a hypothesis, I wished to carry out exploratory research around the chosen topic, which is in line with the purpose of qualitative methodologies.

Finally, as the chosen research topic is sensitive and the population associated with the topic is an overlooked group, I felt it was incredibly important to use a method which does not marginalise or generalise individuals' experiences. Qualitative methodologies offer the ability of taking a person-centred approach towards data collection, which I felt could be incredibly valuable when speaking to individuals about their experiences (Sandvik & McCormack, 2018). The person-centred approach, within psychological work, refers to a therapists way of being when with his or her clients (Wilkins, 2003; Rogers, 1980). The framework emphasises that one should be respectful, empathetic, non-judgemental and open towards the experiences of clients, and views the client as the expert of their experiences (Wilkins, 2003; Rogers, 1980; Mearns, Thorne & McLeod, 2013; Rogers, 1963; Sandvik & McCormack, 2018; Jacobs, van Lieshout, Borgg & Ness, 2017). It also emphasises the importance of

having a positive relationship with the client and the ability to bracket pre-conceived views (Wilkins, 2003; Rogers, 1980).

Whilst there is substantial evidence for the effectiveness of person-centred therapy in treating different types of mental health distress, it does have its limitations (Stiles, Barkham, Mellor-Clark & Connell, 2008). Some see the approach as too simplistic and idealistic, as it sees all individuals of being able to reach their full potential, solely focuses on the client's subjective present and does not acknowledge feelings of transference (Kress, Seligman & Reichenberg, 2021; Wilkins, 2003; Brown, 2015). Other critiques of the person-centred approach are that it does not follow an explicit structure, is not goal oriented, and does not use specific techniques which work towards creating change (Kress, Seligman & Reichenberg, 2021; Moon, 2007; Brown, 2015). It can also be said that too strong of an emphasis is placed on the therapists ability to 'be' and bracket all preconceptions, which requires comprehensive understanding of the person-centred concepts in order to be successful (Wilkins, 2003).

I feel that these principles can be said to be powerfully relevant as well for researchers and their interaction with participants. As highlighted by Sandvik and McCormack in their article, the ability to engage with participants in a holistic manner, to be critically reflexive and the ability to focus on having sensitive dialogue with participants is key to researching from this framework (Sandvik & McCormack, 2018). Taking such an approach allows for a deeper exploration to take place of an experience as the researcher remains empathetic, understanding and non-judgemental (Sandvik & McCormack, 2018; Jacobs, van Lieshout, Borgg & Ness, 2017). Taking such an

approach towards research can thus increase the potential for individuals to be more open and detailed when sharing their experiences. This could lead to more meaningful data being collected and the ability to develop a theory which meaningfully responds to the established research question.

2.4.2 Evaluation of Qualitative Methods

Deciding on a methodology for my study proved challenging, as the central purpose was to find one which was appropriate in answering the research question and resonated with my personal values and beliefs (Nagel, Burns, Tilley & Aubin, 2015). Methodologies considered included interpretative phenomenological analysis (IPA) (Willig & Stainton-Rogers, 2017), thematic analysis (Clarke & Braun, 2013) and grounded theory (Glaser & Strauss, 1967). Whilst all of the contemplated methodologies could offer greater insight into the research topic and it can be argued that there are similarities between the three approaches, I decided through a thorough process of reflection that constructivist grounded theory would be most suitable. Prior to detailing the chosen method, I reflect below on the purpose and value of the other two methods considered as well as my reasons for not choosing them.

IPA is an interpretative method which focuses on investigating people's lived experiences of a phenomenon (Willig & Stainton-Rogers, 2017; Smith, Flowers & Larkin, 2009). IPA has become a hugely popular method within qualitative research, which can be accounted for by its core aim, as increasing understanding of subjective lived experiences is a fundamental aspect of psychological research (Willig & Stainton-Rogers, 2017; Smith, Flowers & Larkin, 2009; Miller, Chan & Farmer, 2018). Whilst the methodological focus of IPA is in-line with several of the aims of the current

study, it does not address the aim of exploring current structures and policies. I felt it was important to not solely provide a thorough description of the experiences, but also to delve into the social processes around mental health issues within prison contexts. It was also important for me to review existing structures and encourage changes to take place around current mental health policies. This is a key reason why grounded theory was chosen over IPA. Alongside this, I felt that the philosophical underpinnings of the method do not align with the my personal beliefs. IPA is considered an experiential approach which is underpinned by phenomenology and hermeneutics, which refers to interpreting and finding meaning behind subjective lived experiences (Love, Vetere & Davis, 2020; Roberts, 2013). My personal philosophical views lean significantly more towards constructivism and critical realism (Willig & Stainton-Rogers, 2017; Smith, Flowers & Larkin, 2009; Miller, Chan & Farmer, 2018).

Thematic analysis is another commonly used approach within research (Nowell, Norris, White & Moules, 2017; Braun & Clarke, 2006; Holloway & Todres, 2003; Thorne, 2000). Whilst several variations of thematic analysis exist, all consist of identifying themes and patterns within the collected data (Mills, Durepos & Wiebe, 2010; Braun & Clarke, 2006; Clarke & Braun, 2013). It's a commonly used approach due to its flexible nature, its ability to respond to a range of research topics, as its compatible with many types of data, and as it is not tied to a specific epistemological position (Mills, Durepos & Wiebe, 2010; Nowell, Norris, White & Moules, 2017; Clarke & Braun, 2013). These factors appealed to me, however the debate around whether it can be considered a methodology in its own right concerned me. Whilst some argue thematic analysis is its own methodology, others suggest that it is solely an analytical

method which acts as a foundation for other analysis methods (Nowell, Norris, White & Moules, 2017; Braun & Clarke, 2006; Holloway & Todres, 2003; Thorne, 2000).

The dispute amongst researchers around the quality of thematic analysis also led to feeling apprehension in choosing this method. There appears to be a lack of clear guidance on how to conduct a high-quality thematic analysis in comparison to other approaches (Nowell, Norris, White & Moules, 2017; Braun & Clarke, 2006). This and the inherent flexibility underlying the approach, are argued to potentially lead to inconsistencies and errors within the analysis as well as the established themes (Nowell, Norris, White & Moules, 2017; Holloway & Todres, 2003). The lack of guidelines also leads to researchers being unable to be fully transparent about their analysis process (Nowell, Norris, White & Moules, 2017). I wished to work with a methodology which was clearly structured and for which comprehensive guidelines exist, which I felt thematic analysis was not able to provide.

2.4.3 The Chosen Method – Grounded Theory

Grounded theory is one of the oldest and one of the most common methodologies used within qualitative research (Ratnapalan, 2019; Higginbottom & Lauridsen, 2014; Birks & Mills, 2015). Glaser and Strauss first established grounded theory in the 1960's and it has evolved significantly since it was first developed (Ratnapalan, 2019; Glaser & Strauss, 1967). This is as more grounded theory researchers began disagreeing with Glaser and Strauss's original version, including its emphasis on researcher objectivity (Charmaz, 2017a; Bryant, 2017; Henwood & Pidgeon, 2003).

The method first evolved as Glaser and Strauss developed separate approaches due to their disagreement around the epistemological and ontological underpinnings of the methodology (Higginbottom & Lauridsen, 2014). Whilst Glaser's approach is grounded in critical-realist, post-positivist and objectivist paradigms, Strauss's version leans more towards symbolic interactionism (Higginbottom & Lauridsen, 2014; Hall, Griffiths & McKenna, 2013). As such, Glaser's is closest to the classical approach, and aims to uncover new knowledge in an objective way (Rieger, 2018). Glaser's approach assumes that the researcher is wholly separate from the research (Charmaz, 2000;). Strauss's version offers a more prescriptive approach, founded in the beliefs that realities are understood through social factors and that realities are complex (Rieger, 2018; Charon, 2010).

Glaser and Strauss's distinctive approaches to grounded theory have both been criticised for several reasons. Regarding Glaser's approach, the objectivist stance has been strongly criticised as naïve and that it values the researcher more than the participants (Rieger, 2018). With Strauss's approach, the prescriptive aspect is seen as too rigid and that the format of the approach creates a power imbalance between the researcher and the participants (Rieger, 2018). With the aim of challenging the criticisms of previous versions of grounded theory, constructivist grounded theory was more recently developed by Kathy Charmaz (Charmaz, 2014). Whilst constructivist grounded theory is based on analytic strategies described in Glaser and Strauss's original style, this version is different in the philosophical stance taken (Willig & Stainton-Rogers, 2017; Charmaz, 2017a). It differs in that it acknowledges both the research and participant within the data collection and analysis process (multiple realities) and allows for reflexive practice, thus attempting to minimise the power

imbalances which existed in the previous versions (Rieger, 2018; Charmaz, 2006). The constructivist approach also situates research in the 'historical, social and situational' circumstances in which it was formed (Willig & Stainton-Rogers, 2017; Charmaz, 2017a; Willig, 2008; Hense & McFerran, 2016). For this research, I chose to use an abbreviated version of Charmaz's constructivist grounded theory, with my reasons for doing so explained in detail in section 2.4.5.

Despite the different research paradigms underlining the distinctive versions of grounded theory, the main purpose of the method has remained the same. The aim of grounded theory research is to understand a process and construct a social process, to build an explanatory theory, which is grounded in the data as much as possible (Glaser & Strauss, 1967; Willig, 2008; Urquhart, 2013; Hense & McFerran, 2016; Starks & Brown-Trinidad, 2007). There are also several common features which run through all variations of grounded theory, which largely revolve around the analysis aspect of the method. These consist of coding, theoretical sensitivity, memo-writing, theoretical sampling, saturated theoretical concepts, continuous systematic comparative analysis and theoretical integration (Birks & Mills, 2015; Willig & Stainton-Rogers, 2017; Charmaz, 2006; Charmaz, 2014; Charmaz, 2017a). Collected data is interpreted and categories are created through systematic coding of the data as well as memo-writing of data as well as of relations between categories and the data (Charmaz, 2017a). Grounded theory also uses comparative analysis as the researcher compares 'data with data, data with codes, codes with codes, and codes with categories' (Charmaz, 2017b, pg. 3).

These strategies strengthen the approach as it increases the efficacy of the data collection and focused analyses processes, and allows for in-depth theory development (Willig & Stainton-Rogers, 2017; Glaser & Strauss, 1967; Charmaz, 2006; Gearing, 2004; Rennie, 2000). The credibility of grounded theory lies in the strategies used to collect, code, analyse and present the data found as well as the researcher's ability to bracket personal biases (Glaser & Strauss, 1967; Charmaz, 2006; Gearing, 2004; Rennie, 2000).

2.4.4 Rationale for Choosing Constructivist Grounded Theory

The constructivist grounded theory methodology was chosen with the aim of capturing a current explanatory theory of what happens when individuals experience mental health distress whilst incarcerated. The thorough, systematic yet flexible, and interactive nature of the method as well as the ability to build a credible and genuine theory proved appealing when deciding on the research strategy (Bryant & Charmaz, 2007; Glaser & Strauss, 1967). The constructivist version of grounded theory specifically was also chosen instead of other versions of grounded theory as it acknowledges the role of the researcher within the data collection and analysis processes. Whilst constructivist grounded theory offers clearly identified procedures based on Glaser and Strauss's original method, it allows for researcher flexibility and creativity (Willig & Stainton-Rogers, 2017). The objectivist nature of previous forms of grounded theory did not resonate with my epistemological framework and I felt it would constrict my ability to freely interact with the emerging concepts. Constructivist grounded theory goes significantly further than earlier versions by encouraging the researcher to critically reflect on their assumptions and preconceptions in daily life, the role of the researcher, and how these impact the research process (Charmaz, 2017a).

Charmaz describes continuous personal reflexivity as “methodological self-consciousness”, which is considered as being able to enrich the quality of critical enquiry (Charmaz, 2017b; Charmaz, 2017c). Qualitative critical inquiry refers to research which explores and confronts issues around justice and injustice (Charmaz, 2017c). A significant amount of critical inquiry research focuses on injustices and inequalities faced by minority and disadvantaged populations. I believe that my research falls into the description of critical inquiry based on the research topic and sample population. Being able to better understand and construct a meaningful theory based on constructivist grounded theory can be used to consider ways of improving therapeutic intervention structures and practices within prison, to better support prisoners with mental health distress. Another deciding factor was that grounded theory is known as an effective research approach for topics for which there is little existing research (Payne, 2016). Whilst substantial quantitative research exists on the chosen topic, there is not a lot of available qualitative research, leading me to recognise that grounded theory would be a suitable approach.

Whilst no methodology fully aligns with my research paradigm, I felt that constructivist grounded theory was most in-line with my epistemological and ontological views and most suitable to answer the established research question. It is important to note that the current study uses an abbreviated version of the constructivist grounded theory methodology, which will be elaborated on in the following section.

2.4.5 Rationale for Choosing Abbreviated Constructivist Grounded Theory

Although my original aim was to carry out the full grounded theory method, I eventually decided to use an abbreviated form of the method. The full version consists of multiple series of data collection and analysis, as an initial semi-structured interview is carried out with a small group of participants, transcribed and analysed to establish concepts and categories (Willig & Stainton-Rogers, 2017; Charmaz, 2006). The analysis of the first interview guides the construction of questions for the following interview with a new group of participants (Glaser & Strauss, 1967; Willig, 2013). As part of this cycle, comparative analysis between data and the theory occurs, which is evolving from the data (Bryant & Charmaz, 2007; Hense & McFerran, 2016; Glaser & Strauss, 1967). This sequence continues until a credible and saturated theory can be formed (Glaser & Strauss, 1967; Bryant & Charmaz, 2007; Galletta, 2013; Charmaz, 2006).

In the current study, one cycle of data collection and analysis was carried out. This was as the research consisted of a relatively small sample population due to it being a hard to reach population and as recruitment took a very long time. Although my aim was to have more participants, I eventually had to make the tough call on how to move forward in terms of the methodology, and decided that enough rich data had been gathered, allowing for an abbreviated grounded theory methodology. Due to the small sample, it was not feasible to carry out multiple interview schedules. Key aspects of the analysis process such as initial coding, focused coding, memo-writing, continuous comparative analysis, theoretical sensitivity, theoretical integration and continuous reflexive practice were still utilised as to not deviate too far from the methodology (Birks & Mills, 2015; Willig & Stainton-Rogers, 2017; Charmaz, 2006; Charmaz, 2014; Charmaz, 2017a; Willig, 2013). As the focus of the method strongly relies on the

analysis strategies taken, I did not feel I was compromising the quality of the study significantly by only carrying out one interview cycle, although I did take into consideration that this decision may limit the ability to develop a fully saturated theory or conceptual sufficiency (Willig, 2013). Whilst deciding on using an abbreviated version should not be the first option, more researchers are choosing this option, generally due to time-constraints (Willig, 2013). For me, choosing the condensed version of the method was due to having a smaller sample population as well as time constraints, which is associated to the length it took to go through the ethical approval process and challenges in recruiting suitable participants.

A key deciding factor was the duration it took to gain ethical approval for this research, which took approximately a year and a half. I faced many challenges during the ethical approval process which meant that I started recruiting participants significantly later than originally planned. Alongside this, due to the specific participant criteria established, I felt it could take a significant length of time to recruit participants, and it did. Considering these factors, I decided to move forward with my research using the abbreviated version of constructivist grounded theory.

2.5 Quality Control

Qualitative research is often criticised in comparison to quantitative research, as some question the validity, reliability and credibility of involved methodologies (Tracy, 2013; Willig & Stainton-Rogers, 2017; Trafimow, 2014; Hammersley & Traianou, 2012). Grounded theory methodology critiques generally refer to the sample sizes used, data collection and analysis tools, as well as researcher bias (Clarke, 2007). In order to

challenge the criticisms around the chosen methodology and to ensure that a respectable qualitative study was conducted, several guidelines were followed.

Henwood and Pidgeon's guidance of essential characteristics for good qualitative research were followed throughout the research process alongside Yardley's criteria for quality control (Henwood & Pidgeon, 2003; Yardley, 2000). The guidance suggests that established categories and codes should appropriately fit the data, links between different aspects of the analysis should be meaningful 'at all levels of abstraction' and that the position of the researcher's position should be reflexively conveyed throughout (Willig, 2013; Henwood & Pidgeon, 2003). There should also be documentation of the research process, a genuine 'sensitivity to negotiated realities', transferability of the findings and the researcher should be constantly reflecting on the emerging theory (Willig, 2013; Henwood & Pidgeon, 2003). Additionally, Yardley's first standard refers to the researchers role of remaining sensitive to context of forthcoming data and the relationship between the researcher and the participants (Yardley, 2000). The researchers commitment to being transparent, coherent and be rigorous within the data collection, analysis and reporting of the research findings is also essential. Finally, the realistic impact and value of the research objectives and findings also reflects the quality of a qualitative research piece (Yardley, 2000). Throughout the thesis, and especially within the analysis and findings chapter, I aim to offer a transparent account of the analysis process by writing in the first person, including memos from different stages of the research process as well as by providing participant quotes.

Regarding the ability to maintain a high level of research quality, I felt it was also important for a relational ethical perspective to be taken in carrying out qualitative research. When taking such a perspective, it is encouraged for the researcher to consider the relationship of the researcher with the research and the researcher's reflexive capability (McLeod, 2015; Carroll & Shaw, 2012). It is also fundamental to reflect on the researchers ability to approach a supervisor and colleagues for support, as well as the ability to consider research participants as co-participants (McLeod, 2015; Carroll & Shaw, 2012). Throughout the research process, I consistently took part in reflective discussions with my supervisors and colleagues, and I also kept a research journal, ensuring that I remained aware and reflective of my own processes.

Through this reflective process, I became aware that there was the potential for me, as the researcher, to become psychologically and emotionally affected by the research process. I specifically found the combination of training to be a counselling psychologist, whilst also carrying out a thesis based on specific research dynamics to be challenging to balance (Seider, Davis & Gardner, 2007; Thompson & Russo, 2012). For instance, there were times during the interviews when I felt that participants expressed therapeutic expectations of me, as they were aware that I was taking part in a doctoral level psychology course. Despite the temptation to take on a therapist role, it is the responsibility of the researcher to remain boundaried and to maintain a researcher role. Whilst there is significant overlap in the role of a researcher and therapist, there are also significant differences which must be adhered to ensure the focus of the research is maintained and to minimise risk of harm to the researcher and participants (Thompson & Russo, 2012). Furthermore, there is the possibility for the researcher to become emotionally and psychologically drained by the data collection

and analysis process (Wu & Beaunae, 2014; Nagel, Burns, Tilley & Aubin, 2015). I certainly found this to be the case in the analysis process and took precautionary measures to ensure it did not take its toll on me. I sought out support systems such as continuous reflective practice, supervisory sessions, as well as friends and family, to maintain my wellbeing, avoid harm to the research and participants, and ultimately, to uphold high research and professional practice standards.

In implementing strategies for ensuring high quality research, the present research aimed to maintain standards outlined within British Psychological Society (BPS) professional practice and research guidelines, as well as HCPC fitness to practice guidelines (BPS, 2014; BPS, 2009; BPS, 2017; HCPC, 2016). As such, throughout the duration of the research process, I ensured to communicate with participants in a way that felt appropriate and effective (HCPC, 2016; Thompson & Russo, 2012). I also focused on maintaining respect of confidentiality measures, manage and report any risk factors and associated to safety concerns, be candid and reliable, and ensure thorough records were kept of researcher contact (HCPC, 2016; Thompson & Russo, 2012). As a whole, I believe that I worked in accordance with the BPS principles of respect, competence, responsibility and integrity (BPS, 2009; BPS, 2017).

2.6 Ethical Considerations

Prior to carrying out this research, ethical approval needed to be granted from the City University Psychology Department Research Ethics Committee. During this process, it was decided that for this research to be approved, considerable amounts of safety and control measures had to be established, to ensure the safety of both the researcher and participants. Considering the sensitivity of the topic and the

vulnerability of the sample population, there was potential for exposure to negative effects and psychological distress as participants were asked to relive memories which may be deemed as traumatising. Additionally, there were also potential risks associated to the researcher due to having face-to-face contact with individuals with criminal backgrounds. As such, factors such as professional competence and conduct, legal obligations relating to informed consent, confidentiality and risk, as well as the role of the researcher in relation to these issues, all had to be considered (BPS, 2017; BPS, 2009; BPS, 2014; HCPC, 2016; Thompson & Russo, 2012).

I found the ethical approval process to be very arduous. Whilst not wishing to underestimate the potential risks associated to this research, at times I felt that the ethics committee did not fully appreciate the value of the research topic and inadvertently were limiting the ability for this research to be carried out. Gaining ethical approval took a long time, and consisted of several amendments being made before it was approved (Appendix A and B). This meant that despite my wish to complete the research within the time-frame of the doctorate (3 years), I had to extend my studies to be able to carry out the research. Whilst I initially felt a sense of frustration by the longevity of the requirements of the ethical approval process, my passion for wanting to research this particular topic motivated me to persevere and extend my study period. With time, I became grateful for what I learned from the process, as the experience provided me with a greater insight into challenges faced by individuals wishing to carry out this type of research.

Further amendments had to be made to the research whilst I was in the process of recruiting and interviewing participants. As I found it challenging to find suitable

participants for this research, additional organisations were recruited over time to support the participant recruitment process. The interviewing strategies were also altered due to the impact of the COVID-19 pandemic. These amendments were approved and I was fortunately able to continue conducting my research. Please see Appendices C to H for the additional ethics amendment forms and approval confirmations.

Details of ethical considerations are further elaborated on within the Methods chapter.

Chapter 3: Method

3.1 Introduction

The previous chapter outlined the methodology and the associated research paradigms for the current study, whilst this chapter outlines the research procedures and strategies undertaken. As detailed in the Methodology Chapter, a shortened version of Constructivist Grounded Theory was used for the data collection and analysis. As such, one cycle of interviews was carried out and a range of grounded theory focused analytic strategies were used to establish an emerging theory.

The chapter begins by offering a detailed summary of the participants, including how they were recruited. I then describe how the data was collected, and follow on by discussing the analytical strategies used. Throughout the chapter, I also report how ethical factors were addressed, including working with informed consent. I believe that outlining the research methods in a detailed manner reflects researcher transparency and displays the ways in which the aims of the study were achieved with high standards.

3.2 Participants

3.2.1 Inclusion and Exclusion Criteria

The ethics approval process highlighted that there was significant potential risk to me as the researcher since the sample population consists of individuals who had previously committed criminal acts. There was also concern around the wellbeing of participants due to the sensitive nature of the topic. On account of the concerns raised,

discussions took place with my supervisor in the early stages of the research regarding the boundaries needed to ensure risk remained as low as possible at all times. Strict inclusion and exclusion criteria were therefore developed. During the process of establishing these criteria, several aspects were thoroughly reflected on, such as:

- The feasibility of accessing individuals currently serving a sentence versus those with previous convictions.
- Whether it is appropriate to include both male and female participants.
- The types of crimes that are considered appropriate for this study as well as the types of non-violent crimes to consider.
- Suitable sentence lengths to include, based on the types of crimes decided on
- Which mental health concerns to focus on.

An adult population who have previously spent time incarcerated prior were chosen for the current study. No specific requirement was identified regarding the gender of participants, so that both male and female individuals could contribute to the research. A key deciding factor for choosing to recruit individuals with prior prison time was as it would have been incredibly challenging to gain ethical approval to recruit within prisons. Participants needed to be incarcerated for a minimum of six months to ensure participants had a deep enough insight into the prison system, to a maximum of two years, as this is usually the time frame given for less violent offenses. To ensure that those with violence-based offenses could be excluded from the research, participants were requested to briefly share the nature of their offense. A time limit of five years since release from prison was also decided. This was to ensure that data provided by participants and thus the findings of this research can be considered as current. A time

limit of release was also decided as studies of memory have evidenced that the quality of memories rapidly decays over time (Hardt, Nader & Nadel, 2013; Wheeler, 2000).

Participants involved in the study were required to have experience of symptoms relating to a mental health concern, as this was the phenomenon being studied. The mental health concerns I aimed to cover in the present study, based on the NICE guidelines descriptions of more commonly experienced mental health concerns, included depression, anxiety, panic, post-traumatic stress disorder and obsessive-compulsive disorder (NICE, 2011). There was not a specific requirement for when their mental health symptoms were experienced. Participants were taken at their word in relation to their symptoms as I was not concerned with whether or not they had received a mental health diagnosis, but rather their self-report of having experienced such concerns, as is consistent with my paradigm. Whilst individuals were not asked to provide proof of their of mental health distress, they were asked several questions. These consisted of questions such as when they first began experiencing symptoms, if symptoms are still ongoing and whether they have any mental health diagnoses. This was done to get a better understanding of their experiences as well as the demographics of participants involved. Finally, due to the method chosen, participants had to be willing for their interviews to be audio-recorded.

Potential participants were screened prior to interviews taking place, by me, to ensure that those participating in the study fit the inclusion criteria. If individuals did not meet any of the inclusion criteria, they were not able to participate and were sensitively informed of this. As only one interview cycle was carried out, the inclusion and exclusion criteria did not change during the data collection process.

3.2.2 Demographic Characteristics

Only a small amount of detail regarding demographic characteristics were taken to guarantee full anonymity and confidentiality of those involved in the research. Generally speaking, demographic characteristics relate to aspects such as race, age, gender, and ethnicity, however, the demographic characteristics described below largely relate to the inclusion criteria set. In hindsight, I feel I could have gathered more demographic details without compromising the anonymity of the participants, and believe that this could have been helpful in contextualising the research findings.

I recruited five adult males for this study based on the inclusion standards, and all individuals were accessing support services, such as drug and alcohol recovery services and homelessness services, located in London. Coincidentally, all of the participants were recruited from the drug and alcohol recovery service. Whilst the inclusion criteria did not specify gender, solely male individuals took part in the research, as the drug and alcohol service was solely for males. The age range of participants varied between thirty and fifty-five years of age.

Interestingly, when asked whether their offense was violence or non-violence based, the majority of the participants were willing to share the exact crime they were convicted of, their exact sentence length and which prison they served their time in. The offenses ranged from theft, drug-dealing, commercial burglary to fraud, which were all considered to be non-violent crimes. The sentence lengths also varied, with one having spent just over six months in prison, others around one year and several just under the two year mark. A variety of prisons were mentioned and these consisted of ones throughout England, not only London. Additionally, whilst the majority of

sentences were served within one prison, one participant mentioned having been moved to different prisons throughout his sentence due to his conviction.

Regarding the experiences of mental health symptoms, anxiety appeared to be the most commonly experienced, followed by depression and post-traumatic stress disorder, and many expressed experiencing more than one at a time. One of the participants also shared experiences of symptoms associated to panic, whilst none expressed feeling symptoms associated to obsessive-compulsive disorder. Many also revealed having a professional diagnosis in relation to their symptoms. Whilst psychosis is globally evidenced to be a common concern amongst the prison population, only one participant expressed having a diagnosis (Chowdhury et al., 2019; Igoumenou et al., 2019; Huddy, Roberts, Jarrett & Valmaggia, 2016). The time of onset of their mental health symptoms varied. Whilst the majority expressed experiencing mental health symptoms prior to entering prison, one shared they felt their distress manifested for the first time in prison. Another individual expressed that his symptoms began upon release from prison. All of the individuals disclosed that they periodically still experience symptoms of mental health distress but that they are less distressing. Below, I offer a table which presents the obtained demographic details of the participants who took part in the study.

	Gender	Age	Ethnicity	Skin Colour
P1	M	Early 30's	British	Black
P2	M	Late 40's	Irish	White
P3	M	Early 50's	British	White
P4	M	Mid 40's	British	Black
P5	M	Early 50's	British	White

Please see Appendix I for a chart outlining the demographic information.

3.2.3 The Recruitment Process

The recruitment process for this research consisted of two stages. The first stage involved reaching out to therapy-based organisations that support previously incarcerated individuals through their services. I contacted several organisations and initially one organisation agreed to support the recruitment process, offering to advertise the research in two of their hubs. Due to a lack of participants coming forward through the already established recruitment organisations, I eventually decided to research demographic statistics associated to ex-offenders. This led to contacting drug and alcohol recovery services, training and development services, as well as homelessness organisations. Whilst initially two services decided to take part, I was eventually able to recruit two additional organisations.

In total, four organisations supported me in recruiting participants for this research. The participating organisations consisted of: a mental health charity, a training and development service, a drug and alcohol recovery service, as well as an organisation which offers homelessness and recovery support. The service managers were

provided with the study advertisement and participant information sheet, to display in communal areas or share with service users (Appendix J, K, L and M). Three participant information sheets were created during the participant recruitment process, as more organisations became involved over time, and due to the need to alter interview procedures during the COVID-19 pandemic. Solely the drug and alcohol recovery service participated in the recruitment process for the remote version of the study, though no additional participants came forward with interest to participate.

The second stage refers to the recruitment of participants. Interested individuals were able to get in touch via the contact information provided on the study advertisement and participant information sheet. I am aware that several factors may have played a role in whether someone conveyed their interest. For instance, participants may have chosen to take part in order to please staff members at the organisations from which they were recruited. Additionally, a discouraging factor could have been that staff had knowledge of their participation, especially when directly contacted or when interviews took place at the service that they accessed. Steps were taken to minimise these types of biases. For instance, staff were not informed of individuals' decisions to take part or whether they met the inclusion criteria. Specific participant details, such as their names and the organisation's names have also purposefully not been shared within this thesis to ensure anonymity.

Once individual's got in touch, we collaboratively set a date and time for them to participate in a screening interview. The screening interview allowed me to verify that all participating individuals met the requirements set in the inclusion criteria (Appendix N). The individuals who did not meet the criteria were informed of this and thanked for

their time, whilst those who met the inclusion criteria were then invited to attend the research interview.

Overall, it was incredibly challenging to recruit participants for this research. Gaining ethical approval from the university due to the risk associated to the research was difficult. I also became aware that it is a very hard to reach population as organisations working with previously incarcerated individuals often feel they do not have the resources to assist with this type of research. Alongside this, many of those who have been imprisoned do not feel comfortable sharing their history or experience.

Recruitment was completed once it was confirmed that five suitable individuals were taking part. Whilst the final sample size is smaller than I had originally aimed for, I decided to stop recruitment after I had confirmed five participants, as the recruitment process had been ongoing for a significant period of time and I felt that I had gathered in-depth data. Another reason was that it is a hard to reach population and I felt that I had exhausted all potential avenues for additional recruitment.

3.2.4 Sampling Strategy

Qualitative sampling consists of a range of strategies which correspond with the objectives of the research and the overall aim of reaching theoretical depth (Abrams, 2010; Curtis, Gesler, Smith & Washburn, 2000). The sampling strategy was also decided based on the characteristics deemed appropriate to the inquiry at hand (Conlon, Timonen, Elliott-O'Dare, O'Keeffe & Foley, 2020). Generally, grounded theory is associated with theoretical sampling, as participant recruitment is dictated by forthcoming categories through the data analysis (Conlon, Timonen, Elliott-O'Dare,

O'Keeffe & Foley, 2020). As I carried out an abbreviated version of grounded theory and only once cycle of interviews and analysis was carried out, theoretical sampling was not deemed appropriate. Instead, purposive sampling was used for this study, to collect data which appropriately responded to the research question (Etikan, Musa & Alkassim, 2016). Participants were recruited on the basis of their experience of the phenomenon being studied and thus their ability to respond in detail to the interview questions (Etikan, Musa & Alkassim, 2016; Willig, 2013; Starks & Brown-Trinidad, 2007; Charmaz, 2014). This type of sampling method is commonly used within qualitative research and is in-line with the constructivist grounded theory methodology, when using the condensed version (Charmaz, 2006; Charmaz, 2014).

Within qualitative methods, theoretical depth is argued to be more feasible when including a smaller sample population, and with purposive sampling, a set number of participants is not needed (Etikan, Musa & Alkassim, 2016; Abrams, 2010; Curtis, Gesler, Smith & Washburn, 2000; Clearly, Horsfall & Hayter, 2014). This research consists of a smaller number of participants and thus the interviews were able to be analysed intensively, suggesting that theoretical depth was more likely. Still, an important factor to consider regarding this sampling method and sample size is that although the findings of this research can offer a meaningful insight into the phenomenon studied, they cannot be considered as representative of anyone outside of the sample population (Sharma, 2017).

3.3 Data Collection

3.3.1 Consent

The main goals of gathering informed consent is to secure individuals right of autonomy as well as their right to be protected from any harm (Rosenfeld, 2002; Jefford & Moore, 2008). As such, it is the researchers' responsibility to ensure that any potential participants are fully informed of the purpose of the study and their role when participating (Rosenfeld, 2002). Additionally, the researcher should share potential risks and benefits of taking part, the voluntary nature of their participation as well as the boundaries of confidentiality (Rosenfeld, 2002). Researchers must also consider an individual's cognitive competency to make an informed decision (Rosenfeld, 2002; Jefford & Moore, 2008). Gathering informed consent from all individuals ensured that I carried out research which upheld the legal ethical conduct standards as well as ethical principles outlined by the BPS and HCPC (BPS, 2014; BPS, 2017; BPS, 2009; HCPC, 2016).

Written informed consent was gathered from all of the participants prior to interviews taking place (Appendix O). For the face-to-face interviews, participants were given the option of reading the briefing and consent form themselves or to read through them together. Prior to the consent forms being signed, participants were sensitively asked whether they understood the different aspects of the forms and whether they had any questions or concerns. The voluntary nature of their participation and their right to withdraw from the study was also emphasised. Participants were then asked to sign two identical copies of the consent form, of which one was for the participant to keep.

The other copy was scanned and stored digitally on the City University One-drive, with the hard copies securely destroyed using official university procedures.

For the remote interviews, a system was set up to allow consent forms to be emailed by the researcher to participants after the screening interview was completed, using the email account created solely for the purpose of the research. Consent forms were then to be signed and emailed by the participants to the researcher prior to the interview. The completed consent forms were then to be deleted from the email account once they were scanned onto the City University One-drive. Whilst this was set-up with the intent of carrying out remote interviews, no additional individuals came forth, and so, this procedure was ultimately not used.

These procedures were established and carried out ensure that all participating individuals were fully aware of the aims of the research and what was expected from their involvement (BPS, 2017; BPS, 2014; BPS, 2009). The measures regarding their information were taken to ensure any identifying information of participants was kept securely, in line with BPS guidelines, university guidelines as well as the 2018 Data Protection Act (UK Parliament, 2018; BPS, 2017; BPS, 2014).

3.3.2 Interviews

Semi-structured interviews were carried out on a one-to-one basis with individuals who directly experienced the phenomenon being studied, ensuring the data collection and analysis was based on a primary data source (Payne, 2007). Whilst there is some debate around the use of semi-structured interviews, they are considered to be strongly compatible with qualitative research and the constructivist grounded theory

methodology (Potter & Hepburn, 2005). This is as they allow for the potential emergence of new material and more detailed insight, through the analytical focus on language to describe experiences (Potter & Hepburn, 2005). As outlined in the previous chapter, I believe that the ability to use a person-centred approach in interviews with participants also further enhances the depth and quality of data gathered through this type of data collection method.

The interview questions were established using Willig's interview-development guidelines (Willig, 2013). Willig argues that good-quality interviews are based on the researcher's ability to remain focused on the overarching research question whilst allowing space for participants to share their experiences (Willig, 2013). The interview schedule thus consisted of several pre-set questions but was not fully structured, to allow participants to disclose information they felt was important and relevant (Appendix P). Questions were designed to be open-ended and the interview agenda was structured to begin with broader questions and lead to more focused questions, as advised by Willig's guidelines (Willig, 2013).

Marks and Yardley's guidance on eliciting rich data were used within interviews (Marks & Yardley, 2004). Marks and Yardley argue that rich data comes from the researcher's ability to be a good listener, compassionate and unbiased (Marks & Yardley, 2004). The guideline also stressed the importance of allowing space for the research participants to explore their feelings around the experiences they share (Marks & Yardley, 2004). Alongside this guidance, alongside Willig's guidelines on semi-structured interviewing with participants was considered (Willig, 2013). Willig claims that researchers should adapt their interview style based on the preferences of the

interviewees and build a positive rapport with the participating individuals, which I strived to do in each interview (Willig, 2013). Willig also emphasises the importance for the researcher to reflect on the impact of the dynamic between the interviewer and interviewee. As such, the researcher should reflect on the meaning of responses as well as the interactions by being considerate of intonation and non-verbal ways of communicating (Willig, 2013).

Considering the sensitive nature of the research topic, it was highly important that I, as the researcher, upheld all of these qualities as well as maintained a continuous reflexive stance when carrying out interviews. I am aware that I had the ability to influence interview questions and participant responses through verbal and nonverbal ways of communication. Alongside this, as participants were aware of my position as a doctoral student and researcher, I acknowledged the different ways I could come across to the participants within our relationship. Thus, it was essential that I bracketed my personal views and pre-existing knowledge as much as possible throughout, to ensure the interview process was carried out from and open and non-biased stance (Payne, 2007; Engward & Davis, 2015). Supervisory discussions and journaling strongly supported me with this. I also strived to provide a comfortable and relaxed environment for participants, through my verbal and non-verbal communicative methods. I feel that taking a person-centred approach to carrying out interviews helped me to achieve this.

The face-to-face interviews took place in a private room to provide a level of discretion and confidentiality, at City University or at the hub of the drug and alcohol recovery service. Interviews were always carried out during staff working hours to offer

additional safety measures for the participant and researcher as well as an additional level of support in case it was needed. The length of interviews ranged between half an hour to ninety minutes. Upon completion of the interview, participants were fully debriefed and offered the opportunity to share any questions or concerns. As part of the debriefing process, individuals were given or emailed a debrief sheet with contact information of mental health support services, as well as an informative leaflet, which offered advice on looking after their personal wellbeing (Appendix Q and R).

3.3.3 Audio Recording and Transcription

Interviews were audio-recorded using an encrypted device, to ensure accurate verbatim transcription was able to take place. The recordings were deleted from the device once they had been transferred to an encrypted and password protected folder on my computer. During the transcription process, the interviews were anonymised.

Transcription refers to the process of converting an oral interview to a written version, and is considered to be an interpretative procedure (Kvale, 2007). Whilst transcriptions have their value, many argue that transcriptions generally do not fully encapsulate the density of the oral version, as it cannot detail tone, intonation, disfluencies, and do not detail the body language displayed during the conversation (Kvale, 2007; Collins, Leonard-Clarke & O'Mahoney, 2019; Maclean, Meyer & Estable, 2004). Alongside this, many describe the transcription process as challenging, as it is time-consuming, strenuous and potentially emotionally exhausting (Sutton & Austin, 2015). All of these factors can negatively impact the quality of the transcripts (Sutton & Austin, 2015).

Whilst there is no specific guidance within grounded theory methodology on the transcription process, there are some steps that can be taken to improve the quality of transcripts. For instance, the researcher is advised to make memos after each interview on emotional content (Maclean, Meyer & Estable, 2004). The researcher is also encouraged to listen to the interviews several times prior to starting the transcription process, and remain aware of confidentiality principles throughout (Maclean, Meyer & Estable, 2004). Additionally, it is advised to use external transcription programmes, such as voice recognition software, especially for those with limited experience of transcribing interviews (Maclean, Meyer & Estable, 2004; Fletcher & Shaw, 2011).

My initial aim was to transcribe the oral interviews myself as I felt it would enhance the analysis process. However, after transcribing the first two interviews, I began to feel overwhelmed by the demanding nature of the process and chose to use a transcription software. I used the dictation programme provided as a free feature on Apple Mac computers, which works by typing out the spoken words through voice-recognition. Using this programme meant that I was able to actively listen to the interviews and make notations on what I felt were important features, such as emotional content, whilst it was being typed out. As the programme is not perfect, I reviewed the transcriptions several times and made amendments as required. Appendix S offers an excerpt of the transcription of the interview completed with one of the participants.

3.4 Analytic Strategy

As mentioned in the previous chapter, the present study uses a condensed version of the constructivist grounded theory method to the data collection and analysis process.

Key features of the constructivist grounded theory analytic strategy were used to ensure the analysis was done in a way which was similar to the full version, such as initial coding, memo-writing, focused coding, continuous comparative analysis and negative case analysis.

3.4.1 Initial Literature Review

The use of literature reviews in the early stages of grounded theory studies have always been fiercely debated (Dunne, 2011; Giles, King & de Lacey, 2013). It is important to emphasise that the debate is not focused on whether an initial literature review should be completed, but rather when it should be done (Dunne, 2011). Many believe that carrying out a literature review prior to carrying out research negates the purpose of the method, as they argue that constructed theories should solely come from the collected data (Dunne, 2011; Giles, King & de Lacey, 2013; McGhee, Marland & Atkinson, 2007; Thornberg, 2012). They claim that researchers should approach the topic with an open, objective and non-biased perspective to ensure that findings are not influenced by the researcher's preconceived views (Dunne, 2011). As the methodology has evolved, researchers have begun to consider the value of carrying out initial literature reviews. Now, many grounded theory researchers argue that completing a literature review can help the researcher rationalise and contextualise the purpose for research being carried out, support in developing theoretical sensitivity, and develop researcher awareness of potential preconceptions (Dunne, 2011; Maijala, Paavilainen & Astedt-Kurki, 2003; McGhee, Marland & Atkinson, 2007; McCann & Clark, 2003).

Constructivist grounded theory acknowledges the role the researcher has within the study and encourages researcher to reflect on how their knowledge and beliefs can impact the research, which is in line with the latter argument. In aiming to respect both perspectives, I decided to complete a brief initial literature review, and a more extensive literature review was done after the analysis stage. Providing an initial brief literature review allowed me to contextualise and rationalise the research topic. Another key reason for completing a brief literature review was as it was a necessary step towards gaining ethical approval from City University.

In carrying out a broader review based on the findings, I was able to link the key aspects of the developed theory to existing research (McGhee, Marland & Atkinson, 2007). In doing so, I was also able to reflect further on how exactly my findings contribute to the existing knowledge base as well as to consider the feasibility of making changes within the prison environment to healthcare and mental health support services. It also allowed me to deliberate potential directions for future research.

3.4.2 Coding

Coding refers to the heuristic process of summarising and categorising the collected data through abstraction, leading to the development of concepts, which in turn supports the process of theory construction (Charmaz, 2014; Bryant, 2017; Charmaz, 2015). Coding allows the researcher to recognise the different processes, actions as well as potential meanings within the data (Charmaz, 2014; Giles, de Lacey & Muir-Cochrane, 2016). There are different types of coding strategies, depending on the version of grounded theory one conducts. When using constructivist grounded theory,

there are two main coding processes, including open coding and focused coding (Charmaz, 2014).

Open coding refers to the first step of the coding process, where provisional codes are developed through line-by-line coding (Charmaz, 2015; Charmaz, 2014). Line-by-line coding allows the researcher to stay closely connected to the interview at hand and encourages the researcher to establish a basis for further analysis (Charmaz, 2015, Charmaz, 2014). Charmaz suggests that open codes should be short, simple, directive, active and analytical (Charmaz, 2015). The process should also be quick intuitive and reflexively done, to ensure that the researcher does not become caught up with pre-determined beliefs (Giles, de Lacey & Muir-Cochrane, 2016). The researcher's goal is to remain open-minded and be guided as much as possible by their observations of the responses provided by participants (Charmaz, 2014). It is also important for the researcher to reflect on the codes captured, the language used, and to be mindful that established codes are from the perspective of the researcher.

Though it was a relatively tedious process, I found line-by-line coding to be a really beneficial analytic strategy, as it ensured that I did not deviate from the data collected. During the initial coding process, I listened to the audio recording of the interview to assist me. This was done to ensure I not only remained closely connected to the data, but also to ensure I was able to capture the emotional content of participant responses. Table 1 provides an example of line-by-line coding of the interview with a participant.

Table 1. An example of line-by-line coding of a participant's interview.

Participant Response	Initial Open Coding
Um, that's a hard one, um, mainly with coming out, getting released and that, um, I	*Release from prison*
needed support with housing and benefits and stuff, and it's all getting stressful when like	*Feeling stressed about release, needing support*
two weeks before you're out and they're telling you someone is going to come and see you	*Getting support/information from staff*
and they don't, and then the day before you get out they just come with a letter for you to	*Discrepancy between what was said and done*
take to the council, and nothing gets done, so.. yeah	*No feeling of support, sense of disappointment (tone)*

Focused coding represents the second key stage of the coding process. The identification of focused codes is guided by the initial codes established, though it is not a linear procedure (Giles, de Lacey & Muir-Cochrane, 2016). The aim of the focused coding process is to develop more conceptual categories, based on the initial codes which appear most often and seem most analytically appropriate (Giles, de Lacey & Muir-Cochrane, 2016; Charmaz, 2014). Continuous comparative analysis supports the process of developing focused codes, as the researcher compares "data with data, data with categories, categories with categories and categories with concepts" (Giles, de Lacey & Muir-Cochrane, 2016, pg. E36; Glaser & Strauss, 1967). This process allows for the identification of differentiations and similarities, leading to the ability to refine categories and develop more abstract concepts (Giles, de Lacey & Muir-Cochrane, 2016; Payne, 2007; Charmaz, 2014; Willig, 2013). Established focused codes are then validated as the researcher works through the interviews once again, to establish incidents where the focused codes appear relevant or not, with the

latter known as negative case analysis (Giles, de Lacey & Muir-Cochrane, 2016; Charmaz, 2014; Willig, 2013).

It is common that some of the initial open codes remain relevant as focused codes, which became evident when I was further analysing the data (Charmaz, 2014). Whilst the majority of the initial codes were reworded or revised to fit more theoretical and conceptual categories, some still felt appropriate to use. Focused coding was tentatively carried out until several main theoretical categories were able to be established, which led to the development of a core category. Please see Appendix T for an example of how focused codes were identified from the initially established line-by-line codes.

3.4.3 Memo-Writing

Memo-writing reflects a key aspect of the analysis and has several functions (Charmaz, 2014; Glaser & Strauss, 1967). Memos refer to spontaneous private conversations the researcher has with herself, and thus documents the researcher's thought process and decision-making in regards to the creation of codes and theoretical categories (Giles, de Lacey & Muir-Cochrane, 2016; Charmaz, 2014; Charmaz, 2015; Montgomery & Bailey, 2007). Memos, much like the constant comparative analysis and negative case analyses processes, guides grounded theory researchers towards the construction of a theory (Charmaz, 2014; Montgomery & Bailey, 2007).

Researchers are encouraged to create memos throughout the research process, and two types of memos exist depending on the stage of the research one is in, including

early memos and advanced memos (Charmaz, 2014). Early memos aim to identify what is happening in the data line-by-line, and highlights possible underlying meanings behind participant responses as well as potential connections between codes through the making of comparisons (Charmaz, 2014; Montgomery & Bailey, 2007). Advanced memos support the researcher in categorising data by detailing how codes have been revised and improved on, and as it allows for the refining of comparisons made (Charmaz, 2014). Memos created early on tend to be more speculative, and they become more analytical as the researcher moves forward in the analysis process (Charmaz, 2014). Memo-writing supports the continuous comparative analysis process as it allows the researcher to explore the data more intently, reflect on any questions the researcher has about the data, and develop potential directions for the development of a core category (Charmaz, 2014; Charmaz, 2015). Memos also help the researcher to amplify their level of abstraction as it as it encourages them to be thoroughly reflexive at all times (Giles, de Lacey & Muir-Cochrane, 2016; Charmaz, 2014).

I found it helpful to keep a memo bank from the beginning of the data collection to the end of the analysis. Memos were first written after each interview to ensure that my initial thoughts as well as emotional content were not forgotten or overlooked at a later stage of the analysis. They were also written throughout the analysis process to account for how codes and categories were created, revised and improved (Giles, de Lacey & Muir-Cochrane, 2016). An example of one of an early memo written during line-by-line coding of the transcript of the interview with a participant can be found in the text box below. Further examples of memos will be provided in the following chapter.

Memo 26/02/2020 – Prison has a negative impact on mental health

I had just asked the participant how he felt he was impacted by the experience of serving time. He responded by reflecting on the dangerous nature of prison and how this impacted his mental health, emotions and behaviour while he was serving time.

"Um, it was dangerous just to go have a shower, just to go and… Just to go out of your cell. If it kicks off and you're in there, it can be dangerous, um, and the impact mentally, it's tough, um, there were times, times I've freaked out, times I've lost control in there and um, I've been down the block and um, frustration takes over, in prison the most simple things become massive things."

When analysing the response, several thoughts are coming to mind, which are associated to the line-by-line codes created:

- Dangerous nature of prison has a negative impact on mental health
- Deteriorating mental health impacts behaviour
- Perceiving and reacting in a way that is out of proportion
- There appears to be an underlying sense of hopelessness, worry and frustration (written response and participant's tone of voice)
- Do PO's tend to respond to behaviour instead of mental health? (put in isolation)

The participant's reflections reminds me of similarities between his response and the experiences shared by other interviewees. It will be important to look through the transcripts to identify cases which fit this early analysis and code as well as where it does not feel relevant, to see whether this early code is appropriate as a focused code and/or theoretical concept.

3.4.4 Conceptual Sufficiency and Theory Development

Theoretical saturation is known as a key aspect of theory development (Aldiabat & Le Navenec, 2018). Theoretical saturation is described as being completed when it is deemed that no new information or patterns can be accounted for within categories, which is relevant to the outcome of the study and in answering the research question (Giles, de Lacey & Muir-Cochrane, 2016; Aldiabat & Le Navenec, 2018; Charmaz,

2014). A significant challenge within grounded theory research is that no explicit strategies exist on how to achieve theoretical saturation (Aldiabat & Le Navenec, 2018; Bowen, 2008; Charmaz, 2014). There is also debate around the feasibility of full theoretical saturation (Nelson, 2017). Many theorists argue that instead of aiming to achieve full data saturation, the researcher can stop the data collection and analysis process once they feel that sufficient conceptual depth has been reached (Nelson, 2017; Charmaz, 2014).

This research focused on achieving conceptual sufficiency rather than theoretical saturation. As such, strategies such as continuous comparative analysis, negative case analysis and memo-writing were carried out until it felt improbable that new categories could be established, and that the developed conceptual categories were considered meaningful and credible (Nelson, 2017).

The following chapter presents the findings of this research. This consists of demonstrating how categories, including main and sub-categories were developed, the relationships between categories, as well as how the categories relate to the established core-category. Through this, I aim to give a detailed account of how an emerging explanatory theory was developed to answer the research question of what happens when individuals experience mental health distress whilst incarcerated.

Chapter 4: Analysis and Findings

4.1 Introduction

In the preceding chapters I provided a brief literature review, described the methodology associated to this research, and identified the methods used for collecting and analysing the data. In this chapter I outline in detail the emerging explanatory theory developed, using the previously identified analytical procedures in response to my research question: “What happens when individuals experience mental health distress in prison?”.

The chapter begins by offering an overview of the findings, followed by a thorough account of the core category, main categories and associated sub-categories. In doing so, I aim to highlight the key findings from this research. At the end of the chapter, I take the time to reflect on the analytical process, including the impact it had on me as the researcher as well as my personal reflection on the findings.

The findings described in this chapter offer a renewed and profound insight into what occurs within prison environments when incarcerated individuals experience mental health distress. By interviewing individuals who have first-hand experience of this phenomenon, I was able to gather meaningful information which addresses a gap within existing literature. The findings emphasise the need for changes to occur and identifies specific areas of focus in regard to change, both in a broader sense within prison environments, as well as specifically within the counselling practice in these contexts.

4.1.1 Notes for Chapter

The findings identified in this chapter are part of an emerging theory, which I identified as conceptually sufficient in answering the research question. The questions asked in the interviews helped me gather in-depth data which allowed me to develop a coherent and meaningful theory. They also identified a structure of the findings in relation to the established core category. It is important to note that the theory offered in this chapter is a tentative and emerging theory.

As a reflection of the research paradigm used for this research, I believe that the findings represent current beliefs and realities that have been co-constructed between myself, the researcher and the research participants. It is important to note that the findings are solely representative of the data gathered through participant interviews as well as my subjective views. Due to the subjective nature of the analysis process, it may be that others researchers could have constructed alternative theories based on the data. Interviewing different individuals, or for example, interviewing an all-female population, also may have resulted in different findings and another theory.

Whilst my aim is to offer a thorough account of the analysis process, the subjective nature of the generation of categories and the emerging theory must be noted. I appreciate that due to the subjective and complex nature of the analysis, it is not feasible for me to offer a fully transparent account of my process of arriving at the emerging theory. In striving to offer a comprehensive description of the analysis process, I have taken several steps. Quotations (full or in part) from participant responses are used throughout to offer supportive evidence of the categories, which

are highlighted by italics. They are also identified by a pseudonym (e.g. Daniel). Some examples of memos and reflective notes are also provided.

In carrying out the analysis, my aim was to create categories that were grounded in the participants' experiences and realities. However, as the participants' experiences of mental health distress whilst incarcerated were very personal, I found it difficult to identify categories which encompassed all aspects of each of their experiences. While most of the initial codes are accounted for within the focused codes, there were extensive amounts of codes generated through the line-by-line coding process. As such, some initial codes did not conceptualise into focused codes. Negative case analysis and continuous comparative analysis strategies supported me in identifying focused codes and the main categories, leading to the identification of the core theory.

The categories outlined below are the ones which were able to be saturated as much as possible within the data and felt most relevant to answering the research question. As inherent to the process of analysing data and the grounded theory methodology, all of the main categories are inter-related to one another and thus there is overlap at times. The strong relationships between the codes and categories made it challenging to make strong distinctions at times. Considering that the categories overlap and to avoid repetition, I have structured the chapter into sections, identifiable as the core category, main categories and primary sub-categories. The secondary sub-categories are described within the primary sub-category sections.

4.2 Overview of Findings

Four main categories materialised through the analysis process, which all have been identified as being strongly associated to what occurs when the participating individuals experienced mental health distress whilst incarcerated. It is important to highlight that the contributors to this research attended a variety of different prisons and naturally, prisons all function in differing ways. However, I was still able to find strongly consistent patterns within their responses. A core category of 'consistent versus inconsistent support' was identified as the connecting concept between all the categories.

Participants expressed that their living environments within prison negatively affected their mental health, leading them to need support from the prison system at different times during their sentence. The impact of the environment on incarcerated individuals led to inmates also necessitating support for a range of different needs. Individual characteristics determined how they coped with mental health distress whilst incarcerated, the type of support they felt they needed and the level of support they felt would appropriately support them. Individual characteristics, such as personal determination, also often dictated whether they felt capable of requesting help for their concerns and whether they received support.

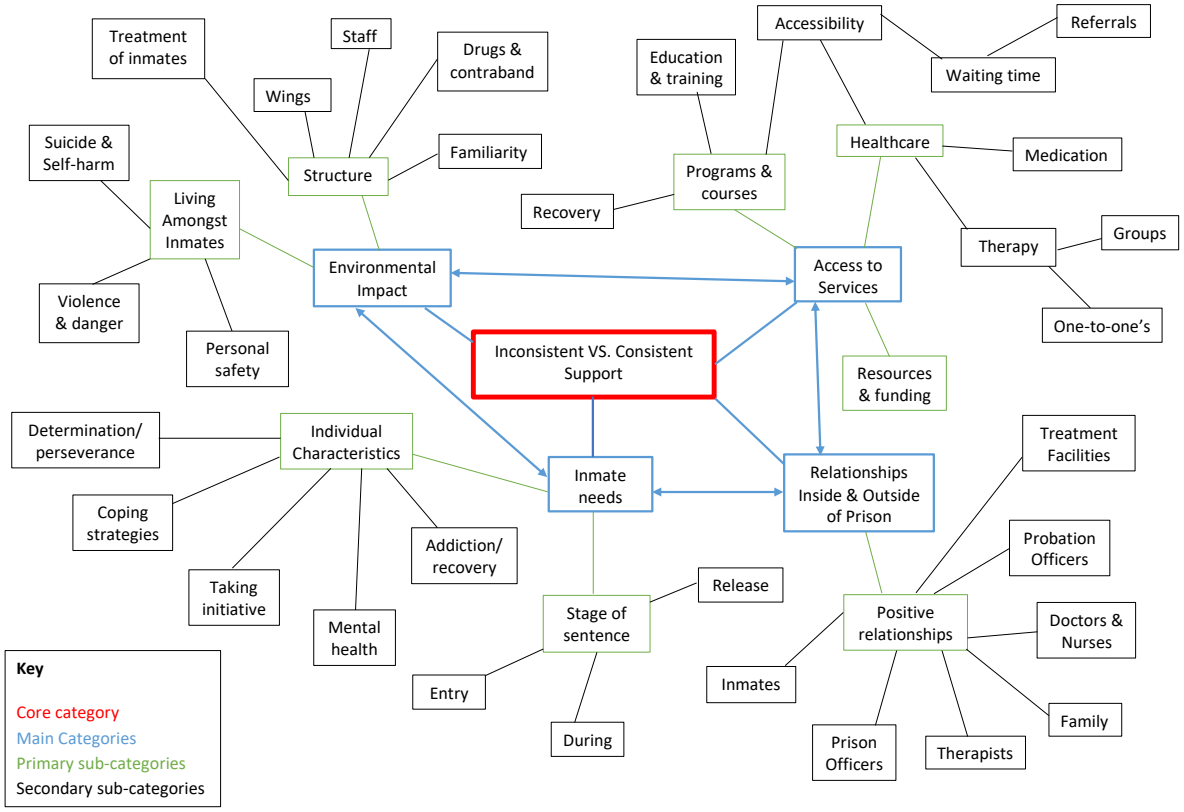
Regardless of their individual characteristics, all of the participants responses identified that receiving consistent support for their mental health distress was a significant challenge. They also highlighted that they would have benefited from receiving more reliable and dependable levels of support whilst incarcerated. Participants often referred to needing access to different types of services, including

healthcare, medication, therapy, as well as different types of programs including drug and alcohol recovery programs. Finally, it also became evident that receiving support throughout their sentence was strongly associated with the types of relationships the individual had and were able to develop, both inside and outside of the prison environment. Positive relationships were crucial in receiving support.

All of the sub-categories were purposefully named through vocabulary used by participants as a way of ensuring data stayed grounded in the data gathered as much as possible. The core category and main categories were not identified using participant vocabulary as they needed to embody a range of identified codes.

Figure 1 illustrates the relationship between the identified core category, main categories and associated sub-categories. The double-ended arrows in the diagram aim to highlight that all the main categories are related to one another. The non-arrowed lines represent how the core category, main categories and primary sub-categories branch out into the components that make up the experiences of the participants. The relationships highlighted in Figure 1 are thoroughly explained within the remainder of the chapter.

Figure 1. Diagram of the core category, main categories and sub-categories.



4.3 The core category – Inconsistent versus Consistent Support

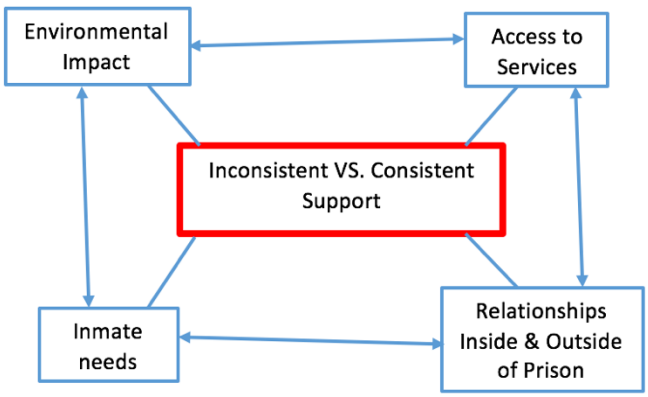
When analysing the interviews, it became clear that the experience of mental health distress when incarcerated is a unique experience. However, a consistent pattern could clearly be identified throughout all the interviews and established codes. Participant's experiences of mental health distress were strongly related to whether they received consistent support when they were serving their sentence. The "what happens" aspect of the research question is thus answered by the process of how and whether the participants were able to receive consistent support. The concept of receiving support was embedded into all of the participant's responses to the interview questions. None of the participants expressed receiving consistent support throughout their sentence and they indicated that this negatively impacted their mental health.

The core category was named as a final step, after all of the sub-categories, primary categories and main categories were distinguished. The identity of the core category did not come immediately. Rather, it developed as I meticulously reviewed the already focused codes and established categories a multitude of times, as well as through a process of reflective questioning. Several reflective questions that I asked myself throughout the analysis process which supported me in identifying the core category, were as follows:

- What is the connecting thread between the established categories?
- What are the participants trying to tell me/what is the data trying to tell me?
- What kind of process are the participants sharing with me?
- How have the categories evolved?

Figure 2, below, highlights the main categories related to the core category of inconsistent versus consistent support.

Figure 2. The main categories associated to the core category of “consistent versus inconsistent support”.



4.3.1 Main Category – The Environmental Impact

When asking participants about their experience of being in prison and how they were affected by their experience of serving time, the impact of the environment on prisoner's mental health and wellbeing was frequently mentioned. A memo written during the focused coding process shows the process I went through to identify how the environmental impact was established as a main category.

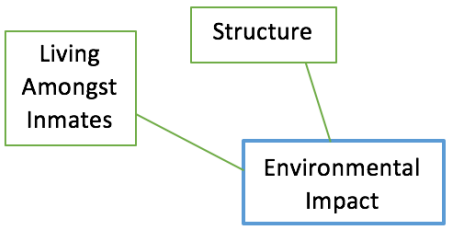
Memo 11/05/2020 – Is the environment going to be a main category?

The participants describe the environment and how it impacts their mental health in a variety of ways. What specific aspects of the environment are they referring to? How can these be brought together into focused codes in a way that represents their experiences?

Does the way they describe the environment and its impact respond to the research question? Is it relevant? How and why? Is the data meaningful and relevant enough for it to be a main category?

Overall, the prison environment does not appear to offer consistent supportive measures associated to personal growth, rehabilitation and overall wellbeing. Throughout the interviews, it was noted that participants consistently reflected that the environment had a significant impact on their mental health. Figure 3, provided below, identifies the aspects of the prison environment which participants described had a negative impact on their mental health and overall wellbeing.

Figure 3. The primary sub-categories related to the main category of "Environmental Impact".



The responses provided by the participants during the interviews suggest that there were key distinctions between the general population wings and rehabilitation wings. Violence tended to be more common within the general population wings than the rehabilitation wings, also known as the drug-free wings. Participants regularly expressed that the general population environment is 'dangerous' and 'violent' due to fighting between inmates, inmates harming themselves as well as the existence of drugs and contraband. The lack of staff in relation to the number of inmates per wing was also identified as a factor associated to prison being a dangerous environment. All of these aspects strongly associated with the unsafe nature of the environment negatively impacted participant's mental wellbeing.

"…go to this really, you know, violent, selfish, all-encompassing environment, it's dangerous" (Matthew)

"They keep people banged and locked up all the time, um, you can't get anything done. You're out of your cell for an hour a day and these four officers have got 250 people bombarding them with stuff, um, let alone what's going on, so suddenly fights will break out, stabbings…" (Jack)

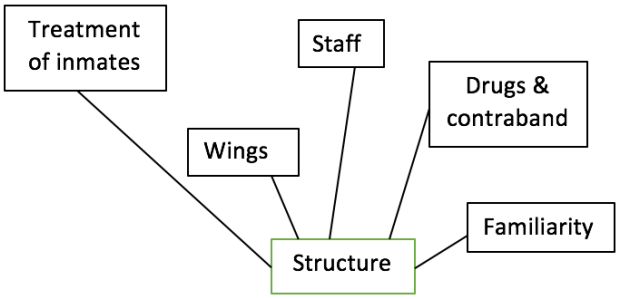
When participants described their experiences and the impact of their incarceration, responses referred to the structure of the prison environment as well as the social aspect of living amongst other inmates. Whilst it has already been evidenced that the prison environment negatively impacts an individual's wellbeing and mental health, the in-depth detail provided by the participants is pertinent to answering the research

question and offers a uniquely thorough insight into the phenomenon (Senior, 2015; Nagel 1976; Gee & Bertrand-Godfrey, 2014; Bowler, Phillips & Rees, 2018).

4.3.1.1 Primary Sub-category – The Structure of the Environment

As mentioned above, the structure of the prison environment was often described by participants as having a significant impact on their wellbeing and mental health. Figure 4, below, outlines the secondary sub-categories in relation to the structure aspect of the environment, which are covered within this section.

Figure 4. Secondary sub-categories related to the primary sub-category of “structure of the environment”.



When describing the impact of the structure of the environment, participants largely mentioned how different wings function in varying ways. It is important to note that all of the participants were struggling with addictions upon entry into prison. As such, some would be automatically assigned to the rehabilitation wing upon entry, whereas others would enter prison through the general population wing and eventually be accepted to the rehabilitation wings in the prisons in which they served their sentence. The nature of the environment and the associated impact thus differed depending on the wing that they were allocated to.

Many expressed that the general wing often had minimal staff, such as prison officers, and that they have a mixed perception of whether the staff cared for their wellbeing and safety of the inmates.

"what officers are on, on that day as well… makes a lot of difference, yeah, cause, you know, you can come out your cell… and you can see an officer who's on and you'll think, 'it's not even worth approaching him" (Carl)

It was noted in participant responses that they often felt overlooked due to a lack of staff in comparison to the number of inmates per wing. The minimal number of staff available also seemed to add to the dangerous nature of the environment. The participants described that the lack of support and the violent nature of the environment made them feel 'lonely', 'stressed', 'depressed', 'anxious', 'hopeless', 'increasingly frustrated', 'scared' and 'vulnerable'.

"So, you get one question, someone asking for a toothbrush, you got another one who's just asked him, 'has my mum…?', 'can I have a visit?' or whatever it is or… So this geezer's had three questions and then you come along… and there's the other side, they're screaming at him, so he'll go over there, listen to their questions...so he comes back, he ain't got a fucking...He don't know his ass from his elbow and I think a lot of it is forgotten" (Daniel)

Some participants mentioned that due to the violence, they felt safer staying inside their cells, despite this having a negative impact on their mental health. As George

described, being in your cell resulted in feeling that they had “no one to talk to” as well as feeling “bored, nothing to do, you know… yeah too much time to think”.

Violence was also highlighted as being associated to the use of contraband and drugs. It appeared, from the interviews, that the use of drugs and contraband, which included getting medication from other inmates, was a common occurrence within the general population wings in the respective prisons.

“I go to this really, you know, violent, selfish, all-encompassing environment, it’s dangerous, you’ve got to be hyper-vigilant” (Matthew)

“It was dangerous just to go have a shower, just to go and…just to go out of your cell. If it kicks off and you’re in there, it can be dangerous, um, and the impact mentally, it’s tough” (Jack)

“…You got people in there specifically to get other people’s drugs and things like that, so you get a lot of robberies and all that…” (Daniel)

Several participants highlighted that their reason for getting medication from other inmates was not based on violent intent. Instead, getting medication from others was a coping strategy to soothe their own distress. On these occasions, they had not been prescribed medication for their concerns or had been unable to access their prescribed medication. Participant responses suggest that most, if not all, inmates are prescribed medication, and so it was an easily-accessible coping strategy for their distress,

especially when they had not received appropriate support from healthcare professionals.

"I was in a bad way, um, I was… I wasn't prescribed so I was buying other people's medication on the wing. So, I was using it just to, for me to get sleep at night and all of that" (Matthew)

"Everyone's trying to get everyone else's because everyone is on some form of medication. It's not enough" (Jack)

Interestingly, participants reflected that having a familiarity with prison officers, such as who was present on the wing on a particular day, influenced the likelihood of receiving appropriate support. Participants expressed that whilst some prison officers were supportive, others were not, suggesting that they found it challenging to receive consistent levels of support from prison staff. Some participating individuals indicated that having an understanding of who would be willing to offer support was beneficial as the pathway towards receiving more consistent and appropriate support was then less challenging as a result.

"Coming out in the morning, out of your cell, recognising the officers that are on, you know who you can approach and you know what officers not to approach, right, because of the way they are. Some of them just don't want to help ya, all they wanna do is just come in, lock you up and go away" (Carl)

Despite these findings, intriguingly, one participant did mention that despite feeling concerned around the violence that exists in prison, the routine nature of the environment allowed for familiarisation and a feeling of safety, compared to life outside of prison. I found it interesting to hear this difference in perspective as it seemed to go against how the rest of the participants described their experience of being in prison.

"I felt more safer in prison than what I did on the outside, cause I got so used to it…. Everything's all set on a routine. I got, I got a set rota. Everything I know, what's going on from day to day, even when it comes down to the meals, you know" (Carl)

When discussing the rehabilitation-focused wings in the prisons attended, some participants expressed that whilst the environment was less violent. However, the use of drugs was still prevalent amongst prisoners despite being classified as 'drug free' environments. This led to participants finding it challenging to manage their addiction problems. Carl identified this clearly in his response, with his intonation reflecting a feeling of disappointment and frustration, due to the availability and accessibility of drugs and contraband within these environments, as he was trying to recover from his addiction issues.

"You're a recovering addict or you're trying to recover, you know, they say, they put you on the drug free wings but them wings are more full of drugs than anything" (Carl)

Participants did reflect that the rehabilitation wings in their respective prisons tended to be more supportive in comparison to the general population wings. This is as

therapy and a range of other programs, educational and treatment orientated, were more readily available. This allowed each participant to begin the process of recovery from their addictions whilst serving their sentence.

"I'd never done any of the programme, um, until I went onto the RAPT (Rehabilitation for Addicted Prisoners Trust) wing, the drug wing" (Jack)

"Umm, I done a few groups when I was there, yeah, um, mindfulness, anger management, um, stepping stones, um, addiction group… yeah" (George)

Whilst the rehabilitation wing was identified as a more suitable environment for the participating individuals due to their addiction problems, participants often felt that being accepted onto the rehabilitation wing was challenging. One participant in particular powerfully conveyed the challenge when he described it as occurring by 'luck'.

"I got put onto that drug-free wing by luck, I'd gone down to reception to pick up some trainers that someone had sent in for me. I'd had to go sign for them, the prison officer took me over and while I was in reception, they were discharging someone, who was from the RAPT wing. He was being released and one of the drug workers had come to see him off, and I got to talking to him and managed to persuade him to let me go on the wing, and there was a waiting list…" (Jack)

4.3.1.2 Primary Sub-category – Living Amongst Inmates

Another factor that was often mentioned by participants was the concept of living around other inmates, referring to the social aspect of the prison environment. Figure 5 identifies the secondary sub-categories related to the primary sub-category of living amongst inmates. The sub-categories stated below are factors that participants expressly related to the environment as well as reasons why living amongst other inmates impacted their mental health.

Figure 5. Secondary categories related to the primary sub-category of "living amongst inmates".

The participants' sense of personal safety appeared to be strongly correlated to not only the structure of the prison environment, but also the amount of inmate-on-inmate violence witnessed. Many expressed feeling a need to 'protect' themselves against violence from others, which resulted in learning specific defence mechanisms in prison. Defence mechanisms mentioned regularly included feeling the need to become more aggressive as well as separating themselves from other inmates. Some of the participants did mention that they had been able to develop positive relationships with other inmates, and whilst this was helpful at times, they expressed not wanting to 'burden' other inmates with their problems.

"You know, it's a dog eat dog prison really, like, no one looks out for no one, it's…you're there on your own basically" (George)

What I was thought was you don't let people take the piss with you, you don't let people, you know, bully you, don't let people… so I've got defence mechanisms in me, that if I think someone is taking the piss, I react to it, do you know what I mean, you know, I'm really quick to react to it as well, you know, I'll cut that threat down immediately" (Matthew)

I observed during the analysis process that the defence mechanisms mentioned by participants often functioned as a double-edged sword. For instance, whilst separating themselves from other inmates tended to lead to feeling safer, it also led to feeling increased levels of loneliness. In regard to becoming more aggressive, whilst this again led to feeling safer within the prison environment, it also impacted the type of relationships they were able to developed with prison officers, tended to result in receiving less support. The coping mechanisms developed within the prison environment associated to personal safety and the violent nature of the environment often inadvertently had a negative impact on participant's mental health. As Carl said in his interview, "doing the right thing can still be the wrong thing". In this response, he was specifically addressing that choosing not to socialise with others ensured he stayed away from violent offenders but that this also led to him feeling lonely.

"'…I go off the wing and go work, I come back and, and that's it, I stay in my cell, I don't socialise with anyone on the wing… I choose not to… it's a good thing but it

was also a bad thing as well, um, because you're isolating yourself… it's quite lonely" (Carl)

Participants also expressed witnessing inmates engaging in acts of self-harm and suicide within prison settings, which impacted their mental health and sense of personal safety. Participants mentioned a range of ways in which inmates were seen harming themselves. Interestingly, some of the participants highlighted that mental health distress is a common phenomenon within prison, and that such distress is worsened by the accessibility to drugs and contraband. They described that access to drugs and contraband was strongly associated to acts of self-harm and suicide.

'"I've seen and I've witnessed, you know, many other people, you know, I've witnessed people taking their own lives, you know, people self-harming, you know, getting cut down, you know, ending themselves and all that" (Matthew)

"You've got someone with mental health issues, let them have a spliff and their illness will come alive really quickly… so they're so… so they're… this is what I've witnessed…So you have a lot of paranoid schizophrenia and you know, and you get people who take spice, um, you know, I've seen someone, two doors down, um off his head and sliced his belly open, pulled his guts out and died in… in jail" (Daniel)

A memo written around Jack's response, offered below, highlighted the emotional content when speaking of the self-harm that he witnessed. The emotional content, such as intonation, breaks in speaking and tone signified the level of impact of witnessing such events. The memo highlighted to me, as the researcher, how

important it is to consider emotional content such as intonation and tone, when establishing codes, categories and the emerging theory. Looking back, this memo also feels very relevant to other responses from participants, especially when speaking of events they have witnessed and experienced, including violence, self-harm and suicide, as well as the level of support available.

"Some people cut themselves, trying to hang themselves, throwing themselves over the landings…I've seen…yeah…just… phew, the self-harming I've seen is just beyond belief" (Jack)

Memo 23/02/2020 – Emotional content in responses

Jack - "Some people cut themselves, trying to hang themselves, throwing themselves over the landings…I've seen…yeah…just… phew, the self-harming I've seen is just beyond belief"

During the transcription process, I noticed how the emotional content, such as his intonation and the extended pauses between speaking, emphasised the impact of participant responses. During the interview and within this response, I felt that that Jack was conveying emotions of sadness, shock and discomfort. Listening to the interview again during the line-by-line coding process reminded me that expressed experiences can often lose a significant amount of meaning and depth when transcribed. The emotional content can be lost and the responses can appear to be more casual than how they intended to come across.

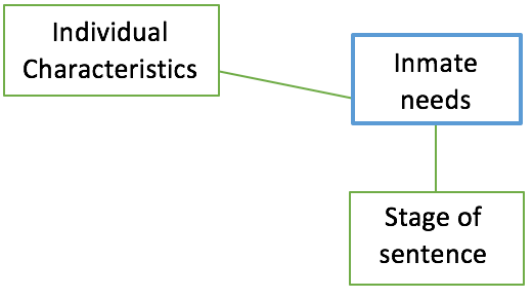
It will be important to recognise and remind myself that this occurs when writing the analysis chapter. It may help to provide contextual descriptions and to describe participant's use of intonation, so that not all meaning and depth is lost.

4.3.2 Main Category – Inmate Needs

Inmate needs was a significant factor strongly associated to the core category of inconsistent versus consistent support. Several different inmate needs were

expressed throughout the interviews. Participants also identified how different support services were required at different stages during their sentence. Figure 6 identifies the primary sub-categories which participants spoke of when reflecting on their needs whilst incarcerated.

Figure 6. The primary sub-categories associated to the main category of “Inmate Needs”.



Inmate needs largely referred to needing support for their mental health and wellbeing. The expressed needs depended on their developed coping strategies, the stage they were in of their addiction recovery as well as the stage of their sentence. The need for mental health support, such as access to counselling and/or medication, was the most predominantly mentioned by individuals in the interviews for this research. Alongside this, the need for support for their addiction issues and associated feelings of distress was also commonly cited by participants.

Whilst the type of support based on the inmates needs remained similar throughout the duration of the participants’ sentences, the level of support needed changed at different times of the sentence. For instance, participants repeatedly mentioned requiring more specific support upon entry into the prison system due to feeling unfamiliar with the surroundings, as well as to help them adapt and navigate the violent

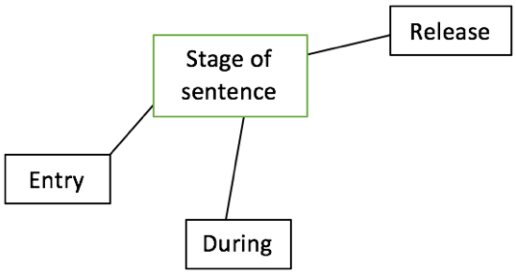
nature of the environment. Participants also expressed needing additional support towards the end of their sentence, due to increased levels of anxiety. They often reiterated that not having their individual needs met through supportive measures had a negative impact on their mental wellbeing and brought on a sense of hopelessness.

Through the analysis process, I identified that individual attributes made a significant difference to how participants experienced mental health in prison, magnifying to me the uniqueness of each individual's experience of being incarcerated. It also emphasised to me that there were many individual factors that influenced how participants felt about what occurs when one experiences mental health distress in a prison environment. Some participants felt that they were able to develop beneficial coping mechanisms, suitable for the environment they were in, which helped them through their period of incarceration. Others described how developed coping mechanisms functioned as a double edged sword.

4.3.2.1 Primary Sub-category – Stage of Sentence

Inmate needs and the type of support required depended largely on the stages of their sentence. Figure 7, below, highlights the times at which participants expressed they felt they needed support. Whilst inmate needs largely remained the same throughout the sentences, more specific support needs were identified when entering prison and during the period prior to their release from prison.

Figure 7. Secondary categories related to the primary sub-category of “Stage of Sentence”.



Regarding entry into the prison environment, participants specifically identified that support from the healthcare team was important as they were struggling with withdrawal symptoms and mental health distress associated to their addictions. They also identified needing support from prison officers due to being in an unfamiliar and challenging environment.

“…Coming off drugs, I don’t feel well, and then you’ve got to deal with trying to get some type of um, stra-, uh, need to know where… where you’re going in your, in your sentence as well, and officers.. they don’t, they don’t… you get some that care and some are there just to open and shut doors” (Daniel)

“You don’t know what’s going on, you’re going to court, you might get out, you might get in, you’re this, you’re that… um, so there’s a lot of unsettledness” (Jack)

During the participants’ time in prison, there was not a significant differentiation described in regard to the type and level support needed. However, participants did describe that they needed consistent support from prison officers and mental health professionals throughout their sentence. Mental health distress was a common

experience throughout the duration of the participant's sentences, and so, support from the healthcare team and therapists was often identified as necessary.

All of the participants indicated in the interviews that they felt they needed additional support within the months close to their release date. Many of the participants reflected that they became increasingly anxious as they were close to going back into society. They expressed that their anxiety generally was due to feeling a high level of uncertainty of what level of support would be in place for them upon release into society. For instance, participants expressed being stressed around money to live from, homelessness, job prospects, receiving further treatment for their addiction issues, as well as the prospect of returning to prison in the future if there was no sufficient support. Whilst some participants identified that they received support near the end of their sentence, many shared feeling a sense of disappointment with the lack of consistent and appropriate support received.

"Mainly with coming out, getting released and that, um, I needed support with housing and benefits and stuff, and it's all getting stressful" (George)

"I knew I was getting out and uh, I know, I think it was six or seven months left and it hit me, the anxiety about getting out and the stress. I know I was coming out and I had nowhere to live, you know, all that stuff, I had no job to go to, you know" (Matthew)

"That's a lot of my fears, you know, going in there as a, as a recovering alcoholic, well, at the time I was active, you know, alcoholic and, and user, um, and then

coming out of there, knowing I'm going somewhere safe, it… that all kind of just settles me a bit" (Carl)

A memo relating to George's response is provided below the quotes. This memo describes the initial curiosity I felt when noticing that this participant emphasised needing additional response specifically towards the end of his sentence. Naturally, George's interview was the first interview analysed, and so this was the first time I created the initial line-by-line code of "increased stress around release". I feel that this memo highlights the thought process behind the analysis process, from creating initial codes to main categories.

Memo 21/12/2019 – Increased stress around release

George – "Mainly with coming out, getting released and that, um, I needed support with housing and benefits and stuff, and it's all getting really stressful''

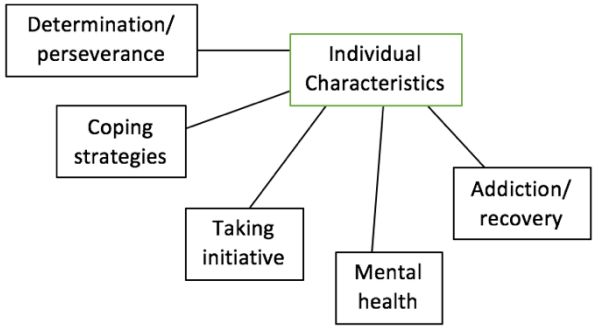
Interestingly, when reflecting on whether he was able to receive the support he felt he needed whilst incarcerate, George's specifically identifies feeling increased stress around the time of release and not any other times during his sentence. If I had the opportunity to have a follow-up interview with this participant, I would ask more questions around the type of support he felt he needed at this time and whether he felt he needed support at any other times during his sentence. This is worth taking into consideration in future interviews.

I wonder if other participants will be highlighting the need for additional support around their release as well. It will be important to keep note of when (at what stage of their sentence) specifically participants identify needing support from the prison system, what they specifically needed support with and whether they feel they were able to receive this.

4.3.2.2 Primary Sub-category – Individual Characteristics

Inmate needs and the level of support deemed necessary generally depended on individual characteristics of the participants. Figure 8 outlines the sub-categories associated to individual characteristics of the participants. These categories tended to dictate when individuals wished to receive support, the type of support required as well as the ability to receive support.

Figure 8. Secondary categories related to the primary sub-category of "Individual characteristics".



A range of characteristics dictated the type and level of support participants needed. The state of the individuals mental health needs as well as the stage of their addiction recovery process generally determined the need for support. When the participants were struggling with their mental health and/or addiction recovery challenges, they generally felt they needed more support. Whether the individual had been able to develop healthy coping strategies for themselves in relation to these challenges as well as to the environment were also significant factors. When speaking with Matthew about his mental health as well as his developed coping strategies, he offered an insight into what helped him cope through his sentence.

"…I learnt many ways of coping with it, you know, whether it was through banter or whether it was like through, um, you know going to the gym or just, ban-, um, taking the piss… and then there as time's when I'd feel down…" (Matthew)

Symptoms of mental health such as anxiety and depression were the most commonly expressed, alongside a feeling of general distress. Several participants, including Daniel, highlighted that whilst addiction is a frequent phenomenon, mental health distress amongst inmates is more predominant. It was also highlighted by some participants that there is a strong relationship between the deterioration in mental health and the consumption of drugs.

*"…A lot of them have mental health, you know… *sighs deeply*… a lot more, it's a lot more than the addiction. There's a lot more other stuff going on…" (Daniel)*

Personal motivation to change was strongly correlated with receiving consistent and appropriate support. Several participants identified that the key to receiving support for their needs was largely based on their ability to take initiative, as well as their levels of determination and perseverance. Higher levels of determination and the ability to take initiative often led to receiving better and more consistent levels of support from the prison system. Alongside this, several participants identified that the individual's will to change was an incredibly important factor related to whether an individual would take up available opportunities.

"You have to try to get hold of the services all the time, and I'm not one that just stands at the gate and uhm, just walks away. I'll fucking go for it until they, I get their

attention. I'm a bit of a rash… it's the squeaky wheel that gets the most grease" (Daniel)

"You can have all the education, you can have all… everything's put in place or… unless that persons open to changing, you know, it's wasted" (Matthew)

Participant responses highlighted that as violence, self-harm and suicide was a common phenomenon due to the prevalence of mental health, services often weren't available as they were focused on managing emergencies. This meant that inmates with needs which were not considered to be an emergency were often not attended to, leading to a lack of support for these individuals.

"Mental health in prison, as you know, is off the charts… off the charts, um, and I guess there is not a lot of funding for it, and there is a psychological team in most prisons and medical and healthcare, and ninety-nine percent of the time they're, from my experience, dealing with emergencies" (Jack)

"They had to shut down every landing, every. Every wing, cause people were taking their… people were… there was lots of stabbings and whatever else…" (Daniel)

Participant responses described that they increasingly lost their feelings of hope if they did not feel listened to when attempting to voice their needs. A sense of hopelessness also came across in participant responses when they spoke of receiving inappropriate support for their specific needs and/or when they had to wait too long to receive support. One of the participants, Matthew, highlighted not only the challenge to getting

support but also the impact it had on him when reflecting on challenges faced in receiving support in prison environments.

"The services, the services in there was just, you know, you go to them, you know, and say I've got nowhere… we'll we've got no access to them, you know, we've got no access to the housing or we've got no access to services like that, so, what are you, you know, well we can signpost you. It was just a, it's quite, it's quite frustrating, um, you know, when you're coming out, you've got nothing in place…its demoralising as well" (Matthew)

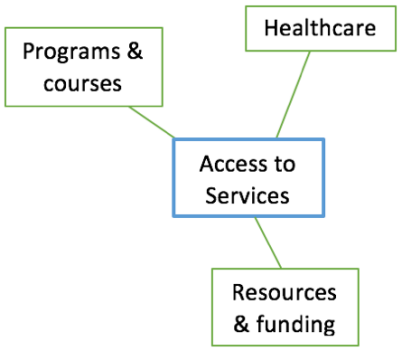
Whilst the majority of participants described the process of receiving support as challenging and leading to a sense of hopelessness, I have used the responses from George below as I feel it powerfully indicates the frustrating reality of attempting to receive appropriate support for their needs. A reflective note written in response to George's response specifically stated the following: "This description of the process of attempting to get support feels very heart-tugging. It highlights how the challenges in receiving support can lead to increasing feelings of hopelessness, to giving up. I wonder if this is a common occurrence in prison and if so, why?"

"I just found that it didn't help me with what I wanted help with so…I was hoping to get help with my medication, what I was on and um, because I wasn't really sleeping well, and they, he, was like, give it another two weeks and see how you're sleeping pattern does and.. but it had been like two or three weeks when I put that in and I wasn't sleeping still" (George)

4.3.3 Main Category – Access to Services

The core-category of consistent versus inconsistent support very much depended on the participant's experiences of the ability to access different types of services and treatments during their period of incarceration and their times of need. The type of support participants' expressed that they predominantly needed access to healthcare, which included the ability to access psychological support. Alongside this, participants shared that the ability to participate in recovery focused programs and educational courses was of benefit to them. Funding and resources were described as being a factor which negatively impacted the ability to access these types of services. Figure 9 outlines the primary sub-categories described by the participants as needed during their incarceration.

Figure 9. The primary-sub-categories related to the main category of "Access to Services".



Many of the participants emphasised that support and access to services is limited. It appears from participant's responses that the ability to access services is minimal within the general population wings but is much more available within the rehabilitation wings. The wing that they were incarcerated in very much dictated what kind of support as well as the level of support they would receive, as well as the ability to access different services. Still, it appears from responses that it was a challenge for them to

gain access to supportive services, including healthcare, psychology and courses. Interestingly, several participants recognised that access to treatment was not as feasible as they would have liked due to a lack of resources and funding that exists within the prison environments, as well as the policy structure in place around supporting inmates.

It became clear through the analysis that participants felt at times that they were not treated respectfully and felt that they were not consistently supported by the prison system through their support services and staff. When participants did receive support for their needs, it was usually not consistently done, but instead, sporadic and unreliable.

When asking participants towards the end of the interviews what they felt could have been helpful for them during their period of incarceration, responses always focused on improvements within the available support services in prison. Participants expressed that they felt quicker healthcare support would have been helpful, alongside the possibility to participate in more therapy programs and educational courses.

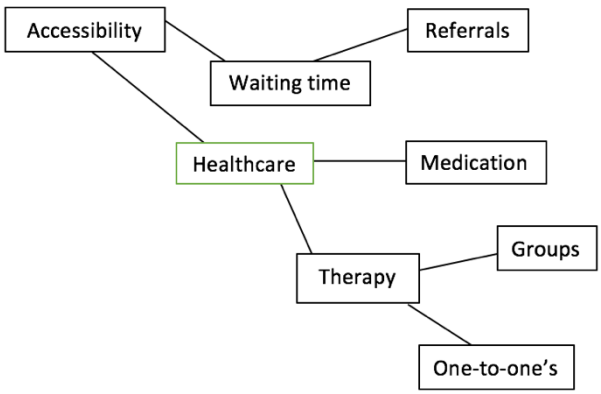
It's important to highlight at this point that not all of the participants had solely negative views on prison services. Through participant responses, it became clear to me that experiences of support were very personal. There were many mixed reviews in regard to the services that exist in prison. Whilst some appeared to be helpful, others were not. The negative experiences were often associated to support received when incarcerated in the general population wings rather than the drug-free wings. It is also important to note that some participants appeared more comfortable in sharing their

experiences in detail than others, especially the negative aspects such as the challenges they faced. A note written at the end of the interviews highlights my reflection process in relation to this: “It’s clear that some participants are more comfortable and willing to delve into the details of their experiences. I wonder what it is that stops some from opening and being more specific. It’s worth considering whether and how this is relevant to the findings.”

4.3.3.1 Primary Sub-category – Healthcare

As described above, the ability to access consistent healthcare support was often described as necessary at different stages of the participants’ sentences. Healthcare support not only refers to being able to see doctors and nurses for treatment for physical injuries and general wellbeing, but also refers to medicinal as well as psychological support for mental health distress. Psychological support alludes to seeing therapists, either for one-to-one support or group sessions, for their mental health distress. Figure 10, below, depicts the secondary sub-categories related to the primary sub-category of healthcare.

Figure 10. Secondary categories related to the primary sub-category of “Healthcare”.



Participating individuals shared that there was a tendency to receive inappropriate support from medical staff when sustaining physical injuries. Some of the participants shared that they did not receive appropriate or reliable support when they reported concerns and also witnessed that this was the case for other inmates. Interestingly, the experiences of healthcare support related to physical injuries was solely mentioned when the participants were based in the general population wings.

"…There was a geezer, uh, he busted his ankle. For three days, all they gave him was paracetamol, before they took him to the hospital. Paracetamol… how's that for a snapped ankle…" (Carl)

Mental health support was identified as the type of support that was most commonly needed, in the form of medicinal and/or psychological support. As described in the previous sections of this chapter, participants described needing this type of support for mental health distress in relation to their addiction and when in recovery, as well as due to the impact of the environment on their wellbeing.

Regarding medicinal support through the prison healthcare system, the participant's views generally weren't positive, and they found the lack of consistent support difficult to cope with. There tended to be long waiting times, too many referral procedures, and prescribed medication was at times not available. Whilst the majority of participants shared this view, Carl described his experience of receiving medicinal support and the impact it had on him in more detail than others did. I felt that his description compellingly conveyed the challenges faced by inmates in getting appropriate and

consistent support for their needs. It's important to highlight that his response referred to medicinal support within the general population wing and not the rehabilitation wing.

"I was on specific medication and uh, I've gone down for my meds and they're like, 'you can't get it here'. I go, 'what do you mean I can't get it here?'… what am I supposed to do tonight you know... 'oh, you'll have to come back tomorrow', so you end up not having nothing, so then you're mental status just goes up and you end leaving there more frustrated, and then for myself, my anxiety goes, goes up even more" (Carl)

Regarding therapy, participants expressed that this type of support was hardly available within the general population wings but much more accessible in the rehabilitation wings. The majority of participants expressed having access to therapeutic support in the drug-free wings and found that such support was highly beneficial to their mental health. It was disclosed by participants that both group work as well as one-to-one counselling sessions were offered in these environments. However, there were mixed opinions between the participants on the availability of therapeutic support. Some expressed that more group-therapy was available, some described having more access to one-to-one therapy sessions, and others described having equal access to both. This finding indicates that the types of available support depended on the prisons attended by each participant.

"Some of the groups that I'd done, I dunno, like mindfulness and stuff like that, that did help, help me how to meditate and you know, like, body check" (George)

"I was on a rapt wing, a drug free wing, where there was one-to-one's and counselling stuff, and we'd see psychologists all the time… and that was much more beneficial, that was helpful" (Jack)

Still, some participants identified that there were challenging aspects in relation to receiving therapeutic support. For instance, one participant expressed that he felt he couldn't openly discuss his concerns in group sessions as there was potential for it to impact other participating inmates negatively. Participant responses also highlighted that even if they did receive support, it tended to be inconsistent and unreliable. If they had healthcare appointments, for instance, it was not certain that they would be seen, as a lot of the healthcare response was geared towards emergencies. A lack of staff and resources meant that there were long waiting times and that those not deemed an emergency would not be seen by professionals. Due to a lack of available staff, when seeing professionals over a period of time, it was not always the same individual and sessions tended to be offered on a limited basis. As a consequence, there was a lack of ability to build trust with these individuals. Being in such an impactful environment, the opportunity to build a rapport with the healthcare professionals was a crucial aspect of feeling appropriately supported. Finally, one of the participants also reflected on the approach taken by staff towards inmates, suggesting that a more understanding, holistic and preventative approach could offer more constructive support.

"Sometimes you'd get the odd person who could support you and that, but it's not a lot of them… Not prison officers, but umm like drug workers and uh, some nurses" (George)

"When I used to have… talk to people, you might get Dr Smith one, one day, and if you're lucky to get another appointment next week, on… next week, you might have Dr Jeffries, you know, it's not necessarily the same person coming to see ya, so there's no building up with rapport or anything" (Jack)

"There's a lot of trauma, a lot of abuse, a lot of sexual abuse, so when you start talking about some of my trauma, where I'm open to talk about that, it can trigger off some of their stuff that's mostly really repressed and it can fucking send them off on a psychotic one, so you know, you've got to be careful" (Daniel)

"There is very little emphasis on, so why has he committed this crime, why… let's look at why he's committed this crime, what factors have been put in place or what factors are there of why, and can we, is there any way we can prevent it, is there any way we can change it, do you know what I mean, so yeah, I think that that's… that's the approach that should be taken" (Matthew)

Some participants highlighted that the treatment by staff, including not being offered consistent and appropriate support, often led to increased levels of frustration and an inability to trust the existing support system. The limited amount of support available also added to increased levels of distress, frustration and hopelessness. I felt that participant Matthew and Carl strongly conveyed the frustration felt by the participants. I found that they powerfully described their experience with the healthcare system in prison and the impact that it had on them.

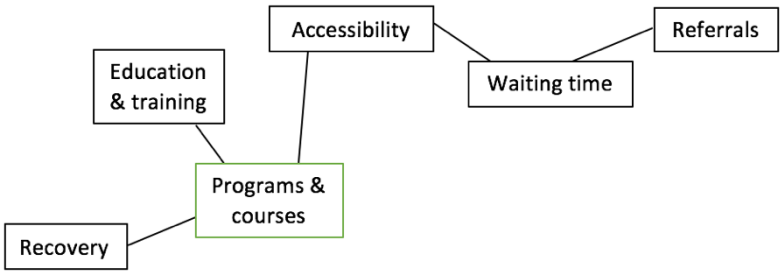
*"Just going from pillar to post, really frustrated and you just go, you know what, I'll just… and that's where I think a lot of people that um, I was talking about myself… where a lot of people just go *shrugs shoulders*… just go, you know what, this is just fucking going nowhere, and they just go back to what they know" (Matthew)*

"They don't care… they look at you completely different, they don't look at you as a human being. They'll just look at you as, you're just a prisoner… it's not right, because they've got a care of duty… When it comes down to the healthcare services in prison mate, I've got no, no trust in them at all" (Carl)

4.3.3.2 Primary Sub-category – Programs and Courses

Participants also expressed that having access to a range of programs and courses whilst incarcerated was of value to them. To offer clarity within this section, programs refers to addiction recovery focused ones, while courses refers to educational and training oriented ones, that would support them with job prospects upon their release. Interestingly, the participant's did not mention taking part in offence-focused programmes within prison. Figure 11, below, identifies the secondary sub-categories associated to the primary sub-category of "Programs and Courses".

Figure 11. Secondary categories related to the primary sub-category of "Programs & Courses".



Participant responses indicated that the accessibility to programs and courses differ between the general population wings and drug-free wings. Participants spoke of educational courses being more available in the general population wings, whereas recovery focused programs were offered more consistently within the drug-free wings. Overall, there were mixed reviews on the quality courses and programs offered. There appears to not be a huge variety in the courses and programs offered, and the quality of what was available varied.

"There is some, you know, good programs in there, some… but a lot of it, they're far and few in-between. A lot of it just feels like a box ticking, box ticking exercises." (Matthew)

"A lot of stuff they do there is uh… what's it called… health and safety stuff, um, what's it called where… using awareness or whatever… so you know, use your needles, use this, it's very basic stuff, making you aware of stuff… stimulants, downers, uppers, opiates and whatever else" (Daniel)

Participants expressed that the courses and programs were limited in their availability and so it was a challenge to be accepted onto them. Waiting lists tended to be long and thus, when an individual was incarcerated for a short period of time, the possibility of being accepted on to a course or program was slim. Interestingly, some of the participants described that they only were able to attend courses due to having a positive relationships with a staff member.

"I met a drug worker who took a liking to me and helped me and got me onto a wing where it was drug free" (Jack)

Courses and programs appeared to be rarely offered within the general population wings, and when they were available, they were inconsistently provided. One participant specifically mentioned that a particular course that he was attending at the time was stopped without notice, which he found difficult to process as he found it was supporting him with his recovery.

"There was one that we did and they shut it down, and that was the meetings… how are you supposed to um, you know, carry on with your… if, if you're practicing at your recovery, and they're trying to work, you know, to keep you recovered, how can you do that by a service not being available to ya" (Carl)

In regard to recovery programs, as mentioned above, these were more readily available within the rehabilitation wings. From participant responses, I gathered that once an individual was accepted onto the drug-free wing, they had consistent access to recovery-oriented programs. Overall, these programs appeared to positively support the participants with their recovery, mental health distress and overall wellbeing. It also increased the likelihood of being accepted to treatment facilities upon release. Several of the participants highlighted that having improved accessibility to courses and programs would have been beneficial for inmates as a whole.

"I never done any of the programmes, um, until I went onto the RAPT wing, the drug free wing… there was group stuff but um, a lot about relapse prevention, triggers and that kind of thing…it was a massive part of getting me clean" (Jack)

"the services, um, they really helped, um, it's just that, you know, I like to talk about my problems… it got me out of my cell, um you know, I was talking about stuff, you know, day went quicker, um… I was doing something positive for my life, so you know, I felt like I, I felt, like, more positive" (Daniel)

"If they had more courses or more groups, like, for people with depression and that, just to get them out of their cell and do something you know… instead of being banged up and listening to everyone that are making noise out their windows or their doors… just to keep them occupied" (George)

4.3.3.3 Primary Sub-category – Resources & Funding

When hearing about the experiences of receiving inconsistent support from the prison system, one wonders why this is so commonly the case. As revealed in the critical literature review chapter, funding dedicated towards prison services, including mental health support services, have lessened significantly over the years. The reduction in funding has consequentially resulted in there being less opportunity to offer consistent, appropriately resourced and effective supportive services to the inmates. It is important to highlight that there is a clear relationship between having a limited amount of resources and funding, a lack of staff, long waiting times and the lack of support experienced by inmates. Due to the lack of resources available, inmate needs are not

deemed an emergency and tend to be overlooked, especially in the general population wings.

"*The biggest challenge to getting anything done in prison is… and it's the same with support, healthcare, anything… it's all the same problem. There's not enough staff, there's not enough time, there's not enough goodwill and there are so many needy prisoners…that's not including, that's not talking about the emergencies" (Jack)*

Several of the participants showed a strong awareness that not receiving the support they felt they needed was due to the reduction in funding over the years. I found it interesting to listen to these reflective moments shared by the participants. A reflective note written in relation to this wondered how the reduction in funding impacted their experiences of what occurred when they experienced mental distress whilst incarcerated.

"…to understand it a bit more is, you know, the way, you know austerity, the prison service as a whole, you know, the money that's been took out of it, you know… the, the drop in numbers of officers, of programs, services in there and all of that" (Matthew)

"The services want to help you in there, but their hands are tied by, their hands are tied by the, um, the prison system" (Daniel)

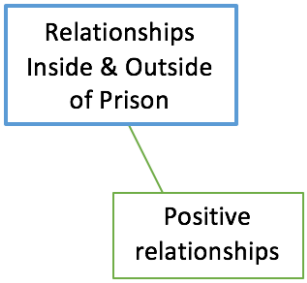
It is important to mention that as of late, there has been a renewed emphasis on the need to improve the environment in prisons as well as to provide additional support

services, which focus on addressing the extensive mental health needs of incarcerated individuals. In recent years, there have been pledges and announcements by the government to increase funding to recruit staff, provide health and safety training and increase support services within prison settings (NHS England, 2018; McKeganey & Liebling, 2017; Senior, 15). The findings of this research would not have been able to pick up on these recent changes.

4.3.4 Main Category – Relationships Inside and Outside of Prison

The final main category that I was able to identify through the analysis was the importance of having relationships inside and outside of the prison environment. This is as the relationships participants had and were able to develop whilst incarcerated tended to dictate what would occur when the individuals experienced mental health distress. Figure 12 outlines the type of relationship that participants described as being vital to receiving support in prison.

Figure 12. The primary sub-category related to the main category of “Relationships Inside and Outside of Prison”.



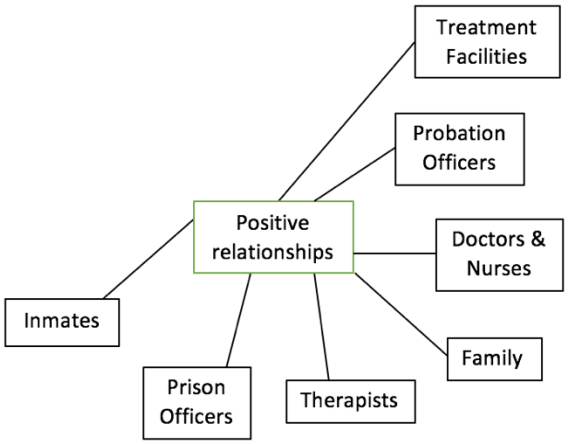
Participant responses indicated that when they had positive relationships with individuals, inside and outside of the prison environment, this often strongly influenced how they coped whilst incarcerated and what would occur once released. It became

clear through the analysis that having positive relationships and networks was key to getting the support they felt they needed to cope. It was preferable to have positive support systems in place both inside and outside of prison, however this appeared to be rare.

4.3.4.1 Primary Sub-Category – Positive Relationships

Many of the participants shared the need to have and be able to develop positive relationships and supportive networks, both inside and outside of the prison environment. Positive types of relationships were a very important means in the ability to receive support for their needs whilst incarcerated as well as upon release from prison. The limited resources available was a key factor of why only limited support offered. However, the type of relationships the participants had and were able to establish played a huge role in the level of support they would receive. Figure 13, below, pinpoints the types of individuals with whom the participants needed a positive relationship with.

Figure 13. Secondary categories related to the primary sub-category of “Positive Relationships”.



With regard to the prison environment, prison officers appeared to be the most important individuals with whom to have a positive relationship with. This is as the role of a prison officer is to manage and supervise the inmates, maintain a safe environment within the wings, and to support the prisoners by attending to their general needs. Alongside this, they also support prisoners by ensuring they receive appropriate treatment by contacting the relevant services when needed as well as to be admitted to courses. As previously mentioned, there is an inconsistency in how prison officers treat inmates. Some see it just as a job whilst others feel it is their duty to give the inmates the best support possible. Thus, knowing who was willing to help was an important factor in getting appropriate support. The attitudes of the inmates towards prison officers also plays an important role. It also appeared, from participant responses, that inmates were able to develop positive relationships with the prison officers influenced their willingness to get support. Participants reflected in their responses that if they didn't have a positive relationship with a prison officer, they were then less likely to get the support or access to courses that they expressed they needed.

"You got the screws, and if you're a bit of a wanker, they don't really have much to do with ya, and you know, if you, you know, if you're well, well, you're trying at least, they'll, they will help you out" (Daniel)

The same appeared to be relevant in relation to receiving support from healthcare teams, such as doctors and nurses, as well as therapists. In regard to the doctors and nurses, some participants described at times that they felt their needs were not taken seriously and that they were not provided with appropriate care. One participant

specifically shared an experience where this occurred, which resulted in him feeling and conveying a sense of frustration, which in turn was interpreted negatively by staff. When this occurred, due to miscommunication, his needs were not taken care of. When he shared his frustration, he was instead reprimanded for what was interpreted as violent behaviour, which further increased his distress. Regarding therapists, participants described that the lack of ability to develop positive relationships and trust, due to time constraints and not meeting with the same staff member for the sessions, was difficult to cope with. The lack of consistent and supportive care provided by the healthcare services was described as challenging to manage and often led to increased levels of distress.

"It took them ages to get my medication sorted out, so that was a bit of a nightmare because I wasn't sleeping and stuff... it takes them ages to do anything in jail, you know, they drag their heels… it told me that they didn't care, I'm on my own" (George)

"I had counselling there but then the counselling, um, that was for three weeks… for me to do counselling with someone, I need more than three weeks, you know, I can't just walk into a room and start discussing what's actually going on for myself and how I'm feeling… it's going to open up a couple of, a load of can of worms for me and then all of the sudden they are gone and I'm left with that can of worms open, and my head's going to be even more messed up" (Carl)

Relationships with other inmates was also an important factor relating to how they coped during their periods of incarceration as well as whether they were able to access

support. Whilst most participants described feeling the need to isolate themselves from other prisoners for their own personal safety, some described being able to develop positive relationships with other incarcerated individuals. Interestingly, one of the participants highlighted however that even when he was able to develop positive relationships with other inmates, he still did not want to share his feelings of distress with them, as he did not want to place his burdens on others. I became aware through the analysis process that some participants also found it more beneficial to seek advice from other inmates than from probation officers, especially about ways of accessing the healthcare services.

"Some of them (inmates), but they've got their own problems as well so I wouldn't really go to them with my problems, you, you know, I'd keep it to myself most of the time." (George)

"The challenge was getting heard and finding the people I need to speak to, So I would ask a lot of questions, 'who I need to speak to about this?' 'who do I need to speak to about that?'… speak to old-terms, the long-termers, that have been there, who know the system." (Daniel)

Participants shared that it was also helpful to have positive relationships and networks outside of the prison environment, with the most important ones being probation officers, family members and treatment facilities. As the participants in this research were all individuals who entered prison with addiction issues and were recruited through recovery treatment facilities, these positive relationships were deemed essential. Several participants reflected that moving to treatment centres upon release

was due to having a supportive probation officer or a family member who had a connection to a treatment facility, rather than being able to rely on support on staff within the prison environment. There were mixed descriptions of the support provided by the probation officers, with some stating that they were very helpful and others stating that they were not. When the probation officer was of no help, the ability to reach out to rehabilitation through a family member was crucial.

"Support for in there for getting, for getting treatment centres and everything like that, no, you don't get no support. I had to do it all myself, i.e. by reaching out and, and speaking to my probation officer… because the prison system, they don't do any of that, you know…" (Carl)

"I wasn't connected as in… I had support from a recovery base, my probation officer was about as usual as a chocolate teapot" (Daniel)

I found it captivating to hear the participants describe how their relationships significantly impacted the type and level of support received in prison. It became evident to me during the interview process and analysis, how important positive relationships were for these individuals. I noticed that it is not just about the availability of services, as even though they do exist, a specific type of relationship is needed in order to access them. A reflective note written after the focused codes were created describes the relationship between being incarcerated, not having one's needs met as well as the need for and the lack of communication skills: "One enters prison and feels the need to put coping mechanisms in place, such as becoming more hostile or isolating themselves, due to the volatile climate of the environment. I can only imagine that this would have an impact on how one communicates with others, including with

staff. Additionally, they are experiencing the feeling of not being heard or being overlooked, leading to feelings of hopelessness. Again, this can significantly impact how one communicates. Without the ability to effectively communicate, the likelihood of being consistently supported is considerably less. This leads me to question the following: what about those who are not able or willing to communicate their needs? Those who are not able to rise above the feeling of hopelessness and unable to persevere to get the support they need? What about the ones who don't have a supportive probation officer or a connection to a treatment facility… what happens to them when leaving prison?

4.4 Personal Reflections on the Analysis Process and the Findings

Overall, I found the analysis process as well as the writing of this chapter to be the most challenging aspect of the thesis. There were times where I felt emotionally drained, and experienced moments where I felt overwhelmed by the sheer amount and complexity of the data. I also experienced feelings of frustration as the demanding and enduring nature of the analysis process clashed with my eagerness to identify an emerging theory. This was mainly as I was feeling constrained due to my portfolio submission deadline and also because my research supervisor was leaving the university.

I had a lot of anxiety around the impact of changing supervisors at such a late stage. I was determined to submit this chapter for feedback to my initial supervisor, prior to him leaving. When I was not able to complete the analysis and write-up of the findings within a specified time frame, I felt an overpowering sense of disappointment, leading to an inability to focus on my work. I took time to reflect upon my feelings and

experience, seeking the support of my family, partner and friends. I became aware that I was initially quite naïve about what the process entailed and set unrealistic expectations upon myself. I was used to operating within the structure that I had established for the previous two chapters, which worked well to meet the deadlines.

I came to realise that it is not feasible to set a time limit on the analysis process as this could potentially compromise the quality of my work. Instead, it should follow a natural process of reflection around the meaning of the data. This chapter required a different way of thinking and consisted of an evolving process, where findings emerged gradually, which was very different to the previous two chapters. The ability to identify this for myself helped me in moving forward and I moved my submission deadline to a later date. Alongside this, meeting my new supervisor and reflecting on my challenges with her encouraged me to continue with this chapter with less anxiety and renewed determination.

Experiences of mental health distress within prison contexts are unique to each individual. As such, I also often found myself worrying throughout the analysis process that the established codes and categories did not fully embody the participants experiences. The terminology used for categories altered slightly throughout the analysis as I wanted to ensure that they fully encompassed the experiences described. There were times where I had named categories, including primary sub-categories, but upon reflection, felt that the title of the category did not appropriately represent participant experiences. This is as words can have many meanings, based on individual perception, and I wanted to ensure that the findings written above encapsulated the experiences of participants as much as possible.

Whilst initially finding it challenging to create initial codes using words which stayed grounded in the participant responses, I found it helped me overall and offered a sense of reassurance when establishing the main categories as well as the core-category. The use of reflective notes and memos significantly supported the process of identifying the categories and core-connecting category. Interestingly, I did notice that the type of questions I asked myself developed and changed as I worked through the analysis process. As Charmaz and Creswell highlighted, this is an essential part the grounded theory analytical method; “Our questions will change and become more refined during the process of research to reflect an increased understanding of the problem” (Agee, 2009; Creswell & Poth, 2018; Charmaz, 2006).

Having been able to interview individuals who directly experienced life in prison in recent years, I feel that I was able to get an eye-opening and significantly deeper understanding of what happens when individuals experience mental health distress. The knowledge brought forth by the participants was incredibly valuable, and interesting to listen to and analyse. Whilst this was a study based on a small sample population, I believe that these findings can positively contribute to the already existing knowledge on the subject and offer a level of detail that I felt was missing from existing research. The findings of this research can act as a powerful driving force to encourage positive changes to take place within the prison environment and lead to better support for inmates with their mental health distress as well as their overall wellbeing.

The following chapter will discuss the value and relevance of the findings. More specifically, the discussion chapter will detail the types of changes that could be made as well as the implications for prisons and the counselling psychology practice in these contexts. Relevant literature will be incorporated in order to assess the weight of the findings of this research as well as the feasibility of introducing practice changes.

Chapter 5: Discussion

5.1 Introduction

As detailed in the first chapter, there were three key motives for carrying out this research. Firstly, I wanted to offer a pathway towards developing a better understanding of how support systems in prisons respond to the mental health distress of incarcerated individuals. Another aim of this research was to review existing support systems within the prison context and identify aspects which could be improved, to better support incarcerated individuals with mental health distress. Thirdly, these individuals are an overlooked group within research, which is the reason I found it imperative to offer them the opportunity to be heard. I felt that the most appropriate way of addressing these aims was to interview individuals who have first-hand experience of this phenomenon.

Constructivist grounded theory was chosen as the most appropriate method to address these aims. In turn, it supported me in constructing a theory which could answer the established research question. On the basis of the analysis process of the interviews, four main categories were identified. Alongside this, a core connecting category of consistent versus inconsistent support was established.

This chapter begins by discussing the significance of the findings, whilst taking into account relevant pre-existing research and knowledge. The quality of the study is then evaluated in relation to the quality standards and guidelines outlined in the second chapter. Following this, the strengths, contributions and limitations of the study are reviewed and implications for future research are outlined. The implications of the

research are also reflected upon and several practice recommendations are identified. Finally, I take the time to reflect on the impact of my role as the researcher on the study and the findings, as well as the impact that the research had on me.

5.2 Discussion and Interpretation of the Findings

A core category of “consistent versus inconsistent support” was established through the analysis process, through which a tentative theory was constructed. The findings of this research clearly indicate that the individuals who took part in this research did not receive consistent support for their mental health distress whilst incarcerated. Furthermore, it highlighted that the existence of mental health support services in prison contexts does not automatically imply that support is reliably provided to those in need. Participants indicated that there were a number of challenges to receiving consistent mental health support, whilst expressing that having access to consistent support would have been beneficial to their mental health and overall wellbeing.

The core category embodies the foundation through which the findings can be understood and is the connecting concept between the main categories. The research findings were categorised into four main factors which are associated to the challenges of accessing consistent mental health support in prison. These consist of the violent nature of the prison environment, the high demand of inmates needs for support as well as limited accessibility to support services. Alongside this, there appears to be a lack of opportunity to develop positive relationships inside and outside of the prison environment, which is a crucial aspect of being able to receive consistent and appropriate support. Broadly speaking, these findings are in-line with existing research, which claims that the current mental health provisions in prison settings are

not adequately equipped to cope with the demand of mental health needs of inmates (Georgiou & Townsend, 2019; RCPsych, 2018; RCPsych, 2019; Tyler, Miles, Karadag & Rogers, 2019; Patel, Harvey & Forrester, 2018).

Whilst the core finding that inmates do not receive consistent support for their mental health needs is not novel, the extensive depth of knowledge provided by the participants offers a level of detail and insight, which is lacking within existing research. A key contribution of this research is that it offers a thorough account of how prison mental health support services function in the real world and how they respond to the mental health needs of incarcerated individuals. Such insight is essential to ensure that improvements made to current support systems are appropriate and effective. The value and relevance of each main factor is discussed in detail below.

5.2.1 Main Category 1: The Environmental Impact

The present study indicates that a range of aspects, which make up the prison environment, negatively impact the mental health of inmates. Participants described how the violent climate within prisons had a significant negative impact on their mental health and overall wellbeing. It also limited the ability to receive consistent support. They attributed the violence to the high prevalence of mental health distress amongst prisoners, a lack of supportive staff, and the availability of drugs and contraband. My research findings are consistent with previous documented research (Goomany & Dickinson, 2015; Van Ginneken, Palmen, Bosma & Sentse, 2019; Liebling & Arnold, 2004; Fazel, Hayes, Bartellas, Clerici & Trestman, 2016; Wheatley, 2016). However it is important to note that there is little existing research specifically exploring the mental health distress of prisoners through qualitative methods and from the perspective of

the prisoner. The research findings on the environmental impact delves into the specifics of this impact, thus contributing to what is already known by addressing a gap in the research and literature.

The violent nature of prisons has been consistently evidenced throughout the years. For instance, a 1994 study found that violence, intimidation and exploitation is common within prison environments, and even goes as far as saying that it is normalised (Goomany & Dickinson, 2015; Sim, 1994). Recent Ministry of Justice safety reports as well as recent protests by prison staff also highlight that violence is still strongly present in these contexts (MoJ, 2019c; Wright, 2018).

As mentioned in the first chapter, the prevalence of mental health problems in prison is significantly higher than in the general UK population (Goomany & Dickinson, 2015; Gunn, Maden & Swinton, 1991; Harty, Jarrett, Thornicroft & Shaw, 2012; Tyler, Miles, Karadag & Rogers, 2019). This research has evidenced that the violent prison climate has an enormous impact on mental health. The impact of the prison environment is even more significant for those who enter prison with pre-existing mental health issues (Goomany & Dickinson, 2015). Both of these findings are in-line with the findings of previous research. For instance, a study, carried out by De Viggiani, found that the violent nature of prisons leads to a sense of fear amongst inmates throughout their sentences (De Viggiani, 2003; Goomany & Dickinson, 2015). In relation to this, research has highlighted that mental health distress is impacted by whether an incarcerated individual feels safe and has been correlated to maladjustment (Van Ginneken, Palmen, Bosma & Sentse, 2019; Steiner & Meade, 2016).

The lack of safety in prisons and mental health deterioration has also been strongly correlated to a lack of supportive staff available and unfair treatment by staff of inmates (Van Ginneken, Palmen, Bosma & Sentse, 2019; Liebling & Arnold, 2004). A reduction in funding over the years has resulted in a decline in staff levels and a lack of adequate training in prison settings (Atkins, et al., 2019). Inevitably, this has had a detrimental impact on the safety of prisons as prison standards have deteriorated, the prison population has increased and incidents of violence have also escalated (Atkins, et al., 2019; Cobb & Farrants, 2014). As described by the participants of this study, staff appear solely to have enough resources to respond to emergencies, indicating that those deemed to not be an emergency are overlooked as a result. Since prison staff hold significant power as they determine access to support services, it makes sense that the participants of the current study described the inconsistent levels of support from staff as challenging and detrimental to their mental health (Van Ginneken, Palmen, Bosma & Sentse, 2019; Liebling & Arnold, 2004).

Another key factor associated to prison violence is the frequence of substance misuse in prison settings (Fazel, Hayes, Bartellas, Clerici & Trestman, 2016; Wheatley, 2016). Research has evidenced that there is high comorbidity between substance misuse and mental health distress, and that substance misuse is a risk factor for violent behaviour in those with mental health concerns (Fazel, Hayes, Bartellas, Clerici & Trestman, 2016; Simpler & Langhinrichen-Rohling, 2005; Boles & Miotto, 2003; Pickard & Fazel, 2014; Lo & Stephens, 2000). The pervasiveness of drugs and contraband in prisons is therefore highly concerning, as it can trigger the onset of mental health distress as well as exacerbate pre-existing mental health conditions. This, in turn, can lead to increased violence as well as increased incidents related to

self-harm and suicide. This relationship was clearly identified by some of the participants of the current study.

Interestingly, previous research has demonstrated that there are also other factors that impact the mental health of incarcerated individuals, which were not frequently mentioned by the participants of the current study. For instance, research has evidenced that the overcrowding in prisons, a loss of freedom and autonomy, a lack of opportunity for mental stimulation have an impact on the mental health of prisoners (Goomany & Dickinson, 2015; Nurse, Woodcock & Ormsby, 2003; World Health Organisation, 2013; De Viggiani, 2003). The lack of ability to connect with their family and other loved ones also has been shown to be directly correlated to the deterioration of mental health of inmates (Goomany & Dickinson, 2015; Nurse, Woodcock & Ormsby, 2003; World Health Organisation, 2013; De Viggiani, 2003). The fact that prison experiences are very personal could explain why the factors described in the research above were not commonly mentioned by the participants of the current research study.

Reflecting on the impact of the prison environment, it does not come as a surprise that the participants of the current study expressed the need to develop particular coping mechanisms. Participants most commonly spoke of the need to become more hostile and to self-isolate, in order to increase their sense of safety. Other studies carried out on the impact of prison on prisoners have demonstrated similar findings. Such studies theorise that the regime and climate which exists in prisons results in inmates feeling the need to convey traits associated to masculinity, such as aggression, in order to survive (Ricciardelli, Maier & Hannah-Mofat, 2015; Evans & Wallace, 2008).

Unfortunately, as indicated by my research findings and existing research, both of these coping mechanisms have an interrelated impact on mental health as well as the likelihood of requesting and receiving support (Nurse, Woodcock & Ormsby, 2003; Goomany & Dickinson, 2015; Novotney, 2019; Kupers, 2005).

The findings of this research highlighted that whether the individual was allocated to the general population wing or rehabilitation wing greatly influenced the level of impact the environment had on the individual. As the drug-free wings were considered less violent and more supportive services were available, the potential for negative impact reduced. As drug-free wings in prison only launched in 2011, solely two previous studies have explored the benefits of such environments for incarcerated individuals with addiction problems. The two reports offer mixed findings on the success of these environments (Powis, Walton & Randhawa, 2014; Lloyd, McKeganey & Liebling, 2017). The Ministry of Justice report implies that such wings offer the opportunity for rehabilitation and positive change, whilst the independent evaluation found that the mental health of incarcerated individuals still declined (Powis, Walton & Randhawa, 2014; Lloyd, McKeganey & Liebling, 2017). Considering the limited research carried out on this topic, the findings of this study offers insights that powerfully contributes to the understanding of the environmental impact and its connection to inmates needs. Still, more research is needed on the strengths and limitations of drug-free prison wings and whether similar rehabilitative environments would also be suitable for those with mental health distress.

5.2.2 Main Category 2: Inmate Needs

The participants of the current study indicated that their needs whilst imprisoned, related to their general wellbeing as well as their mental health, with mental health support identified as most commonly required. In this research, participant's responses indicated that depression and anxiety were the most commonly experienced mental health concerns, leading to the need of support for these types of mental health problems.

The findings of this study identify that mental health support is most commonly needed by inmates, which fits with available statistics on prevalence of mental health distress amongst the prison population. Alongside this, research has evidenced that there is a high comorbidity rate between depression and anxiety amongst the prison population, which may explain the findings of the current study (Jakobowitz et al., 2017). However, it is challenging to compare the findings of this research on prisoner's needs to earlier research. Previous research has not solely explored more commonly experienced mental health concerns as those included within the present study.

Existing large-scale quantitative studies have highlighted that comorbidity is common amongst the prison population, with many suffering from mental health problems such as psychosis, alongside issues substance additions (Senior, 2015; Fazel, Hayes, Bartellas, Clerici & Trestman, 2016; Jakobwitz et al., 2016; Cobb & Farrants, 2014). Due to the prevalence of co-morbidity amongst the prison population, research has not focused on the mental health concerns included in the current study. However, the need for more focused research is very apparent for several reasons. The prevalence of the more commonly experienced mental health concerns amongst the prison

population is significantly higher compared to the general public in England (Goomany & Dickinson, 2015; Gunn, Maden & Swinton, 1991; Harty, Jarrett; Tyler, Miles, Karadag & Rogers, 2019). Additionally, research has demonstrated that inmate needs have become more complex throughout the years (Thornicroft & Shaw, 2012; Atkins et al., 2019).

Focused research, such as the current study, allows for a deeper understanding of the mental health concerns in prison and ability to pinpoint specific areas which needs to be addressed; the prison policies related to the mental health as well as mental health services. By using a qualitative methodology and focusing on specific mental health issues, this research was able to provide more meaningful and in-depth findings, missing in previous research.

The participants described having similar types of needs throughout their sentences, but expressed having more specific needs upon entry into prison and upon re-entry into society. Regarding entry into prison, the research contributors identified needing support with addiction withdrawal symptoms alongside support to adjust to the prison environment. When nearing their release date, participants shared experiencing distress due to their worry around money, job prospects, continuing with their addiction recovery process as well as the potential for homelessness. Some reflected that their distress and a lack of support led to feelings of hopelessness as well as a worry of returning to prison in the future.

It appears that there is significantly more research which explores the challenges faced by prisoners upon re-entry into society than when first entering prison. When

looking into research on prisoner health and mental health needs upon entry to prison, it also became clear that such research is often focused on specific populations. For instance, I found research specifically focused on the needs of younger adults, older adults, indigenous groups, as well as individuals with nicotine addictions. Whilst such focus is valuable to our understanding of the mental health problems within prison environments, it does indicate that there are a range of groups within the prison population that are overlooked. It is also important to note that a majority of the studies exploring prisoner needs are based on prison populations outside of the UK. Whilst studies completed outside of the UK can be argued to be broadly relevant, it will not directly apply or be fully representative of the UK prison population.

One study that I found, which does explore psychiatric needs of incarcerated individuals within the UK upon entry, discovered that prisoners tend to experience low mood within the first weeks of their sentence (Jakobowitz et al., 2017). The same study also found that around five percent of the prison population suffers from adjustment disorders, which is partially due to the stress created by the prison environment (Jakobowitz et al., 2017). Finally, it found that drug and alcohol abuse is a predominant issue faced by the prison population, and that depression and substance misuse are prone to reinforce each other (Jakobowitz et al., 2017). A study on the perceived needs of prisoners with addictions upon entering prison in America found that three out of five believed it would be beneficial to receive relevant treatment support (Lo & Stephens, 2000). The findings of these studies are consistent and in-line with the findings of my study. Considering the lack of research carried out on sample population of my study and generally on inmate needs upon entering prison, the current study offers meaningful information which contributes to the knowledge base.

Still, additional research is needed on this particular topic, to enhance our understanding of inmate needs when first entering the prison system.

Regarding prisoner release into society, a substantial amount of research has been carried out on this topic, although the majority of research has not been on a UK prison population. Whilst these cannot be considered as fully representational of the UK prison population, the findings on prisoner needs upon re-entry into society of non-UK populations broadly fits the findings of the current research findings. Preceding research has consistently evidenced that incarcerated individuals face difficult challenges upon their release into society. Research has shown that employment prospects are significantly reduced once an individual has a criminal record, and that those who do find employment are likely to be employed within low-skill roles (Li, 2018; Visher, Debus-Sherrill & Yahner, 2011; MoJ, 2013b). Previously incarcerated individuals also face challenges when it comes to housing due to strict housing policies, leading to increased prospects of becoming homeless upon release (Li, 2018; Leasure & Martin, 2017; MoJ, 2012b; Woodall, Dixey & South, 2013). Alongside this, those previously imprisoned who suffer from mental health distress appear to find release into society more challenging (Hopkin, Evans-Lacko, Forrester, Shaw & Thornicroft, 2018; Woodall, Dixey & South, 2013). The lack of community mental health support available for recently released individuals can lead to the worsening of an individual's mental state and increase the likelihood of reoffending (Hopkin, Evans-Lacko, Forrester, Shaw & Thornicroft, 2018; Woodall, Dixey & South, 2013). The same can be said for addiction treatment support upon release, as previously incarcerated individuals face several barriers to receiving such support (Owens, Chen, Simpson, Timko & Williams, 2018; Woodall, Dixey & South, 2013).

Mental health difficulties, a lack of job opportunity, appropriate rehabilitation support, and a lack of housing support upon release have all been evidenced directly to an increased likelihood of reoffending and returning to prison (Martin, 2011; Li, 2018; Owens, Chen, Simpson, Timko & Williams, 2018; Baybutt & Chemlal, 2016). Considering the findings of previous research and reports, the worries and the need for consistent and continuing support, described by the participants of my research are clearly justified.

A final finding of my study in relation to inmate needs was that the severity of their needs as well as the level of support needed depended on individual characteristics such as developed coping strategies, their stage of addiction recovery as well as the stage of their sentence. A crucial finding was that the key to getting support was the ability to take initiative and consistently persevere in order for their needs to be heard and met.

The fact that incarcerated individuals have a range of needs, and that more specific needs are associated to different stages of their sentence has already been evidenced. However, there is very little existing research that focuses on how individual characteristics impact inmate needs. An older study that I found backed this finding however, stating that seeking out mental health support related to personal characteristics such as self-assertion (Skogstad, Deane & Spicer, 2006; Gambrill, 1997). A more recent study identified that the severity of the mental health distress impacted the likelihood of seeking support; higher levels of distress are associated with requesting more support (Skogstad, Deane & Spicer, 2006).

Interestingly, the majority of other research I found was solely based on a female population and on factors such as religion and spirituality, which cannot be applied to the sample population of the current study. As such, the current research study addresses this gap in the research and delves into the specifics of inmates needs significantly more than other research. I feel that having this detailed information, provided by those who experience the phenomenon first-hand, is very relevant, to building a deeper and more meaningful understanding. This type of knowledge allows us to establish effective practice changes so that prisoner needs are more appropriately and consistently met. It would be crucial for future research to focus on exploring the impact of personal characteristics on the ability to access support in prison settings.

5.2.3 Main Category 3: Access to Services

The findings of this research indicated that there is a strong correlation between the level of consistency of support staff and the ability to access support services in prison. The participants reflected needing consistent support from a range of services, such as healthcare, including psychological support as well as recovery-focused programs and educational courses. There were mixed perceptions on the quality of support services in prison as this depended on the wing to which they were allocated, but they emphasised that gaining access to support was challenging. Participants clearly indicated that support was more readily available and of better quality in the drug-free wings than in the general population wings.

Factors related to the challenges faced by the participants consisted of a lack of supportive staff, long waiting lists and inappropriate referral procedures. They also

said that support services in prison settings are inadequately equipped due to a lack of resources and available funding in such contexts. When receiving support, it also tended to be offered inconsistently and thus there was a lack of opportunity to develop relationships based on trust with support staff, such as psychologists. The participants described that the challenging nature of receiving support and the inconsistent support provided by staff and services, often led to the feelings of being overlooked and unheard. This consequently had a negative impact on their mental health as they experienced increased feelings of hopelessness and frustration.

Legislative changes and structural improvements have been made over the years to better support incarcerated individuals with their mental health and wellbeing. For instance, in 2007, NHS-IAPT programmes were introduced to improve mental health support and in 2013, NHS England became responsible for commissioning all health services in prisons, with the aim of offering prisoners equivalent support to the general public (Adamson, Gibbs, McLaughlin, 2014; Senior, 2015; NHS England, 2013; Powis, Walton & Randhawa, 2014; Lloyd, McKeganey & Liebling, 2017; Baybutt & Chemlal, 2016; Cobb & Farrants, 2014). Additionally, in 2011, drug recovery programs were introduced to support those with addiction issues (Reed & Lyne, 2000). Several guidelines, such as the 2018 NICE guidelines and the 2002 Department of Health advisory document, have also been introduced to promote improved mental health and wellbeing support services in prisons (NHS England, 2018; Department of Health, 2002). It is important to note that research currently being carried out or that was carried out in recent years, such as this study, would not have been able to pick-up on the impact of the more recent changes. Still, research carried out throughout the years

has consistently demonstrated that prison support services are unsatisfactorily equipped to cope with inmate's needs.

Research has showed that the prevalence of mental health distress is extraordinarily high in prisons and that prisoners are more likely to request health support than those in the general public (Condon et al., 2017; Goomany & Dickinson, 2015; Gunn, Maden & Swinton, 1991; Harty, Jarrett, Thornicroft & Shaw, 2012; Tyler, Miles, Karadag & Rogers, 2019). Despite the new initiatives, access to supportive services in prisons has tended to be low and the ability to receive appropriate and consistent support, including psychological therapy, is limited (Mansoor, Perwez, Swamy & Ramaseshan, 2015, Georgiou & Townsend, 2019; RCPsych, 2018; RCPsych, 2019; Tyler, Miles, Karadag & Rogers, 2019; Patel, Harvey & Forrester, 2018; Mills & Kendall, 2016). When accessing healthcare and psychological support, there is a lack of continuity which is concerning, as such inconsistency can lead to the deterioration of prisoners mental health (House of Commons, 2017). The research evidences that overall, the original intention of offering the same level of support to prisoners as the NHS offers to the general public has not been successful (Mills & Kendall, 2016; Cobb & Farrants, 2014).

Research has shown that the detection process of mental health distress upon entry into the prison system is poor and when identified, may still go untreated (Senior, 2015; Brooker, et al., 2002; Cobb & Farrants, 2014). Whilst some prisoners may refuse treatment due to a worry that this would negatively impact their reputation, a fear of feeling vulnerable and/or a lack of trust in staff, it is clear that the lack of detection of mental health distress is also due to the flaws within the prison structure and system

(Mills & Kendall, 2016; Cobb & Farrants, 2014; Howerton., et al, 2007; Skogstad, Deane & Spicer, 2006). Studies have highlighted that the standard of healthcare is lower in prisons than in the community, that there is a lack of staff and resources, as well as a lack of multidisciplinary and co-ordinated work (Reed & Lyne, 2000; Mills & Kendall, 2016; House of Commons, 2017). Healthcare staff, such as nurses, are often also not appropriately trained, which can lead to expressed behaviours associated to mental health distress being overlooked, disregarded or misinterpreted (Reed & Lyne, 2000; Seddon, 2007; Mills & Kendall, 2016). As help-seeking behaviours of prisoners can be strongly influenced by the attitudes of staff as well as the level of support provided by such individuals, this is concerning and needs to be addressed (Cobb & Farrants, 2014; Skogstad, Deane & Spicer, 2006).

As prisons in England represent the punishment-based system for criminal offenses, there is little opportunity for mental health needs to be prioritised (Mills & Kendall, 2016; Cobb & Farrants, 2014). The prison regime largely focuses on encouraging discipline and maintaining safety and security, so healthcare initiatives tend to not be prioritised (De Viggianni, 2003). These factors have led authors and researchers to debate whether the values of health and wellbeing services align with the culture and regimes which exist within the prison environment (Baybutt & Chemlal, 2016; Smith, 2002; Woodall, Dixey & South, 2014; Niveau, 2007; Harvey & Smedley, 2010). I agree with these views and believe that the prison system in the UK is currently not set up to prioritise the delivery of consistent and appropriate support which addresses the mental health needs of inmates. This view is backed by the findings of the current research as well as the extensive amount of previous research which has been carried out on this topic. However, that is not to say that rehabilitative prisons are not a feasible

prospect. For instance, the prison system in Norway has changed over the years to focusing primarily on rehabilitation and re-integration instead of punishment (Pakes & Holt, 2017; Larsen, Hean & Odegard, 2019). In comparison to England, which arguably has a similar cultural and societal values to Norway, the Norwegian incarceration system is known to provide improved outcomes for prisoners (Pakes & Holt, 2017; Larsen, Hean & Odegard, 2019). Recidivism rates are also significantly lower in Norway (Pakes & Holt, 2017; Larsen, Hean & Odegard, 2019).

Reviewing the methods of the existing research, it appears that little research has focused on qualitatively exploring the experiences of incarcerated individuals in relation to the prison healthcare system. As a result their voices have continued to go largely unheard. As such, whilst existing research identifies the support systems that are in place, they predominantly do not account for how these services operate within the real world and how they respond to inmate needs. Whilst there is no one-size-fits-all solution to addressing prisoner mental health needs, by ignoring those with personal and first-hand experience of this reality, inappropriate policies and structural changes may well be implemented. The current study aimed to address these gaps by offering a thorough insight into prisoner experiences and perceptions of the existing healthcare system, thus contributing powerfully to the knowledge base by identifying particular areas to address.

5.2.4 Main Category 4: Relationships Inside and Outside of Prison

According to the research participants, the ability to access support was strongly dictated by the types of relationships they had and were able to develop inside and outside of the prison environment. Inside of the prison environment, it was crucial to

have positive relationships with prison officers, other inmates as well as healthcare staff such as doctors, nurses and therapists. Positive relationships with such individuals increased the likelihood of accessing consistent support whilst incarcerated. Outside of prison, it was key to have positive relationships with their families, their probation officers as well as treatment facilities. When moving towards the end of their incarceration period, these relationships were crucial as they influenced the ability to access appropriate and consistent support once released.

Several studies have demonstrated that the prison environment can offer a restorative space, away from the usual chaos that encompasses their lives, where they can regain control of their health (Woodall, Dixey & South, 2014; Wacquant, 2002; Foucault, 1977). Some find it comforting to live within such a regime as they will have the ability to access support which they otherwise may not be inclined to seek out or have access to. It is important to note, however, that there are significant power dynamics at play within prison settings, where the lives of the incarcerated individuals are, to a large extent, controlled by the prison system and the prison officers (Woodall, Dixey & South, 2014; Liebling, Price & Schefer, 2011). Research has demonstrated that prisoners have a lack of freedom, autonomy and choice, as these are governed by the system (Woodall, Dixey & South, 2014; Smith, 2002; Godderis, 2006). For instance, at what time they eat, the time they go to sleep, permissible activities, access allowance and medical assistance, are all decided by the prison regime and depend on the actions of the staff. The day-to-day life in prison is a constant reminder of their lack of agency (Woodall, Dixey & South, 2014; Smith, 2002; Godderis, 2006). This way of living can lead to feelings of frustration, hopelessness and thus a deterioration in mental health (Woodall, Dixey & South, 2014).

Since prison officers are the ones who most often interact with prisoners, especially when it comes to getting their needs addressed, there is huge value placed on these relationships (Galanek, 2014; Beijersbergen, Dirkzwager, van der Laan & Nieuwbeerta, 2016). To a large extent, prison officers act as gatekeepers to support services. The relationship between prisoners and prison officers can thus influence whether and to which extent they are supported and can hugely impact mental health support outcomes (Reed & Lyne, 2000; Galanek, 2014; Beijersbergen, Dirkzwager, van der Laan & Nieuwbeerta, 2016). A negative relationship between the inmate and prison officer makes it less likely for prisoners to seek support or receive quick and appropriate support (Skogstad, Deane & Spicer, 2006). Unfortunately, the ability for incarcerated individuals to form positive relationships with staff is challenging due to a lack of staff, a lack of proper staff training, and inefficient management of staff (Nurse, Woodcock & Ormsby, 2003; Liebling, Price & Schefer, 2011). Research has also evidenced that prison staff suffer from high levels of stress due to the environment and the demanding nature of the role, which has led to a fast turnover of staff (Nurse, Woodcock & Ormsby, 2003; Liebling, Price & Schefer, 2011). The challenges regarding the ability to develop positive relationships with prison officers, mentioned above, were invariably described by the participants of the current study.

Exploratory research on prisoner perceptions of prison officers has identified that the views of inmates generally falls into several categories (Liebling, Price & Schefer, 2011; Tait, 2008). Overall, these studies have identified that prisoners only view a small number of staff as ‘good’ and that those will take their time to support inmates but that a large number of staff view their role as a ‘job’ and were less likely to support inmates but did view them as ‘human beings’ (Liebling, Price & Schefer, 2011). Finally,

a small proportion of staff were seen as ‘bad’ and could be vindictive towards inmates (Liebling, Price & Schefer, 2011). These findings indicate that there is no consistency in staff attitudes towards inmates, which will influence the likelihood that an incarcerated individual reaches out for support for their mental health distress. This inconsistency and the related impact was powerfully described by the participants of the current study as well.

The evidence described above is backed by the findings of the current research and the deterioration of mental health due to these factors was certainly something to which the participants could relate. The lack of research into the importance of relationships, from the perspective of the previously incarcerated individual, makes the findings of this research study of huge significance. This is as it improves our understanding of the prisoner experience. The findings identifies important aspects which need to be addressed, regarding the prisoners ability to develop positive relationships with prison officers. It is clear however that more research needs to be carried out on this topic, as there is not a substantial amount of research available to confirm the research findings.

A few studies have also explored the impact of inmate-on-inmate relationships, the support of family as well as the existing healthcare teams in prisons, and how these impact the likelihood of seeking support for mental health needs. Studies have evidenced that prisoners who are not encouraged to seek support by their support system, such as other inmates, family members and healthcare teams in prison, are less likely to reach out to supportive services (Skogstad, Deane & Spicer, 2006; Armitage & Conner, 2001; Mills & Kendall, 2016). This is due to a worry of not being

appropriately helped and of not being accepted or understood (Skogstad, Deane & Spicer, 2006; Armitage & Conner, 2001; Mills & Kendall, 2016). As mentioned in the previous section, some prisoners may also not seek support due to their fear of coming across as vulnerable or weak in relation to others as well as a lack of trust in the prison healthcare system (Mills & Kendall, 2016; Cobb & Farrants, 2014; Howerton., et al, 2007; Skogstad, Deane & Spicer, 2006; De Viggianni, 2003). Something that I found particularly interesting in my findings is that whilst inmate support and healthcare attitudes were commonly declared by participants as influencing the likelihood of seeking support, the influence of family members was not mentioned. The findings of previous studies are in line with the research findings of this study, except for the existing literature which highlights the importance of supportive family members. Overall, I believe that the current study explore the meaning and impact of these relationships more profoundly than previous research has done.

The relationship between prisoners and therapists are also crucial when addressing prisoner mental health needs. I was not able to find research which specifically focuses on the importance of the relationship between an incarcerated male and psychological practitioners. However, non-prison related research has consistently evidenced the value that the therapeutic alliance between a therapist and client holds. A strong therapeutic relationship, both in short and long term therapeutic work, offers a pathway to predicting change, positively impacts client engagement and is more likely to lead to positive treatment outcomes as a whole (Bordin, 1979; Renik, 2000; Ross, Polaschek & Ward, 2008; Cailhol et al., 2009). These findings can be transferred to prison settings, and it could be said that the therapeutic alliance is even more important in such settings. The findings of the current research indicates that due to a

lack of staff, a lack of opportunity to access therapeutic support, not being seen by the same healthcare professional, as well as the time-limited duration of therapeutic support, it is challenging to build positive relationships with therapists. It would be fundamental to address these issues considering the positive impact that a strong therapeutic alliance can have on the outcomes of mental health distress outcomes.

With regards to relationships outside the prison environment, it is important to have positive relationships with the probation officer and treatment facilities, so that upon release of prison, the ex-prisoner can be appropriately and consistently supported. Participants highlighted that a connection with a treatment facility through a family member was also essential to ensuring they received appropriate support post release. They highlighted that this was especially important when a positive relationship with the probation officer was not possible or when the probation officer was not appropriately supportive.

Access to appropriate and consistent support upon release, such as treatment facilities and a support network, have a substantial impact on recidivism rate (Chamberlain, Gricius, Wallace, Borjas & Ware, 2017; Batty, 2020). They also increase the likelihood of positive outcomes for previously incarcerated individuals with mental health distress (Hopkin, Evans-Lacko, Forrester, Shaw & Thornicroft, 2018). As such, it is fundamental that those with mental health distress are consistently supported upon release and have access to support services if needed. Probation officers play a very important role in the lives of prisoners who have recently been released from prison on probation. They are said to play a dual role, one of support and of ensuring that their clients adhere to the terms of the probation (Chamberlain,

Gricius, Wallace, Borjas & Ware, 2017; Cnaan & Woida, 2019). Considering the characteristics of the sample population of the current study, a key aspect of the supportive role of probation officers would be to find appropriate treatment centres. Participants had mixed opinions of their probation officers, with some describing them as helpful whilst others described them as not being supportive or accommodating.

Minimal research has explored the importance of the relationship between the previously incarcerated individual and the probation officer. Additionally, the majority of research on this topic has been from the view of the probation officer, rather than that of the prisoner on probation. However, studies that have been carried out clearly demonstrate that probation officers play a crucial role in the re-entry into society process of a previously incarcerated individuals as well as the impact on the likelihood of reoffending in the future (Chamberlain, Gricius, Wallace, Borjas & Ware, 2017; Klockars, 1972). Additionally, the parolee's willingness to comply with the conditions of their probationary contract and willingness to speak openly with their probation officers is strongly dependent on their relationship (Chamberlain, Gricius, Wallace, Borjas & Ware, 2017; Bonta, Rugge, Scott, Bourgon & Yessine, 2008; Robinson, 2005). In relation to this, a negative relationship can lead to the client feeling higher levels of anxiety and distress alongside lower levels of self-efficacy (Cnaan & Woida, 2019). The impacts of a positive or negative relationship were described in more detail by the participants of the current study than previous research, thus contributing to the existing knowledge base in a meaningful way.

Alongside probation officers, family support has been evidenced, by both quantitative and qualitative research studies, to play a huge role in the lives of those who have

recently been released from prison (Mowen, Stansfield & Boman, 2018). Whilst the contributors of the current study solely discussed the importance of family support and access in relation to gaining access to treatment facilities post-release, further research has identified several other important reasons. Consistent family support can have a far reaching impact on those who have recently been released as it can positively increase reintegration outcomes (Boman & Mowen, 2017; Berg & Huebner, 2011; Vishner, Debus & Yahner, 2008; Grieb et al., 2014; Wallace et al., 2016). For instance, it can impact reoffending behaviours, mental health and job employment prospects (Boman & Mowen, 2017; Berg & Huebner, 2011; Vishner, Debus & Yahner, 2008; Grieb et al., 2014; Wallace et al., 2016). Interestingly, despite the substantial amount of research that has been carried out on the importance of family support, I have not found any studies which go into detail on the impact of family connections to treatment facilities. One can appropriately assume that it has a positive impact, however it would be vital that future research focuses on researching this specific area. Considering this gap in the research, the findings of the current study, on the importance of family connections, can be considered to be an original contribution which adds to the pre-existing knowledge base.

5.3 Evaluation of the Study

In this section, I reflect on the ways in which I ensured that a high-quality study was carried out, the strengths and contributions of study, limitations of the study as well implications for future research.

5.3.1 Standards and Measures of Quality

As described in the methodology chapter, the quality of this study was assured at all times a I strictly adhered to several guidelines. Whilst a range of guidelines have been established throughout the years to evaluate qualitative research, I have used Henwood and Pidgeon's guidelines of good qualitative research alongside Yardley's standards for quality control and Charmaz's identified qualities for credible and good qualitative research (Henwood & Pidgeon, 2003; Henwood & Pidgeon, 1992; Yardley, 2000; Charmaz, 2014). Adhering to these guidelines has allowed me to ensure that a thorough, credible and useful research study was carried out.

The recommendations from the guidelines used have been grouped into the several headings, which are briefly summarised on the left side of table 2, below. Table 2 also outlines the strategies I used, with the aim of striving to meet the recommendations outlined in the guidelines.

Table 2. Approaches taken to ensure a high quality study was carried out.

Quality Standards	Adopted Approaches
Proximity to the Data Charmaz as well as Henwood and Pidgeon emphasise the importance of staying close to the data, to ensure that meaning is not lost in the analysis process, to ensure sensitivity to the negotiated realities, and to ensure that the constructed theory appropriately fits the collected data (Charmaz, 2014; Henwood & Pidgeon, 2003; Henwood & Pidgeon, 1992).	• Line-by-line coding and action-focused coding was carried out to ensure I did not deviate from the descriptions and meanings of experiences shared by the participants. • Constant comparative analysis and negative case analysis was carried out to ensure that findings fit the data.
Reflexivity Henwood and Pidgeon identify in their guidelines the need for researchers to	• Continuously engaged in personal, methodological, epistemological at all stages of the research.

reflexively consider their position and role in relation to the research at all stages of the research process (Henwood & Pidgeon, 2003; Henwood & Pidgeon, 1992). Yardley stresses the importance of remaining sensitive to the relationship between the researcher and the participants, and the ways in which this relationship can impact the findings (Yardley, 2000). Both state that the reflexive practice should be recorded.	• Consistently created reflective notes, memos and used a reflexive journal throughout the research process. Examples of reflective notes and memos are provided in the method as well as the findings and analysis chapters. • Ensured I wrote from a first-person perspective when appropriate, to highlight my awareness of my role within the research process and in constructing a theory based on the data. • An exhaustive review of the relevance, value and originality of the findings is carried out in section 5.2 of this chapter.
Credibility Charmaz emphasises that the credibility of research is directly correlated to the depth and scope of the data, the engagement of the researcher with the data, as well as the suitability and sufficiency for describing empirical events (Charmaz, 2014). Yardley's guidelines highlights the importance of being committed to a process of transparency and coherency and of ensuring a rigorous stance is taken throughout the data collection, analysis and reporting processes (Yardley, 2000).	• Quotes of participants were included throughout the analysis and findings chapter. • Supervisor feedback was sought at all stages of this research, including review of each chapter, the different coding and analytical strategies used, as well as the coherence of the findings in relation to the research question. • A thorough and in-depth analysis was carried out. Extracts of the transcription process and the process of developing focused codes are provided in findings and analysis chapter as well as in the appendices. • Contextualising data, such as demographic information and inclusion criteria of the sample are detailed within the methods chapter as well as the findings and analysis chapter, in order to contextualise the findings of the research. • The limitations of the study are reflected upon in section 5.3.3.
Clarity & Usefulness Henwood and Pidgeon's suggests that findings should be able to be applied more generally whilst maintaining significance (Henwood & Pidgeon, 2003). Charmaz highlights the importance of original findings Charmaz (Charmaz, 2014)	• The strengths, contributions and originality of the study are thoroughly reviewed in relation to relevant existing literature and research, in section 5.3.2. • Implications of the study and potential applications to practice are addressed in section 5.4. • Constructed a tentative model and theory, based on the core connecting category and four main categories established, which aims to explain the analysis and my understanding of the collected data.

5.3.2 Strengths and Contributions of the Study

This study offers several contributions to a number of under-researched topics related to the current study. These consist of the impact of the prison environment on mental health, experiences of mental health distress of male incarcerated individuals as well as their experiences of access to support services in prison. The research also pinpoints factors which facilitate improved access to prison support services as well as factors which influence the help-seeking behaviours of imprisoned individuals. When reflecting on the lack of qualitative research that exists as well as the key aims of this particular study, I believe that using a qualitative method strengthened the study as it allowed me to address several gaps that exist within the available literature.

Having completed an initial brief literature review as well as an extended review of the existing literature in relation to the findings, it is clear that there is a lack of research. The literature which does exist has tended to be carried out through quantitative methodologies. As a consequence, there has been a lack of focus on researching the individual experiences of those who suffer from mental health distress whilst incarcerated. Key strengths of qualitative research studies, in comparison to quantitative research, are that they allow the voices of the participants to come through, are able to focus on the subjective nature of experiences and allow the researcher to remain sensitive to context throughout (Yardley, 2000). They also encourage the researcher to practice reflexivity, they incorporate researcher subjectivity and offers more detailed findings (Yardley, 2000).

In using a qualitative method, I was able to extensively interview individuals who have first-hand experience of being incarcerated. When looking into the existing literature

and empirical research, I became aware that prisoners are an overlooked group. This surprised me. By not including these individuals in exploratory research, the probability of implementing inappropriate and incompatible changes to support services increases. My research aims consist of; offering a developed understanding of how the current prison support system responds to mental health distress, reviewing existing structures and policies as well as highlight aspects to improve. Speaking with those who have direct experience of the phenomenon was thus deemed essential. Through interviewing such an informed sample population, I was able to develop a deep and meaningful understanding of the impact of the prison environment. I was also able to review how the current prison support system actually operates and responds to mental health distress, thus contributing to the knowledge base.

There were several findings in the current research which were in-line with the findings of previous research. There were also findings which can be deemed to be original. Firstly, existing research has not focused on exploring the impact of different prison wings on mental health distress (i.e. rehabilitative versus general), whilst the current research clearly suggests that the impact is hugely different. The study also demonstrated the ways in which individual characteristics impact the level of mental health distress experienced by prisoners as well as the ways in which individuals seek support from the prison system. Finally, the research findings clearly emphasise the importance and impact of a prisoner's ability to develop positive relationships with individuals inside and outside of the prison environment, whilst incarcerated. I believe these are crucial findings as they have not been covered in previous research and thus allow for a developed understanding of the prison experience. These findings can drive the implementation of appropriate changes within mental health support

services, especially if future research focuses on investigating these topics further and the findings align.

I am confident that I was able to offer such comprehensive and unique findings for several reasons. Firstly, I am convinced that the small participant sample meant that I was able to get an incredibly detailed insight into the experiences of the participants, allowing me to offer meaningful findings. Whilst I was initially worried that I would not get enough data based on the number of participants, the far-reaching interviews provided an extensive amount of data which I was then able to analyse thoroughly and to a high standard. I believe that if I had more data, I may have become overwhelmed, which could have compromised the analysis process.

Secondly, in my opinion, the person-centred approach I took to interviewing participants had a positive impact on the research findings. Whilst not wishing to undermine the openness and inclination of participants to share their experiences, I feel that taking a person-centred approach during the interview positively influenced the participants cooperation and willingness to share their experiences with me. By offering a non-judgemental, respectful, open and empathic space for the research participants, this encouraged them to divulge relevant and important information directly to me. I also ensured that I listened to the voices of those who tend to not have their voices heard both in the prison system as well as in research. Upon reflection, I have come to realise that the way I approached the research interviews would have been in sharp contrast to the command-driven climate of prison institutions. Whilst this was unintentional, I sense that it could have impacted upon the participant's willingness to share their experiences with me in such a detailed manner.

Finally, I firmly believe that my position towards researching the topic of how mental health in prisons from a unique perspective positively impacted the study and findings. As stated by Witcher, it is important to consider the impact the researchers position can have on the data that is collected and how data is interpreted (Witcher, 2010). My position towards the research was unique in comparison to the previous studies that have been carried out. A substantial amount of the research that has been covered on the topic has been done by government bodies and organisations which are directly linked to the criminal justice system. It can be argued that there is a potential for significant bias when studies are carried out by such bodies and organisations, as they will have pre-conceived views and may feel pressure to reach certain outcomes. In comparison, whilst I did have my pre-conceived views based on my work experience and knowledge on the topic, I had no specific stake in the outcome of the research, so as such, there was no conflict of interest. Instead, I was purely fascinated by the narrative of the individuals; I wanted to develop my understanding of the phenomena being studied as well as to be able to highlight ways of the improving psychological experiences within prison settings.

I am of the opinion that approaching the research from the perspective as a counselling psychologist was also of benefit. Despite the challenges that individuals face when taking on the dual role of counselling psychologist and researcher, studies have evidenced that carrying out studies as a counselling psychologist can have a positive impact (Berman, Chapman, Nash, Kivlighan Paquin, 2017). This is as it allows for high-quality research to be carried out which inevitably focuses on improving healthcare services, thus contributing positively to the healthcare system as a whole

(Castonguay, Youn, Xiao, Muran & Barber, 2015; Berman, Chapman, Nash, Kivlighan Paquin, 2017).

The high quality research that is carried out by counselling psychologist researchers can be attributed to the thorough educational programs and personal professional development practices in which one participates (Berman, Chapman, Nash, Kivlighan Paquin, 2017). I believe that researching and completing this research whilst completing the counselling psychology doctorate, have both considerably added to the quality of my work. Throughout the doctorate, I have developed research skills, have learned how to be a critical reader, had many opportunities to submit work and further discuss with tutors. I also had the opportunity to work extensively with vulnerable individuals through healthcare services that are relevant to my research. The varied academic components of the course also emphasise the importance of language, the meaning behind communication as well as bringing the voices of individuals to the forefront. All of these skills were crucially relevant to completing a qualitative research piece and supported me in carrying out a high-quality study.

Reflecting on the strengths of this study, I believe that I have carried out a distinctive piece of research which has contributed, in a meaningful way, to existing knowledge by offering original findings.

5.3.3 Limitations and Implications for Future Research

As part of the evaluation of the study, it is imperative to reflect on the potential limitations with regard to the methodology and methods used as well as the findings. There were a few limitations of this study which I feel are important to discuss.

Whilst grounded theory offers a strong methodology, it is important to note that it only offers one theory and model, being that the application of the theory can be used in different ways (Willig, 2008). I am also aware that my preconceived views of the prison mental health system and my experience of working within forensic healthcare settings inevitably influenced the findings. For instance, my empathy towards the social injustices faced by incarcerated individuals may have meant that I placed greater importance on descriptions which matched this predisposition. To address this issue, I incorporated measures to ensure that I was able to bracket my assumptions and views as much as possible during the data collection and analysis processes. I found reflective discussions with my supervisors, my family and my partner to be very helpful. I also found that it helped to make reflective notations during the initial coding process. These measures ensured that I continuously thought carefully about my assumptions and kept the findings grounded in the data provided by the participants as much as possible. Still, I am aware that another individual, with different experiences and views, may have constructed an alternative theory.

Alongside this, I am aware that I was solely reliant on the grounded theory methodology and the inclusion of other methodologies may have resulted in different findings or another theory. As mentioned in the methodology chapter, I considered several methodologies before choosing grounded theory including IPA and thematic analysis. Whilst these approaches did not fully align with my research objectives, they also offer the ability to create a deeper insight into the topic studied and thus could have offered valuable findings. As such, I would recommend that future research sincerely considers these methods. Upon reflection, I feel that an alternative method to consider in future research is narrative analysis. A significant focus of the current

study consisted of reflecting on the incarcerated individuals' narrative of their experiences. Narrative analysis, like grounded theory, concentrates on analysing experiences and looking at ways to encourage social change (Wertz et al., 2011). The use of any of these methods, whether combined or separate, may produce a different theory or model, which could also be of significant value.

In hindsight, I believe it also could have been important to consider using the participatory action research (PAR) framework. The PAR framework strives to minimalize the hierarchical dynamic of the researcher versus participant, as they are instead seen as co-authors (Fine & Torre, 2006; Penrod, Loeb, Ladonne & Martin, 2016; Haarmans, Perkins & Jellicoe-Jones, 2021). In this dynamic, the researcher is the outsider and the individuals having experienced the phenomenon are the insiders (Fine & Torre, 2006; Haarmans, Perkins & Jellicoe-Jones, 2021). As co-authors, they work through the research process together, from creating the research questions to deciding on data collection strategies and publishing the findings (Haarmans, Perkins & Jellicoe-Jones, 2021; Fine & Torre, 2006; Payne & Bryant, 2018). Reflecting on the focus and aims of the current research, it could have been an incredibly powerful method to use. This is as it allows for a much deeper involvement of the service-user, as it strives to bring their voices to the forefront and as it is focused on addressing inequalities (Haarmans, Perkins & Jellicoe-Jones, 2021). Using this type of approach for research focused on the prison environment, where the service-user tends to be marginalised and oppressed, would thus allow for the development meaningful knowledge, which is more likely to lead to appropriate change.

I recognise that there were also some limitations related to not having used the full grounded theory model, as I opted to use an abbreviated version for this study. I feel that my decision to use an abbreviated version was justified due to challenging ethical approval process I went through in order to carry out this study. Additionally, I experienced challenges in recruiting participants and had to consider the timescale needed to complete the study. However, I fully acknowledge that this decision meant that I was only able to offer a tentative theory, not a fully saturated theory (Willig, 2008). Still, I do feel that I have been able to offer a thorough account of what occurs when incarcerated individuals experience mental health distress.

Using an abbreviated version of the grounded theory methodology also meant that I was not able to use theoretical sampling as a recruitment strategy. The inability to use theoretical sampling consequently resulted in not being able to carry out follow-up interviews on concepts which arose from the interviews and analysis or to request feedback from the participants on the findings gathered. With the aim of tackling this limitation, I ensured that I carried out all the appropriate aspects of the analysis strategy, such as initial coding, focused coding, memo-writing, continuous comparative analysis, theoretical sensitivity, theoretical integration and continuous reflexive practice. I also aimed to offer a balance of describing participant experiences whilst also providing a tentative model of the social processes at play. In doing so, I believe that the quality and findings of the study have not been significantly compromised. Still, if I had the opportunity to develop this study further, I would carry out a follow-up interview with the individuals which contributed to the study, to gather their feedback on the findings as well as evaluating the tentatively constructed theory.

This would have allowed me to reflect on the theory developed thus far and potentially identify additional areas which could be further developed upon.

Another limitation of this study related to the sample size and sample population of the current study. When looking into sample sizes of PhD-level qualitative studies, I noted that an average sample size for qualitative research is around thirty two, meaning that qualitative studies overall tend to have a substantially larger sample than I had (Mason, 2010). I feel it is important to mention that qualitative researchers have not identified what constitutes an appropriate sample size, as there are factors which contribute to the value of sample sizes, such as the scope and nature of the topic (Mason, 2010). It is also argued that larger samples do not always result in additional valuable information (Mason, 2010). Still, I do believe that a larger sample could have provided benefits. For instance, a larger sample size could have increased the diversity of the sample population.

The sample population, whilst it had a broad age range, solely consisted of the male prison population and mainly consisted of white British individuals, all of whom had a background associated to addiction. As such, these findings may not represent the experiences of other sub-population; for instance, male incarcerated individuals from ethnic minority backgrounds with mental health distress or prisoners without addiction issues. It would be important for future research to include larger and more diverse samples. Such research could review whether the findings of the current study can be applied to other sub-populations that exist within the prison environments.

Regarding future research, the review of existing literature and relevant empirical research carried out highlighted the lack of exploratory research that exists on the topics related to this thesis. There were several findings which can be deemed as original, however it would be crucial that these findings are followed up through additional fieldwork. It would be of benefit if the findings of this research were accompanied by supplementary research, to address the gaps in my study and tentatively constructed theory. This would allow the opportunity to better evaluate the findings of the research.

5.4 Implications of the Research

Research has strongly demonstrated that receiving consistent and appropriate support can have a huge impact on the incarcerated individual and can reduce recidivism rates (Condon, Hek, Harris, Powell, Kemple & Price, 2017). Based on the findings of the current study, several practice recommendations can be made, both to the prison system as a whole as well as to prison mental health support services such as psychological interventions. The practice recommendations that are detailed below refer to reducing the violent climate which currently exists in prisons, increasing access and improving the quality of mental health support services. I would consider it to be essential to implement these practice recommendations as they can ensure that the prison environment has less of a negative impact on the mental health of inmates and ensure that mental health needs of prisoners are more appropriately addressed. Whilst I appreciate that the changes outlined below requires an increased commitment to prisons and prisoners from the authorities, I believe it would be worthwhile and vital, as it would ensure that incarcerated individuals are included in the political discourses around mental health provisions.

Since previous research and the findings of the current study have revealed that violence is not only due to violent offenders and their mental health needs, but is also stimulated through the way prisons are designed, this would be an important aspect to address (Specter, 2006). The findings of the current study have highlighted several pathways to improving the prison environment, with the aim of reducing the level of violence that exists and thus ensuring that the environment does not have a detrimental impact on the mental health of incarcerated individuals.

A key aspect which needs to be addressed is the inconsistent behaviour by prison officers towards prisoners, especially in the general population wings. Previous research, alongside the current findings, has clearly identified that the treatment of inmates by prison staff has been strongly correlated to psychological distress experienced by inmates (Beijersbergen, Dirkzwager, van der Laan & Nieuwbeerta, 2016). As previously mentioned, prison officers most commonly interact with the inmates and to a large degree, act as gatekeepers to receiving mental health support. I believe that there are two strategic ways of addressing this issue, including increasing staff numbers and providing appropriate training, such as mental health training for all prison officers.

Participants consistently mentioned that a lack of prison staff and a lack of appropriate training led to a lack of appropriate support. They also stated that mental health needs and associated behavioural issues tended to be interpreted incorrectly and thus inappropriately managed, leading to increased acts of violence. A lack of dealing with the staff also made it challenging for incarcerated individuals to develop positive

relationships inside the prison environment. Increasing the amount of prison officers and offering appropriate training can have far-reaching positive impacts. Appropriate training can reduce the rate of staff turnover, as it will ensure that they are better equipped to cope with the demanding nature of the job. This can, alongside increased staff numbers, improve the ability for incarcerated individuals to develop positive relationships with staff. This, in turn, can improve the experiences of incarcerated individuals. A reduced staff turnover rate and appropriate mental health training can also ensure that prisoners are better supported in the long run, as they will be appropriately referred to mental health support services. Additional funding would be needed to allow for appropriate training and the hiring of additional staff.

Another aspect to review is the current healthcare system and how it responds to mental health distress. This includes reviewing the standard of psychological services, reviewing the number of services available as well as the suitability of referral procedures. Based on the findings of this study, it is clear that there currently are not enough mental health support services available compared to the demand and that the support offered is time-limited. The current referral procedures are also not appropriate as there are long waiting times. This inevitably has a negative impact on the mental health of inmates. One way of addressing this issue would be to increase the number of healthcare and psychological staff, thus reducing waiting times and offering improved access to the appropriate type of support. Appropriate training for healthcare staff would also be essential as this would impact the staff turnover rates and improve the ways in which healthcare staff responds to the mental health distress of inmates. I also believe that longer-term therapy would positively support incarcerated individuals due to the severity and complexity of mental health distress

that exists in these environments. It would also be worth reflecting on ways that this can be integrated into the current healthcare system. This would, of course, require more funding.

It would also be important to review and reflect on the suitability of the psychological approaches taken by psychologists and therapists to support prisoners with mental health distress. Some of the participants noted in their interviews that within the therapy services, there is not a lot of emphasis on reflection of the reasons for committing the crime, the impact of their background as well as factors which led to mental health distress. There is also a lack of opportunity for reflection on prevention strategies which could avoid the individual from committing future offenses. I feel that it would be pertinent to review the types of therapy which are currently offered, which psychological approaches the inmates could benefit from and ways in which these approaches could be introduced within therapy services.

One particular approach which I believe could be of huge support to incarcerated individuals with mental health distress is the person-centred approach. As mentioned previously, I sense that this approach, considering that it is non-confrontational, could offer a space which contrasts the current the prison processes and could offer a positive effect on the overall prison environment. The inherent components of person-centred therapy, which consist of offering unconditional positive regard, empathy, openness and focuses on social justice can offer an environment which facilitates recovery and healing (Wilkins, 2003; Rogers, 1980; Mearns, Thorne & McLeod, 2013; Rogers, 1963; Sandvik & McCormack, 2018; Jacobs, van Lieshout, Borgg & Ness, 2017). Additionally, I believe that the use of cognitive-behavioural therapy, systemic

therapy and psychodynamic therapy could also be appropriate, either separately or in-combination. For instance, systemic therapy could be helpful as it would look at how different relationships in the individuals life both inside and outside of prison has impacted the individual (Bertrando, 2018). Psychodynamic therapy would offer the individuals an opportunity to reflect on their emotional processes and cognitive-behavioural therapy could support individuals with developing their understanding of how their thoughts, feelings and behaviours are connected (Leichsenring & Steinert, 2019; Dobson & Dobson, 2009). All of these approaches are suitable for a range of mental health issues and could support incarcerated individuals with developing helpful problem-solving capabilities (Bertrando, 2018; Leichsenring & Steinert, 2019; Dobson & Dobson, 2009)

The use of any of these approaches as well as the length of therapy would depend on the individuals' preferences and needs as well as the length of their sentence. This would need to be appropriately and thoroughly assessed prior to starting therapy. Comprehensive mental health and assessment training would support staff in being able to identify which approach would be most suitable for the incarcerated individual. I believe that hiring additional therapists, more specifically, counselling psychologists, could also be constructive due to their holistic and client-focused approach. Counselling psychologists are also trained in a range of approaches and have thorough knowledge of assessing client's needs.

Finally, the impact of the environment on support-seeking strategies as well as the prevalence of mental health and substance misuse, indicates that it would be constructive to promote the awareness of mental health and substance-abuse in

prison. Promotion could encourage prisoners to access support services in the long-term. Promotion could take the form of workshops for instance; which could be carried out by internal or external individuals with expertise on this topic. These workshops could focus on factors associated to mental health deterioration, triggers for mental health distress and ways of improving mental health within prison settings. Alongside workshops, I believe that appropriate training of staff can promote a more conscientious environment which focuses on looking after the mental health needs of inmates. Additional access to psychological support could also improve mental health awareness in prison settings.

5.5 Personal Reflexivity

In conscientiously reflected throughout the study on my role as the researcher in relation to the participants and the chosen topic. I became aware that I had an impact on the findings and the tentatively constructed theory (Charmaz, 2014; Henwood & Pidgeon, 1992; Henwood & Pidgeon, 2003). I also feel that the research had a significant impact on me, especially when carrying out the interviews.

Throughout the study, I felt that I took up the position of an outsider as I personally do not have experience of being imprisoned and as I was trying to gain a better understanding of the experiences of what occurs when incarcerated individuals experience mental health distress (Dwyer & Buckle, 2009; Witcher, 2010). However, there were also times when I felt closer to the position of an insider, especially when the participants described their experiences (Dwyer & Buckle, 2009; Gair, 2011). At times, I felt compassion, sympathy, empathy, frustration and hopelessness when listening to participants' experiences of the challenges they faced in seeking mental

health support whilst incarcerated. Their own experiences of feeling frustrated and hopeless aligned with my views on the injustices faced by incarcerated individuals, due to my pre-existing knowledge of the system as well as my previous work experience in prison settings and with those deemed more vulnerable. The experience of such feelings are understandable and not uncommon when carrying out exploratory qualitative research and some grounded theory theorists even suggest that researchers should aim to have an empathetic understanding of those being studied (Gair, 2011). However, it is crucial to be aware of the ways these feelings can influence the data provided by the participants as these can be verbally and non-verbally conveyed to the participants (Gair, 2011).

The person-centred approach of focusing on the participants' responses and having developed the ability to bracket my own pre-conceptions through the doctorate, helped me navigate these feelings and my relationship to the research. I also found that the constructivist grounded theory analytical strategies helped me manage this, as the line-by-line coding ensured that I stayed close to the participants' responses as much as possible. Supervision meetings, writing in my research journal and the use of reflective notes and memos also allowed me to remain aware of my position in relation to the research and participants and the impacts my position could have at different times in the research process.

Upon reflection, I appreciate that the research process also had a profound impact on me personally as a developing counselling psychologist and as a researcher. There were times that I found it difficult to manage the demanding nature of the doctoral thesis, leading to feelings of anxiety and distress. Having now come to the end of the

research and the doctorate, I am experiencing a strange combination of emotions, including happiness, gratefulness and excitement. I am also feeling grateful for the opportunity of researching this topic and humbled by the experiences shared by the participants as well as the meaningful findings. Listening to their experiences also has further stimulated my passion to work as a counselling psychologist within the criminal justice system, such as in prisons, forensic hospitals, or organisations which holistically work with previously incarcerated individuals. I have also begun reflecting on the potential of carrying out additional studies on topics related to this research, something I did not previously have an inclination to do as part of my career.

I hope that the findings of this research will contribute to positive changes within the prison environment as a whole as well as more specifically within mental health services in these settings. I believe that the completion of this research and thesis offers a positive contribution towards encouraging positive change and ensuring that those with mental health distress are consistently and appropriately supported whilst incarcerated.

References

Abrams, L. (2010). Sampling 'Hard to Reach' Populations in Qualitative Research. *Qualitative Social Work*, *9*(4), 536–550. doi: 10.1177/1473325010367821.

Adamson, V., Gibbs, M., & McLaughlin, D. (2014). Evaluation of the improving access to psychological therapies for offenders programme at HMP Lincoln: a three year prospective cohort study. *The Journal Of Forensic Psychiatry & Psychology*, *26*(2), 185-201. doi: 10.1080/14789949.2014.985695.

Agee, J. (2009). Developing qualitative research questions: a reflective process. *International Journal Of Qualitative Studies In Education*, *22*(4), 431-447. doi: 10.1080/09518390902736512.

Ajji, A., & Hughes, J. (2019). Counselling in Men's Prisons. *BACP Therapy Today*, *30*(10), 36-39.

Aldiabat, K., & Le Navenec, C. (2018). Data Saturation: The Mysterious Step In Grounded Theory Method. *The Qualitative Report*, *23*(1), 245-261.

Alper, M., Durose, M. R., & Markman, J. (2018). *2018 Update on Prisoner Recidivism: A 9-Year Follow-up Period (2005-2014)* (pp. 1-24). Bureau of Justice Statistics of the U.S. Department of Justice. Retrieved from https://www.bjs.gov/content/pub/pdf/18upr9yfup0514.pdf.

Altintas, M., & Bilici, M. (2018). Evaluation of childhood trauma with respect to criminal behavior, dissociative experiences, adverse family experiences and psychiatric backgrounds among prison inmates. *Comprehensive Psychiatry*, *82*(1), 100-107.

Antecol, H., & Bedard, K. (2007). Does single parenthood increase the probability of teenage promiscuity, substance use, and crime?. *Journal Of Population Economics*, *20*(1), 55-71.

Armitage, C. J., & Conner, M. (2001). Efficacy of the theory of planned behaviour: a meta-analytic review. *British Journal Of Social Psychology*, *40*(4), 471-499. doi: 10.1348/014466601164939.

Atkins, G., Davies, N., Wilkinson, F., Guerin, B., Pope, T., & Tetlow, G. (2019). *Performance Tracker 2019* (pp. 163-176). Institute for Government. Retrieved from https://www.instituteforgovernment.org.uk/sites/default/files/publications/performance-tracker-2019_0.pdf.

Baker, C. (2018). *Mental health statistics for England: prevalence, services and funding* (pp. 3-31). House of Commons. Retrieved from https://researchbriefings.files.parliament.uk.

Batty, E. (2020). 'Without the Right Support Network I'd Probably Be Either Dead or in the Prison System': The Role of Support in Helping Offenders on their Journey to

Desistance. *The Howard Journal Of Crime And Justice*, *59*(2), 174-193. doi: 10.1111/hojo.12355.

Baybutt, M., & Chemlal, K. (2016). Health-promoting prisons: theory to practice. *Global Health Promotion*, *23*(1), 66-74. doi: 10.1177/1757975915614182.

Behan, C., Doyle, R., Masterson, S., Shiers, D., & Clarke, M. (2015). A double-edged sword: review of the interplay between physical health and mental health. *Irish Journal Of Medical Science*, *184*(1), 107-112. Retrieved from http://0-web.b.ebscohost.com.wam.city.ac.uk/ehost/pdfviewer/pdfviewer?vid=2&sid=48f33506-adee-4d34-9027-ed4baa75f6ba%40pdc-v-sessmgr02.

Beijersbergen, K. A., Dirkzwager, A. J. E., van der Laan, P. H., & Nieuwbeerta, P. (2016). A social building? prison architecture and staff-prisoner relationships. *Crime & Delinquency*, *62*(7), 843-874. doi: 10.1177/0011128714530657.

Berg, M. T., & Huebner, B. M. (2011). Reentry and the Ties That Bind: An Examination of Social Ties, Employment and Recidivism. *Justice Quarterly*, *28*(2), 382-410. doi: 10.1080/07418825.2010.498383.

Berger, R. (2015). Now I see it, now I don't: researcher's position and reflexivity in qualitative research. *Qualitative Research*, *15*(2), 219–234. doi: 10.1177/1468794112468475.

Berman, M. I., Chapman, N., Nash, B., Kivlighan, D. M., & Paquin, J. D. (2017). Sharing wisdom: Challenges, benefits, and developmental path to becoming a successful therapist-researcher. *Counselling Psychology Quarterly*, *30*(3), 234-254. doi: 10.1080/09515070.2017.129361.

Bertrando, P. (2018). *Systemic Therapy with Individuals* [Ebook] (1st ed., pp. 41-90). London: Routledge. Retrieved from https://www.taylorfrancis.com/books/9780429480676.

Besemer, S., Farrington, D. P., & Bijleveld, C. C. J. H. (2017). Labeling and intergenerational transmission of crime: The interaction between criminal justice intervention and a convicted parent. *Plos ONE*, *12*(3), 1-16.

Bhugra, D., Till, A., & Sartorius, N. (2013). What is mental health?. *International Journal Of Social Psychiatry*, *59*(1), 3-4. doi: 10.1177/0020764012463315.

Birks, M., & Mill, J. (2015). *Grounded theory: A practical guide* (2nd ed., pp. 1-15, 49-124). London: SAGE Publications Ltd.

Boles, S. M., & Miotto, K. (2003). Substance abuse and violence: A review of the literature. *Aggression And Violent Behavior*, *8*(2), 155-174. doi: 10.1016/S1359-1789(01)00057-X.

Boman, J. H., & Mowen, T. J. (2017). Building the Ties That Bind, Breaking the Ties That Don't: Family Support, Criminal Peers, and Reentry Success. *Criminology & Public Policy*, *16*(3), 753–774. doi: 10.1111/1745-9133.12307.

Bonta, J., Rugge, T., Scott, T., Bourgon, G., & Yessine, A. K. (2008). Exploring the Black Box of Community Supervision. *Journal Of Offender Rehabilitation*, *47*(3), 248-270. doi: 10.1080/10509670802134085.

Bordin, E. S. (1979). The generalizability of the psychoanalytic concept of the working alliance. *Psychotherapy: Theory, Research And Practice*, *16*(3), 252−260. doi: 10.1037/h0085885.

Bowen, G. (2008). Naturalistic inquiry and the saturation concept: a research note. *Qualitative Research*, *8*(1), 137-152. doi: 10.1177/1468794107085301.

Bowler, N., Phillips, C., & Rees, P. (2018). The association between imported factors and prisoners' mental health: Implications for adaptation and intervention. *International Journal Of Law And Psychiatry*, *57*, 61-66.

BPS (2009). *Code of Ethics and Conduc*t. Leicester: British Psychological Society.

BPS (2014). *Code of Human Research Ethics*. Leicester: BPS. Retrieved from http://beta.bps.org.uk/sites/beta.bps.org.uk/files/Policy%20-%20Files/Code%20of%20Human%20Research%20Ethics%20%282014%29.pdf.

BPS (2017). *Generic Professional Practice Guidelines*. (3nd ed.). Leicester: British Psychological Society.

Bradley, K. (2009). *The Bradley Report: Lord Bradley's review of people with mental health problems or learning disabilities in the criminal justice system.* (pp. 16-21, 28-50, 90-112). Department of Health. Retrieved from http://webarchive.nationalarchives.gov.uk/20130107105354/http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_098698.pdf.

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research In Psychology*, *3*(1), 77–101. doi: 10.1191/ 1478088706qp063oa.

Bridges, L. (2017). Lammy Review: will it change outcomes in the criminal justice system?. *Institute Of Race Relations*, *59*(3), 80-90. doi: 10.1177/0306396817742075.

Brooker, C., Repper, J., Beverley, C., Ferriter, M., & Brewer, N. (2002). *Mental Health Services and Prisoners: A Review* (pp. 3-34, 42-55). Department of Health. Retrieved from http://www.ohrn.nhs.uk/resource/Research/MHSysRevIntro.pdf.

Brooker, & Webster. (2017). Prison mental health in-reach teams, serious mental illness and the Care Programme Approach in England. *Journal Of Forensic And Legal Medicine*, *50*, 44-48. doi: 10.1016/j.jflm.2017.07.010.

Brown, C. (2015). *Understanding Person-Centred Counselling: A Personal Journey* (pp. 153-172). London: SAGE Publications Ltd.

Brown, K., Cullen, A., Kooyman, I., & Forrester, A. (2015). Mental health expertise at prison reception. *The Journal Of Forensic Psychiatry & Psychology*, *26*(1), 107-115. doi: 10.1080/14789949.2014.955810.

Bryant, A. (2017). *Grounded Theory and Grounded Theorizing: Pragmatism in Research Practice* (pp. 83-112). New York: Oxford University Press.

Bryant, A., & Charmaz, K. (2007). *The SAGE Handbook of Grounded Theory* (pp. 1-30, 75-93). London: SAGE Publications Ltd.

Bunge, M. (1993). Realism and Antirealism in Social Science. *Theory And Decision*, *35*(3), 207-235. doi: 10.1007/BF01075199.

Cailhol, L., Rodgers, R., Burnand, Y., Brunet, A., Damsa, C., & Andreoli, A. (2009). Therapeutic alliance in short-term supportive and psychodynamic psychotherapies: A necessary but not sufficient condition for outcome?. *Psychiatry Research*, *170*(2-3), 229-233. doi: 10.1016/j.psychres.2008.09.005.

Caplan, G. (2013). *An Approach to Community Mental Health* (pp. 1-32, 205-230). Oxfordshire: Routledge.

Carrol, M., & Shaw, E. (2012). *Ethical Maturity in the Helping Professions: Making Difficult Life and Work Decisions* (pp. 42-60, 101-188). Melbourne: PsychOz.

Castonguay, L. G., Youn, S. J., Xiao, H., Muran, J. C., & Barber, J. P. (2015). Building clinicians-researchers partnerships: Lessons from diverse natural settings and practice-oriented initiatives. *Psychotherapy Research*, *5*(1), 166–184. doi: 10503307.2014.973923.

Chamberlain, A. W., Gricius, M., Wallace, D. M., Borjas, D., & Ware, V. M. (2017). Parolee–Parole Officer Rapport: Does It Impact Recidivism?. *International Journal Of Offender Therapy And Comparative Criminology*, *62*(11), 3581-3602. doi: 10.1177/0306624x17741593.

Charmaz, K. (2008). Constructionism and the Grounded Theory Method. In J. A. Holstein & J. F. Gubrium, *Handbook of Constructionist Research* (1st ed., pp. 397-412). London: The Guildford Press.

Charmaz, K. (2006). *Constructing Grounded Theory: A Practical Guide Through Qualitative Analysis* (pp. 1-12, 177-183). London: SAGE Publications Ltd.

Charmaz, K. (2014). *Constructing Grounded Theory* (2nd ed., pp. 1-16, 225-240). London: Sage Publications Ltd.

Charmaz, K. (2006). *Constructing Grounded Theory: A Practical Guide Through Qualitative Analysis* (pp. 1-12, 177-183). London: SAGE Publications Ltd.

Charmaz, K. (2017a). Constructivist grounded theory. *The Journal of Positive Psychology*, *12*(3), 299-300. doi:10.1080/17439760.2016.1262612.

Charmaz, K. (2000). Grounded theory: Objectivist and constructivist methods. In N. Denzin & Y. Lincolm, *Handbook of qualitative research* (2nd ed., pp. 509–536). Thousand Oaks: SAGE Publications.

Charmaz, K. (2017b). Special Invited Paper: Continuities, Contradictions, and Critical Inquiry in Grounded Theory. *International Journal Of Qualitative Methods*, *16*(1), 1-8. doi: 10.1177/1609406917719350.

Charmaz, K. (2015). Teaching Theory Construction With Initial Grounded Theory Tools: A Reflection on Lessons and Learning. *Qualitative Health Research*, *25*(12), 1610–1622. doi: 10.1177/1049732315613982.

Charmaz, K. (2017c). The Power of Constructivist Grounded Theory for Critical Inquiry. *Qualitative Inquiry*, *23*(1), 34-45. doi: 10.1177/1077800416657105.

Charmaz, K., & Bryant, A. (2010). Grounded Theory. In P. Peterson, E. Baker & B. McGaw, *International Encyclopedia of Education* (3rd ed., pp. 406-412). London: Elsevier Ltd.

Charon, J. M. (2010). *Symbolic interactionism: An introduction, an interpretation, an integration* (10th ed., pp. 30-55). New York: Prentice Hall.

Chowdhury, N. A., Albalawi, O., Wand, H., Adily, A., Kariminia, A., & Allnutt, S. et al. (2019). First diagnosis of psychosis in the prison: results from a data-linkage study. *BJ Psych Open*, *5*(6), 1-8. doi: 10.1192/bjo.2019.74

Clarke, A. (2007). Grounded Theory: Critiques, Debates, and Situational Analysis. In W. Outhwaite & S. Turner (Ed.), *The SAGE Handbook of Social Science Methodology* (pp. 423-442). London: Sage Publications.

Clarke, V., & Braun, V. (2013). Methods: Teaching thematic analysis. *The Psychologist*, *26*(2), 120-123. Retrieved from https://thepsychologist.bps.org.uk/volume-26/edition-2/methods-teaching-thematic-analysis.

Clearly, M., Horsfall, J., & Hayter, M. (2014). Data collection and sampling in qualitative research: does size matter?. *Journal Of Advanced Nursing*, *70*(3), 473-475.

Cnaan, R. A., & Woida, K. (2019). Power, anxiety, and relationships between returning citizens and parole officers. *Journal Of Social Work*, *20*(5), 576-598. doi: 10.1177/1468017319852692.

Cobb, S., & Farrants, J. (2014). Male prisoners' constructions of help-seeking. *Journal Of Forensic Practice*, *16*(1), 46-57. doi: 10.1108/JFP-01-2013-0005.

Collier, A. (1994). *Critical Realism: An Introduction to Roy Bhaskar's Philosophy* (pp. 3-69, 237-260). London: Verso.

Collins, H., Leonard-Clarke, W., & O'Mahoney, H. (2019). 'Um, er': how meaning varies R between speech and its typed transcript. *Qualitative Research*, *19*(6), 653–668. doi: 10.1177/1468794118816615.

Condon, L., Hek, G., Harris, F., Powell, J., Kemple, T., & Price, S. (2017). Users' views of prison health services: a qualitative study. *Journal Of Advanced Nursing*, *58*(3), 216-226. Retrieved from https://0-onlinelibrary-wiley-com.wam.city.ac.uk/doi/full/10.1111/j.1365-2648.2007.04221.x.

Conlon, E., Timonen, V., Elliott-O'Dare, C., O'Keeffe, S., & Foley, G. (2020). Confused About Theoretical Sampling? Engaging Theoretical Sampling in Diverse Grounded Theory Studies. *Qualitative Health Research*, *1*, 1-13. doi: 10.1177/1049732319899139.

Cooper, D. B. (2011). *Introduction to Mental Health – Substance Use* (pp. 30-43, 107-119). Oxon: Radcliffe Publishing Ltd.

Creswell, J. W., & Poth, C. N. (2018). *Qualitative Inquiry and Research Design: Choosing Among Five Approaches* (4th ed., pp. 41-64). London: SAGE Publications Ltd.

Cronley, C., Jeong, S., Davis, J., & Madden, E. (2015). Effects of Homelessness and Child Maltreatment on the Likelihood of Engaging in Property and Violent Crime During Adulthood. *Journal Of Human Behavior In The Social Environment*, *25*(3), 192-203.

Curtis, S., Gesler, W., Smith, G., & Washburn, S. (2000). Approaches to Sampling and Case Selection in Qualitative Research: Examples in the Geography of Health. *Social Science & Medicine*, *50*(1), 1000–1014.

Cygan-Rehm, K., Kuehnle, D. and Oberfichter, M. (2017). Bounding the Causal Effect of Unemployment on Mental Health: Nonparametric Evidence from Four Countries. *Health Economics*, 26(12), pp.1844-1861.

Davies, S. C. (2014). *Annual Report of the Chief Medical Officer 2013, Public Mental Health Priorities: Investing in the Evidence*. London: Department of Health. Accessed via: https://www.mrc.ac.uk/documents/pdf/chief-medical-officer-annual-report-2013/.

Dean, K., & Korobanova, D. (2018). Brief mental health screening of prison entrants: psychiatric history versus symptom screening for the prediction of in-prison outcomes. *The Journal Of Forensic Psychiatry & Psychology*, *29*(3), 455-466. doi: 10.1080/14789949.2017.1421247.

Viggiani, N. (2003). *(Un)healthy prison masculinities: Theorising men's health in prison (PhD)* (pp. 15-77, 121-196). University of Bristol. Retrieved from https://www.researchgate.net/publication/277862762_Unhealthy_prison_masculinities_Theorising_men's_health_in_prison.

Das-Mundi, J., Castro-Costa, E., Dewey, M. E., Nazroo, J., & Prince, M. (2014). Cross-cultural factorial validation of the Clinical Interview Schedule-Revised (CIS-R);

findings from a nationally representative survey (EMPIRIC). *International Journal of Methods in Psychiatric Research, 23*(2), pp. 229.

Department of Health. (2002). *Health Promoting Prisons: A Shared Approach* (pp. 16-63). London: Department of Health. Retrieved from https://webarchive.nationalarchives.gov.uk/20120513005947/http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4034265.pdf.

Department of Health. (2012). *Preventing suicide in England: A cross-government outcomes strategy to save lives* (pp. 5-38). Department of Health. Retrieved from https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/430720/Preventing-Suicide-.pdf.

Dickinson, E. (1990). From Madness to Mental Health: A Brief History of Psychiatric Treatments in the UK from 1800 to the Present. *British Journal Of Occupational Therapy*, *53*(10), 419-424.

Dobson, D., & Dobson, K. S. (2009). *Evidence-Based Practice of Cognitive-Behavioral Therapy* (1st ed., pp. 1-12, 90-148). London: The Guildford Press.

Dunne, C. (2011). The place of the literature review in grounded theory research. *International Journal Of Social Research Methodology*, *14*(2), 111-124. doi: 10.1080/13645579.2010.494930.

Durcan, G., Saunders, A., Gadsby, B., & Hazard, A. (2014). *The Bradley Report five years on: An independent review of progress to date and priorities for further development* (pp. 5-33). Centre for Mental Health. Retrieved from http://www.mentalhealthchallenge.org.uk/library-files/MHC151-Bradley_report_five_years_on.pdf.

Dwyer, S. C., & Buckle, J. L. (2009). The Space Between: On Being an Insider-Outsider in Qualitative Research. *International Journal Of Qualitative Methods*, *8*(1), 54-63. doi: 10.1177/160940690900800105.

Engward, H., & Davis, G. (2015). Being reflexive in qualitative grounded theory: discussion and application of a model of reflexivity. *Journal of Advanced Nursing*, *71*(1), 1530–1538.

Etherington, K. (2007). Ethical Research in Reflexive Relationships. *Qualitative inquiry*, *13*(5), p. 599-616.

Etikan, I., Musa, S. A., & Alkassim, R. S. (2016). Comparison of Convenience Sampling and Purposive Sampling. *American Journal Of Theoretical And Applied Statistics*, *5*(1), 1-4.

Evans, T., & Wallace, P. (2008). A Prison within a Prison?. *Men And Masculinities*, *10*(4), 484-507. doi: 10.1177/1097184X06291903.

Fazel, S., Hayes, A. J., Bartellas, K., Clerici, M., & Trestman, R. (2016). Mental health of prisoners: prevalence, adverse outcomes, and interventions. *The Lancet Psychiatry*, *3*(9), 871-881. doi: 10.1016/S2215-0366(16)30142-0.

Fekete, L. (2017). Lammy Review: without racial justice, can there be trust?. *Institute Of Race Relations*, *59*(3), 75–79. doi: 10.1177/0306396817742074.

Fine, M., & Torre, M. E. (2006). Intimate details: Participatory action research in prison. *Action Research*, *4*(3), 253–269. doi: 10.1177/1476750306066801.

Finlay, L. (2002). “Outing” the Researcher: The Provenance, Process, and Practice of Reflexivity. *Qualitative Health Research*, *531-545*(4), 531-545.

Fischer, S. N., Shinn, M., Shrout, P., & Tsemberis, S. (2008). Homelessness, Mental Illness, and Criminal Activity: Examining Patterns Over Time. *American Journal Of Community Psychology*, *42*(3), 251-265.

Fletcher, A. (2017). Applying critical realism in qualitative research: methodology meets method. *International Journal of Social Research Methodology*, *20*(2), 181-194. doi:10.1080/13645579.2016.1144401.

Fletcher, F., & Shaw, G. (2011). How voice-recognition software presents a useful transcription tool for qualitative and mixed methods researchers. *International Journal Of Multiple Research Approaches*, *5*(2), 200-206.

Forrester, A., Exworthy, T., Olumoroti, O., Sessay, M., Parrott, J., Spencer, S., & Whyte, S. (2013). Variations in prison mental health services in England and Wales. *International Journal Of Law And Psychiatry*, *36*(3-4), 326–332. doi: 10.1016/j.ijlp.2013.04.007.

Foucault, M. (1977). *Discipline and Punish: The Birth of the Prison* (pp. 73-170). Harmondsworth: Penguin.

Fraser, A. (2009). Mental health in prisons: A public health agenda. *International Journal Of Prisoner Health*, *5*(3), 132-140.

Friendship, F., Blud, L., Erikson, M., & Travers, R. (2002). *An evaluation of cognitive behavioural treatment for prisoners* (pp. 1-4). Home Office. Retrieved from http://library.college.police.uk/docs/hofindings/r161.pdf.

Galdderisi, S., Heinz, A., Kastrup, M., Beezhold, J., & Sartorius, N. (2015). Toward a new definition of mental health. *World Psychiatry*, *14*(2), 231–233.

Galletta, A. (2013). *Mastering the Semi-Structured Interview and Beyond: From Research Design to Analysis and Publication* (pp. 1-6, 45-72, 75-118). New York: New York University Press.

Gair, S. (2012). Feeling Their Stories: Contemplating Empathy, Insider/Outsider Positionings, and Enriching Qualitative Research. *Qualitative Health Research*, *22*(1), 134-143. doi: 10.1177/1049732311420580.

Galanek, J. (2014). Correctional Officers and the Incarcerated Mentally Ill: Responses to Psychiatric Illness in Prison. *Medical Anthropology Quarterl*, *29*(1), 116–136. doi: 10.1111/maq.12137.

Gambrill, E. (1997). Assertion skills training. In W. O'Donohue & L. Krasner, *Handbook of Psychological Skills Training: Clinical Techniques and Applications* (1st ed., pp. 81–118). Boston: Allyn & Bacon.

Gee, J., & Bertrand-Godfrey, B. (2014). Researching the psychological therapies in prison: considerations and future recommendations. *International Journal Of Prisoner Health*, *10*(2), 118-131. doi: 10.1108/IJPH-06-2013-0030.

Gearing, R. E. (2004). Bracketing in research: A typology. Qualitative Health Research, 14(1), 1429-1452.

Genders, E., & Player, E. (2013). Rehabilitation, risk management and prisoners' rights. *Criminology & Criminal Justice*, *14*(4), 434-457. doi: 10.1177/1748895813502500.

Georgiou, M., & Townsend, K. (2019). Quality Network for Prison Mental Health Services: reviewing the quality of mental health provision in prisons. *The Journal Of Forensic Psychiatry & Psychology*, *30*(5), 794-806. doi: 10.1080/14789949.2019.1637918.

Giles, T., de Lacey, S., & Muir-Cochrane, E. (2016). Coding, Constant Comparisons, and Core Categories: A Worked Example for Novice Constructivist Grounded Theorists. *Advances In Nursing Science*, *39*(1), 29-44. doi: 10.1097/ANS.0000000000000109.

Giles, T., King, L., & de Lacey, S. (2013). The Timing of the Literature Review in Grounded Theory Research: An Open Mind Versus an Empty Head. *Advances In Nursing Science*, *36*(2), 29-40. doi: 10.1097/ANS.0b013e3182902035.

Glaser, B., & Strauss, A. (1967). *The Discovery of Grounded Theory: Strategies for Qualitative Research* (pp. 1-45, 101-116, 223-236). London: AldineTransaction.

Godderis, R. (2006). Dining in: the symbolic power of food in prison. *The Howard Journal of Crime and Justice*, *45*(3), 255 - 267. doi: 10.1111/j.1468-2311.2006.00420.x.

Goomany, A., & Dickinson, T. (2015). The influence of prison climate on the mental health of adult prisoners: a literature review. *Journal Of Psychiatric And Mental Health Nursing*, *22*(6), 413–422. Doi: 10.1111/jpm.12231.

Gough, B., & Lyons, A. (2016). The Future of Qualitative Research in Psychology: Accentuating the Positive. *Integrative Psychological & Behavioral Science*, *50*, 234–243. doi: 10.1007/s12124-015-9320-8.

Grieb, S. M. D., Crawford, A., Fields, J., Smith, H., Harris, R., & Matson, P. (2014). The Stress Will Kill You': Prisoner Reentry as Experienced by Family Members and the Urgent Need for Support Services. *Journal Of Health Care For The Poor And Underserved*, *25*(3), 1183-1200. doi: 10.1353/hpu.2014.0118.

Grimwood, G. (2015). *Categorisation of prisoners in the UK* (pp. 3-10). The House of Commons Library. Retrieved from http://www.parliament.uk/commons-library.

Guillemin, M., & Gillam, L. (2004). Ethics, Reflexivity, and "Ethically Important Moments" in Research. *Qualitative Inquiry*, *10*(2), 261-280. doi:10.1177/1077800403262360.

Gunn, J., Maden, A., & Swinton, M. (1991). Treatment needs of prisoners with psychiatric disorders. *British Medical Journal*, *303*(6798), 338-341.

Gupta, U. (2016). Age, Mental Health and Well-being. *Journal Of Psychosocial Research*, *11*(1), 147-156.

Gyani, A., Shafran, R., Layard, R., & Clark, D. M. (2013). Enhancing recovery rates: Lessons from year one of IAPT. *Behaviour Research And Therapy*, *51*(9), 597-606. Retrieved from https://0-www-sciencedirect-com.wam.city.ac.uk/science/article/pii/S0005796713001150#bib15.

Haarmans, M., PAR Team, Perkins, E., & Jellicoe-Jones, L. (2021). "It's Us Doing It!" The Power of Participatory Action Research in Prison: A Contradiction in Terms? –

Phase 1. *International Journal Of Forensic Mental Health*, *20*(3), 238-252. doi: 10.1080/14999013.2020.1863524.

Hall, H., Griffiths, D., & McKenna, L. (2013). From Darwin to constructivism: the evolution of grounded theory. *Nurse Researcher*, *20*(3), 17-21.

Hall, W., & Callery, P. (2001). Enhancing the Rigor of Grounded Theory: Incorporating Reflexivity and Relationality. *Qualitative Health Research*, *11*(2), 257-272.

Hammersley, M., & Traianou, A. (2012). *Ethics in Qualitative Research: Controversies and Contexts*. London: Sage Publications Ltd.

Harding, D. J., Morenoff, J. D., & Wyse, J. J. B. (2019). *On the Outside: Prisoner Reentry and Reintegration* (1st ed., pp. 215-242). London: The University of Chicago Press.

Hardt, O., Nader, K., & Nadel, L. (2013). Decay happens: the role of active forgetting in memory. *Trends in Cognitive Sciences*, *17*(3), 111-120.

Harty, M., Jarrett, M., Thornicroft, G., & Shaw, J. (2012). Unmet needs of male prisoners under the care of prison Mental Health Inreach Services. *The Journal Of Forensic Psychiatry & Psychology*, *23*(3), 285-296. doi: 10.1080/14789949.2012.690101.

Harvey, J., & Smedley, K. (2010). *Psychological Therapy in Prisons and Other Settings* (pp. 3-42). Oxon: Willan Publishing.

Haverkamp, B. (2005). Ethical Perspectives on Qualitative Research in Applied Psychology. *Journal Of Counseling Psychology*, *52*(2), 146–155. doi: 10.1037/0022-0167.52.2.146.

Hawton, K., Houston, K., Haw, C., Townsend, E., & Harriss, L. (2003). Comorbidity of Axis I and Axis II Disorders in Patients Who Attempted Suicide. *The American Journal of Psychiatry, 160*(8), 1494.

HCPC (2016). *Guidance on Conduct and Ethics for students*. London: HCPC.

Health and Social Care Information Centre. (2015). *Psychological Theories: Annual Report on the Use of IAPT Services England, 2014/15*. Retrieved from http://content.digital.nhs.uk/catalogue/PUB19098/psyc-ther-ann-rep-2014-15.pdf.

Henley, C., & Ketron, J. B. (2018). The predictive ability of childhood animal cruelty methods for later interpersonal crimes. *Behavioral Sciences & The Law*, *36*(6), 730-738.

Hense, C., & McFerran, K. (2016). Toward a critical grounded theory. *Qualitative Research Journal*, *16*(4), 75-101. doi:10.1108/QRJ-08-2015-0073.

Henwood, K., & Pidgeon, N. (2003). Grounded theory in psychological research. In P. Camic, J. Rhodes & L. Yardley (Ed.), *Qualitative research in psychology: Expanding perspectives in methodology and design* (pp. 131-155). Washington: American Psychological Association.

Henwood, K., & Pidgeon, N. (1992). Qualitative research and psychological theorizing. *British Journal of Psychology*, *83*(1), 97-112.

Hewlett, E. & K. Horner. (2015). Mental Health Analysis Profiles (MhAPs): England. Organisation for Economic Co-operation and Development Health Working Papers, No. 81, Paris: OECD Publishing. Accessed via: http://dx.doi.org/10.1787/5jrxr7vj1g9v-en.

Higginbottom, G. & Lauridsen, E. I. (2014). The roots and development of constructivist grounded theory. *Nurse Researcher*, 21(5), pp.8–13.

Holloway, I., & Todres, L. (2003). The status of method: Flexibility, consistency and coherence. *Qualitative Research,*, *3*(1), 345–357. doi: 10.1177/1468794103033004.

Hopkin, G., Evans-Lacko, S., Forrester, A., Shaw, J., & Thornicroft, G. (2018). Interventions at the Transition from Prison to the Community for Prisoners with Mental Illness: A Systematic Review. *Administration And Policy In Mental Health*, *45*(4), 623–634. doi: 10.1007/s10488-018-0848-z.

House of Commons. (2017). *Mental health in prisons* (pp. 4-15). House of Commons. Retrieved from https://publications.parliament.uk/pa/cm201719/cmselect/cmpubacc/400/400.pdf.

Howerton, A., Byng, R., Campbell, J., Hess, D., Owens, C., & Aitken, P. (2007). Understanding help seeking behaviour among male offenders: qualitative interview study. *The British Medical Journal*, *334*(7588), 303-313. doi: 10.1136/bmj.39059.594444.AE.

Huddy, V., Roberts, A., Jarrett, M., & Valmaggia, L. (2016). Psychological Therapy for At Risk Mental State for Psychosis in a Prison Setting: A Case Study. *Journal Of Clinical Psychology*, *72*(2), 142-151. doi: 10.1002/jclp.22250

Hwang, S., Kim, G., Yang, J., & Yang, E. (2016). The Moderating Effects of Age on the Relationships of Self-Compassion, Self-Esteem, and Mental Health. *Japanese Psychological Research*, *58*(2), 194–205. Retrieved from https://self-compassion.org/wp-content/uploads/2016/06/Hwang_etal_2016.pdf.

Igoumenou, A., Kallis, C., Huband, N., Haque, Q., Coid, J. W., & Duggan, C. (2019). Prison vs. hospital for offenders with psychosis; effects on reoffending. *The Journal Of Forensic Psychiatry & Psychology*, *30*(6), 939-958. doi: 939-958.

Jakobowitz, S., Bebbington, P., McKenzie, N., Iveson, R., Duffield, G., Kerr, M., & Killaspy, H. (2017). Assessing needs for psychiatric treatment in prisoners: 2. Met and

unmet need. *Social Psychiatry & Psychiatric Epidemiology*, *52*, 231–240. doi: 10.1007/s00127-016-1313-5.

Jacobs, G., van Lieshout, F., Borgg, M., & Ness, O. (2017). Being a Person-Centred Researcher: Principles and Methods for Doing Research in a Person-Centred Way. In B. McCormack, S. van Dulmen, H. Eide, K. Skovdahl & T. Eide, *Person-Centred Healthcare Research* (1st ed., pp. 51-60). Chichester: John Wiley & Sons Ltd.

Jefford, M., & Moore, R. (2008). Improvement of informed consent and the quality of consent documents. *Lancet Oncology*, *9*(5), 485–493. doi: 10.1016/S1470-2045(08)70128-1.

Johnson, A. L. (2021). Changes in Mental Health and Treatment, 1997–2017. *Journal Of Health And Social Behavior*, *62*(1), 53-68. doi: 10.1177/0022146520984136.

Johnstone, G. (2011). *Restorative Justice: Ideas, Values, Debates* (2nd ed., pp. 9-20, 55-57, 72-93). London: Routledge.

Kassing, F., Godwin, J., Lochman, J. D., & Coie, J. D. (2019). Using Early Childhood Behavior Problems to Predict Adult Convictions. *Journal Of Abnormal Child Psychology*, *47*(5), 765–778.

Klockars, C. B. (1972). A theory of probation supervision. *The Journal Of Criminal Law, Criminology And Police Science*, *63*(4), 550-557. doi: 10.2307/1141809.

Knudsen. L. (2016) Chapter 1: Mental Health and Wellbeing, in Campbell-Jack D, Hinchliffe S and Rutherford L. (eds.). *The 2015 Scottish Health Survey – Volume 1: Main report*. Edinburgh: Scottish Government.

Kress, V., Seligman, L., & Reichenberg, L. (2021). *Theories of Counseling and Psychotherapy Systems, Strategies, and Skills* (5th ed., pp. 307-333). New Jersey: Pearson Education, Inc.

Kvale, S. (2007). *Doing Interviews* (pp. 92-100). London: Sage Publications Ltd.

Kwan, B. M., Dimidjian, S., & Rizvi, S. L. (2010). Treatment preference, engagement, and clinical improvement in pharmacotherapy versus psychotherapy for depression. *Behaviour Research And Therapy*, *48*(1), 799-804.

Kupers, T. A. (2005). Toxic masculinity as a barrier to mental health treatment in prison. *Journal Of Clinical Psychology*, *61*(6), 713-724. doi: 10.1002/jclp.20105.

Lammy, D. (2017). *The Lammy Review* (pp. 3-70). GOV. Retrieved from https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/643001/lammy-review-final-report.pdf.

Larsen, B.K., Hean, S., & Odegard, A. (2019). A conceptual model on reintegration after prison in Norway. *International Journal Of Prisoner Health*, *15*(3), 282-292. doi: 10.1108/IJPH-06-2018-0032.

Leasure, P., & Martin, T. (2017). Criminal records and housing: an experimental study. *Journal Of Experimental Criminology*, *13*, 527–535. doi: 10.1007/s11292-017-9289-z.

Leichsenring, F., & Steinert, C. (2019). The efficacy of psychodynamic psychotherapy: an up-to-date review. In D. Kealy & J. Ogrodniczuk, *Contemporary Psychodynamic Psychotherapy: Evolving Clinical Practice* (1st ed., pp. 49-74). London: Elsevier. Retrieved from https://0-www-sciencedirect-com.wam.city.ac.uk/book/9780128133736/contemporary-psychodynamic-psychotherapy.

Li, M. (2018). From prisons to communities: Confronting re-entry challenges and social inequality. What makes re-entry into communities challenging?. Retrieved 1 October 2020, from https://www.apa.org/pi/ses/resources/indicator/2018/03/prisons-to-communities.

Liebling, A., & Arnold, H. (2004). *Prisons and their moral performance: A study of values, quality and prison life* (pp. 131-167, 205-259, 41-453). Oxford: Oxford University Press.

Liebling, A., Price, D., & Schefer, G. (2011). *The Prison Officer* (2nd ed., pp. 63-120). Abingdon: William Publishing.

Lieger, K. L. (2018). Discriminating among grounded theory approaches. *Nursing Inquiry*, *26*(1), 1-12. doi: doi.org/10.1111/nin.12261.

Lloyd, C., McKeganey, N., & Liebling, A. (2017). *The Evaluation of the Drug Recovery Wing Pilots* (pp. 37-60, 213-255). Department of Health. Retrieved from https://www.york.ac.uk/media/healthsciences/documents/research/mentalhealthresearch/DRWsFinalPublishedReport.pdf.

Lo, C. C., & Stephens, R. C. (2000). Drugs and prisoners: treatment needs on entering prison. *American Journal Of Drug & Alcohol Abuse*, *26*(2), 229-245. doi: 10.1081/ADA-100100602.

Love, B., Vetere, A., & Davis, P. (2020). Should Interpretative Phenomenological Analysis (IPA) be Used With Focus Groups? Navigating the Bumpy Road of "Iterative Loops," Idiographic Journeys, and "Phenomenological Bridges". *International Journal Of Qualitative Methods Volume*, *19*(1), 1-17. doi: 10.1177/1609406920921600.

MacDonald, M. (2018). Overcrowding and its impact on prison conditions and health. *International Journal Of Prisoner Health*, *14*(2), 65-68. doi: 10.1108/IJPH-04-2018-0014.

MacKenzie, M. B., & Kocovski, N. L. (2016). Mindfulness-based cognitive therapy for depression: trends and developments. *Psychology Research And Behavior Management*, *9*(1), 125–132. doi: 10.2147/PRBM.S63949.

Maclean, L. M., Meyer, M., & Estable, A. (2004). Improving Accuracy of Transcripts in Qualitative Research. *Qualitative Health Research*, *14*(1), 113-123.

Maijala, H., Paavilainen, E., & Astedt-Kurki, P. (2003). The use of grounded theory to study interaction. *Nurse Researcher*, 11(2), 40–57.

Manderscheid, R. W., Ryff, C. D., Freeman, E. J., McKnight-Eily, L. R., Dhingra, S., & Strine, T. W. (2010). Evolving Definitions of Mental Illness and Wellness. *Preventing Chronic Disease:*, *7*(1), 1-6.

Mansoor, M., Perwez, S. K., Swamy, T., N. V. R. & Ramaseshan, H. (2015). A Critical Review on Role of Prison Environment on Stress and Psychiatric Problems among Prisoners. *Mediterranean Journal Of Social Sciences*, *6*(1), 218-223. doi: 10.5901/mjss.2015.v6n1s1p218.

Marks, D., & Yardley, L. (2004). *Research Methods for Clinical and Health Psychology* (pp. 39-55). London: Sage Publications Ltd.

Martin, L. L. (2011). Debt to Society: Asset Poverty and Prisoner Reentry. *Review Of Black Political Economy*, *38*(2), 131-143. doi: 10.1007/s12114-011-9087-1.

Mason, M. (2010). Sample Size and Saturation in PhD Studies Using Qualitative Interviews. *Forum, Qualitative Social Research*, *11*(3), 19-37. Retrieved from http://0-web.a.ebscohost.com.wam.city.ac.uk/ehost/pdfviewer/pdfviewer?vid=1&sid=9af1477d-f8b0-46ce-97ac-ecd11f7ee91c%40sdc-v-sessmgr02.

McCann, T., & Clark, E. (2003). Grounded theory in nursing research: Part 1 – Methodology. *Nurse Researcher*, 11(2), 7–18.

McGhee, G., Marland, G.R., & Atkinson, J. (2007). Grounded theory research: Literature reviewing and reflexivity. Journal of Advanced Nursing, 60(3), 334–342.

McLeod, J. (2015). *Doing Research in Counselling and Psychotherapy* (3rd ed., pp. 61-79). London: Sage Publications Ltd.

McManus, S., Bebbington, P., Jenkins, R., Brugha, T., & Cooper, C., (eds.). (2016) *Mental health and wellbeing in England: Adult Psychiatric Morbidity Survey 2014*. NHS Digital. Accessed via: http://content.digital.nhs.uk/catalogue/PUB21748/apms-2014-full-rpt.pdf.

McManus, S., Meltzer, H., Brugha, T., Bebbington, P., & Jenkins, R. (2009). *Adult psychiatric morbidity in England, 2007: Results of a household survey* (pp. 21-79). Leicester: The NHS Information Centre for health and social care. Retrieved from https://files.digital.nhs.uk/publicationimport/pub02xxx/pub02931/adul-psyc-morb-res-hou-sur-eng-2007-rep.pdf.

McNeill, F. (2014). Punishment as rehabilitation. In D. Weisburd & G. Bruinsma, *Encyclopedia of Criminology and Criminal Justice* (1st ed., pp. 4195-4206). New York: Springer. Retrieved from https://eprints.gla.ac.uk/91580/1/91580.pdf.

Mearns, D., Thorne, B., & McLeod, J. (2013). *Person-Centred Counselling in Action* (4th ed., pp. 1-128). London: SAGE Publications Ltd.

Mental Health Foundation. (2016). *Fundamental Facts about Mental Health 2016*. London: MHF. Accessed via: https://www.mentalhealth.org.uk/sites/default/files/fundamental-facts-about-mental-health-2016.pdf.

Mental Health Foundation. (2008). *What works for you?* London: Mental Health Foundation. Accessed via: https://www.mentalhealth.org.uk/sites/default/files/what-works-for-you-new.pdf.

Miller, P. (2021). "System Conditions", System Failure, Structural Racism and Anti-Racism in the United Kingdom: Evidence from Education and Beyond. *Societies*, *11*(2), 42-57. doi: 10.3390/soc11020042.

Miller, R. M., Chan, C. D., & Farmer, L. B. (2018). Interpretative Phenomenological Analysis: A Contemporary Qualitative Approach. *Counselor: Education And Supervision*, *57*(4), 240-254. doi: 10.1002/ceas.12114.

Mills, A. J., Durepos, G., & Wiebe, E. (2010). *Encyclopedia of Case Study Research* (1st ed., pp. 925-927). Thousand Oaks: SAGE Publications Ltd.

Mills, A., & Kendall, K. (2016). Mental health in prisons. In Y. Jewkes, B. Crewe & J. Bennett, *Handbook on Prisons* (2nd ed., pp. 187-199). London: Routledge.

MoJ. (2012b). *Accommodation, homelessness and reoffending of prisoners: Results from the Surveying Prisoner Crime Reduction (SPCR) survey* (pp. 1-5). MoJ. Retrieved from https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/278806/homelessness-reoffending-prisoners.pdf.

MoJ. (2013b). *Analysis of the impact of employment on re-offending following release from custody, using Propensity Score Matching* (pp. 1-5, 24-33). MoJ. Retrieved from https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/217412/impact-employment-reoffending.pdf.

MoJ. (2019a). *Annual Prison Performance Ratings 2018/19* (pp. 1-8). Ministry of Justice. Retrieved from https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/820618/annual-prison-performance-ratings-2018-19-bulletin.pdf.

MoJ. (2011a). *Categorisation and Recategorisation Of Adult Male Prisoners* (pp. 5-15). Ministry of Justice.

MoJ. (2011b). *Categorisation And Recategorisation Of Women Prisoners* (pp. 5-12). Ministry of Justice.

MoJ. (2011c). *Categorisation And Recategorisation Of Young Adult Male Prisoners* (pp. 4-10). Ministry of Justice.

MoJ. (2019b). *HMPPS Annual Digest 2018/19* (pp. 1-49). Ministry of Justice. Retrieved from https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/821148/HMPPS_Annual_Digest_bulletin_2018-2019.pdf.

MoJ. (2020). *Population bulletin: Monthly July 2020*. MoJ. Retrieved from https://www.gov.uk/government/statistics/prison-population-figures-2020.

MoJ. (2012). *Prisoners' childhood and family backgrounds* (pp. 1-25). Ministry of Justice. Retrieved from https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/278837/prisoners-childhood-family-backgrounds.pdf.

MoJ. (2019d). *Proven Reoffending Statistics Quarterly Bulletin, April 2017 to June 2017* (pp. 1-9). Ministry of Justice. Retrieved from https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/797439/proven_reoffending_bulletin_April_to_June_17.pdf.

MoJ. (2019c). *Safety in Custody Statistics, England and Wales: Deaths in Prison Custody to June 2019, Assaults and Self-harm to March 2019* (pp. 1-7). Ministry of Justice. Retrieved from https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/820627/safety-in-custody-q1-2019.pdf.

MoJ. (2013). Transforming Rehabilitation, A Strategy for Reform, Response to Consultation CP(R)16/2013. Accessed via: https://consult.justice.gov.uk/digital-communications/transforming-rehabilitation/results/transforming-rehabilitation-response.pdf.

Mok, P. L. H., Astrup, A., Carr, M. J., Antonsen, S., Webb, R. T., & Pederson, C. B. (2018). Experience of Child–Parent Separation and Later Risk of Violent Criminality. *American Journal Of Preventive Medicine*, *55*(2), 178-186.

Montgomery, P., & Bailey, P. H. (2007). Field Notes and Theoretical Memos in Grounded Theory. *Western Journal Of Nursing Research*, *29*(1), 65-79. doi: 10.1177/0193945906292557.

Moon, K. (2007). A Client-Centered Review of Rogers With Gloria. *Journal Of Counseling And Development*, *85*(3), 277-285. doi: 10.1002/j.1556-6678.2007.tb00475.x.

Mowen, T. J., Stansfield, R., & Boman, J. H. (2018). Family Matters: Moving Beyond "If" Family Support Matters to "Why" Family Support Matters during Reentry from Prison. *Journal Of Research In Crime And Delinquency*, *56*(4), 483-523. doi: 10.1177/0022427818820902.

Nagel, D. A., Burns, V. F., Tilley, C., & Aubin, D. (2015). When novice researchers adopt constructivist grounded theory: Navigating less travelled paradigmatic and

methodological paths in PhD dissertation work. *International Journal of Doctoral Studies, 10*, 365-383.

Nagel, W. (1976). Environmental influences in prison violence. In A. Cohen, G. Cole & R. Bailey, *Prison Violence* (pp. 135-146). Massachusetts: Lexington Books.

National Collaborating Centre for Mental Health. (2005). *Post-traumatic stress disorder: The management of PTSD in adults and children in primary and secondary care* (pp. 5-18, 52-92). Gaskell and the British Psychological Society. Retrieved from https://www.ncbi.nlm.nih.gov/books/NBK56494/pdf/Bookshelf_NBK56494.pdf.

Nelson, J. (2017). Using conceptual depth criteria: addressing the challenge of reaching saturation in qualitative research. *Qualitative Research*, *17*(5), 554–570. doi: 10.1177/1468794116679873.

NHS. (2018). *Talking therapies explained*. Retrieved from http://www.nhs.uk/Conditions/stress-anxiety-depression/Pages/Types-of-therapy.aspx.

NHS England. (2013). *Improving Access to Psychological Therapies* (pp. 3-21). NHS England. Retrieved from https://www.uea.ac.uk/documents/246046/11919343/offenders-positive-practice-guide.pdf/b73e11b9-0122-436b-819d-fb0db5b7a984.

NHS England. (2018). *Service Specification* (pp. 8-36). NHS England. Retrieved from https://www.england.nhs.uk/wp-content/uploads/2018/10/service-specification-mental-health-for-prisons-in-england-2.pdf.

NICE. (2011). *Common mental health problems: identification and pathways to care* (pp. 13-40, 58-90). NICE. Retrieved from https://www.nice.org.uk/guidance/cg123/resources/common-mental-health-problems-identification-and-pathways-to-care-pdf-35109448223173.

NICE. (2009). *Depression in adults: recognition and management*. Retrieved from https://www.nice.org.uk/Guidance/CG90.

NICE. (2019). *Generalised anxiety disorder and panic disorder in adults: management* (pp. 7-33). NICE. Retrieved from https://www.nice.org.uk/guidance/cg113/resources/generalised-anxiety-disorder-and-panic-disorder-in-adults-management-pdf-35109387756997.

NICE. (2005). *Obsessive-compulsive disorder and body dysmorphic disorder: treatment* (pp. 8-31). NICE. Retrieved from https://www.nice.org.uk/guidance/cg31/resources/obsessivecompulsive-disorder-and-body-dysmorphic-disorder-treatment-pdf-975381519301.

NICE. (2018). *Post-traumatic stress disorder* (pp. 6-20). NICE. Retrieved from https://www.nice.org.uk/guidance/ng116/resources/posttraumatic-stress-disorder-pdf-66141601777861.

NICE. (2013). *Social anxiety disorder: recognition, assessment and treatment* (pp. 6-36). NICE. Retrieved from https://www.nice.org.uk/guidance/cg159/resources/social-anxiety-disorder-recognition-assessment-and-treatment-pdf-35109639699397.

Niveau, G. (2007). Relevance and limits of the principle of “equivalence of care” in prison medicine. *Journal Of Medical Ethics*, *33*(10), 610-613.

Novotney, A. (2019). The risks of social isolation. *Monitor On Psychology*, *50*(5), 32-34. Retrieved from https://www.apa.org/monitor/2019/05/ce-corner-isolation.

Nowell, L. S., Norris, J. M., White, D. E., & Moules, N. J. (2017). Thematic Analysis: Striving to Meet the Trustworthiness Criteria. *International Journal Of Qualitative Methods*, *16*(1), 1-13. doi: 10.1177/1609406917733847.

Nurse, J., Woodcock, P., & Ormsby, J. (2003). Influence of environmental factors on mental health within prisons: focus group study. *British Medical Journal*, *327*(7413), 1-5. doi: 10.1136/bmj.327.7413.480.

Oliver, C. (2012). Critical Realist Grounded Theory: A New Approach for Social Work Research. *British Journal Of Social Work*, *42*(1), 371–387. Retrieved from https://0-www-jstor-org.wam.city.ac.uk/stable/43771640?pq-origsite=summon&seq=1#metadata_info_tab_contents.

Owens, M., Chen, J., Simpson, T., Timko, C., & Williams, E. (2018). Barriers to addiction treatment among formerly incarcerated adults with substance use disorders. *Addiction Science & Clinical Practice*, *13*(19), 2-11. doi: 10.1186/s13722-018-0120-6.

Pakes, F., & Holt, K. (2017). Crimmigration and the prison: Comparing trends in prison policy and practice in England & Wales and Norway. *European Journal Of Criminology*, *14*(1), 63-77. doi: 10.1177/1477370816636905.

Payne, S. (2007). Grounded theory. In E. Lyons & A. Coyle, *Analysing qualitative data in psychology* (2nd ed., pp. 119-146). London: Sage Publications Ltd. Retrieved from http://0-methods.sagepub.com.wam.city.ac.uk/book/analysing-qualitative-data-in-psychology?utm_source=ss360&utm_medium=discovery-provider.

Payne, Y. A., & Bryant, A. (2018). Street Participatory Action Research in Prison: A Methodology to Challenge Privilege and Power in Correctional Facilities. *The Prison Journal*, *98*(4), 449–469. doi: 10.1177/0032885518776378.

Patel, R., Harvey, J., & Forrester, A. (2018). Systemic limitations in the delivery of mental health care in prisons in England. *International Journal Of Law And Psychiatry*, *60*, 17–25. doi: 10.1016/j.ijlp.2018.06.003.

Penrod, J., Loeb, S. J., Ladonne, R. A., & Martin, L. M. (2016). Empowering Change Agents in Hierarchical Organizations: Participatory Action Research in Prisons. *Research In Nursing & Health*, *39*, 142–153. doi: 10.1002/nur.21716.

Pickard, H., & Fazel, S. (2014). Substance abuse as a risk factor for violence in mental illness: some implications for forensic psychiatric practice and clinical ethics. *Current Opinion Psychiatry*, *6*(4), 349–354. doi: 10.1097/YCO.0b013e328361e798.

Pineles, S. L., & Borba, C. P. C. (2018). A Path Towards Effectively Investigating the Impact of Sex and Gender on Mental Health. *Clinical Psychology Review*, *66*, 1-2.

Ponterotto, J. G., Kuriakose, G., & Granovskaya, Y. (2008). Counselling and Psychotherapy. In C. Willig & W. Stainton-Rogers, *The SAGE Handbook of Qualitative Research in Psychology* (1st ed., pp. 455-471). London: Sage Publications Ltd.

Ponterotto, J. G. (2005). Integrating qualitative research requirements into professional psychology training programs in North America: Rationale and curriculum model. *Qualitative Research In Psychology*, *2*(2), 97–116.

Ponterotto, J. G. (2005). Qualitative Research in Counseling Psychology: A Primer on Research Paradigms and Philosophy of Science. *Journal of Counseling Psychology*, *52*(2), 126–136.

Potter, J., & Hepburn, A. (2005). Qualitative interviews in psychology: problems and possibilities. *Qualitative Research in Psychology*, *2*(4), 281-307. doi:10.1191/1478088705qp045oa.

Powell, J., Harris, F., Condon, L., & Kemple, T. (2010). Nursing care of prisoners: staff views and experiences. *Journal Of Advanced Nursing*, *66*(6), 1257-1265.

Powis, B., Walton, C., & Randhawa, K. (2014). *Drug Recovery Wings Set Up, Delivery and Lessons Learned: Process Study of First Tranche DRW Pilot Sites* (pp. 1-37). Ministry of Justice. Retrieved from https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/286040/Drug-recovery-wings-process-study.pdf.

Prisons & Probation Ombudsman. (2019). *Annual Report 2018 – 19* (pp. 14-58). Ministry of Justice. Retrieved from https://s3-eu-west-2.amazonaws.com/ppo-prod-storage-1g9rkhjhkjmgw/uploads/2019/10/PPO_Annual-Report-2018-19_WEB-final-1.pdf.

Prisons and Probation Ombudsman. (2016). *Learning from PPO Investigations: Prisoner Mental Health* (pp. 5-37). London: Prisons and Probation Ombudsman.

Prison Reform Trust. (2019). *Prison: the facts. Bromley Briefings Summer 2019* (pp. 1-16). Prison Reform Trust. Retrieved from http://www.thebromleytrust.org.uk.

Racher, F., & Robinson, S. (2003). Are phenomenology and positivism strange bedfellows?. *Western Journal Of Nursing Research*, *25*(5), 464-481. doi: 10.1177/0193945903253909.

Ratnapalan, S. (2019). Qualitative approaches: Variations of grounded theory methodology. *Canadian Family Physician*, *65*(9), 667–668.

RCPsych. (2018). *QNPMHS Annual Report: Cycle 3 2017-2018* (pp. 9-40). RCPsych. Retrieved from https://www.rcpsych.ac.uk/docs/default-source/improving-care/ccqi/quality-networks/prison-quality-network-prison/prison-forensic-picu/qnpmhs-annual-report-cycle-3.pdf?sfvrsn=9fcadb06_4.

RCPsych. (2019). *QNPMHS Annual Report: Cycle 4 2018-2019* (pp. 9-41). Royal College of Psychiatrists Centre for Quality Improvement. Retrieved from https://www.rcpsych.ac.uk/docs/default-source/improving-care/ccqi/quality-networks/prison-quality-network-prison/prison-forensic-picu/qnpmhs-annual-report-cycle-4.pdf?sfvrsn=1e8ba52b_2.

Redman-MacLaren, M., & Mills, J. (2015). Transformational Grounded Theory: Theory, Voice, and Action. *International Journal of Qualitative Methods*, *14*(3), 1-12.

Reed, J. (2003). Mental health care in prisons. *The British Journal Of Psychiatry*, *182*(4), 287-288. Doi: 10.1192/bjp.182.4.287.

Reed, J., & Lyne, M. (2000). Inpatient care of mentally ill people in prison: results of a year's programme of semistructured inspections. *The British Medical Journal*, *320*(7241), 1031-1034. Doi: 10.1136/bmj.320.7241.1031.

Renik, O. (2000). Discussion of the Therapeutic Alliance. In S. T. Levy, *The Therapeutic Alliance* (pp. 95-108). Madison: International Universities Press. Retrieved from http://0-www.pep-web.org.wam.city.ac.uk/document.php?id=zbk.073.0095a#p0095.

Rennie, D. (2000). Grounded Theory Methodology as Methodical Hermeneutics: Reconciling Realism and Relativism. *Theory and Psychology*, *10*(4), 481-502.

Ricciardelli, R., Maier, K., & Hannah-Mofat, K. (2015). Strategic masculinities: Vulnerabilities, risk and the production of prison masculinities. *Theoretical Criminology*, *19*(4), 491-513. Doi: 10.1177/1362480614565849.

Roberts, J. M. (2014). Critical Realism, Dialectics, and Qualitative Research Methods. *Theory of Social Behaviour*, *44*(1), 1–23. Doi:10.1111/jtsb.12056.

Roberts, J. V., & Hough, M. (2002). *Changing Attitudes to Punishment: Public Opinion, Crime and Justice* (1st ed., pp. 1-14, 93-114). Devon: Willan Publishing.

Roberts, T. (2013). Understanding the research methodology of interpretative phenomenological analysis. *British Journal Of Midwifery*, *21*(3), 215-218. doi: 10.12968/bjom.2013.21.3.215.

Robinson, G. (2005). What Works in Offender Management?. *Howard Journal of Crime and Justice*, *44*(3), 307-318. Doi: 10.1111/j.1468-2311.2005.00374.x.

Rogers, C. R. (1980). *A Way of Being* (pp. 5-26, 113-126). New York: Houghton Mifflin Company.

Rogers, C. R. (1963). The actualizing tendency in relation to “motives” and to consciousness. In M. R. Jones, *Nebraska symposium on motivation* (11th ed., pp. 1-24). Lincoln: University of Nebraska Press.

Rosenfeld, B. (2002). The psychology of competence and informed consent: Understanding decision-making with regard to clinical research. Fordham Urban Law Review, 30(1), 173-186.

Ross, E. C., Polaschek, D. L. L., & Ward, T. (2008). The therapeutic alliance: A theoretical revision for offender rehabilitation. *Aggression & Violent Behaviour*, *13*(6), 462-480. Doi: 10.1016/j.avb.2008.07.003.

Sandvik, B. M., & McCormack, B. (2018). Being person-centred in qualitative interviews: reflections on a process. *International Practice Development Journal*, *8*(2), 1-8. Doi: 10.19043/ipdj.82.008.

Scott, D. (2013). *Why Prison?* (1st ed., pp. 1-64, 108-124). Cambridge: Cambridge University Press.

Seddon, T. (2007). *Punishment and Madness: Governing Prisoners with Mental Health Problems,* (pp. 123-170). Ebingdon: Glasshouse.

Seider, S., Davis, K., & Gardner, H. (2007). Good work in psychology, *The Psychologist*, *20*(11), pp. 672–6.

Senior, J. (2015). Mental health in prisons. *Trends In Urology & Men's Health*, *6*(1), 9-11. Retrieved from https://wileymicrositebuilder.com/trends/wp-content/uploads/sites/13/2015/01/Mental-health-in-prisons.pdf.

Shapiro, F. (2018). *Eye Movement Desensitization and Reprocessing (EMDR) Therapy, Third Edition : Basic Principles, Protocols, and Procedures* (3rd ed., pp. 1-24, 53-84). New York: The Guildford Press.

Sharma, G. (2017). Pros and cons of different sampling techniques. *International Journal Of Applied Research*, *3*(7), 749-752.

Siegel, D. J. (2019). The mind in psychotherapy: An interpersonal neurobiology framework for understanding and cultivating mental health. *Psychology and psychotherapy: Theory, Research and Practice*, 92(2), pp.224-237.

Sim, J. (1994). Tougher than the Rest? Men in Prison. In T. Newburn & E. Stanko, *Just boys doing business? Men, masculinities and crime* (pp. 57– 68). London: Routledge.

Simpler, A. H., & Langhinrichen-Rohling, J. (2005). Substance use in prison: How much occurs and is it associated with psychopathology?. *Addiction Research And Theory*, *13*(5), 503–511. Doi: 10.1080/16066350500151739.

Skogstad, P., Deane, F. P., & Spicer, J. (2006). Social-cognitive determinants of help-seeking for mental health problems among prison inmates. *Criminal Behaviour And Mental Health*, *43*(59), 43-57. Doi: 10.1002/cbm.54.

Smith, C. (2002). 'Healthy Prisons': A Contradiction in Terms?. *The Howard Journal Of Criminal Justice*, *39*(4), 339-353. Doi: 10.1111/1468-2311.00174.

Smith, J. A., Flowers, P., & Larkin, M. (2009). *Interpretative phenomenological analysis: theory, method and research* (1st ed., pp. 1-40). London: SAGE.

Specter, D. (2006). Making Prisons Safe: Strategies for Reducing Violence. *Washington University Journal Of Law & Policy*, *22*, 125-134. Retrieved from https://0-heinonline-org.wam.city.ac.uk/HOL/Page?lname=&handle=hein.journals/wajlp22&collection=&page=125&collection=journals.

Starks, H., & Brown-Trinidad, S. (2007). Choose Your Method: A Comparison of Phenomenology, Discourse Analysis, and Grounded Theory. *Qualitative Health Research*, *17*(10), 1372-1380.

Steiner, B., & Meade, B. (2016). Assessing the Link Between Exposure to a Violent Prison Context and Inmate Maladjustment. *Journal Of Contemporary Criminal Justice*, *32*(4), 328-356. Doi: 10.1177/1043986216660009.

Sternbenz, C. (2014). Why Norway's prison system is so successful. *Business Insider*, 1-3.

Sturge, G. (2020). *UK Prison Population Statistics* (pp. 3-13, 23). House of Commons Library. Retrieved from http://www.parliament.uk/commons-library.

Sutton, J., & Austin, Z. (2015). Qualitative Research: Data Collection, Analysis, and Management. *The Canadian Journal Of Hospital Pharmacy*, *68*(3), 226–231. Doi: 10.4212/cjhp.v68i3.1456.

Tait, S. (2008). Care and the prison officer: beyond 'turnkeys and 'care bears'. *Prison Service Journal*, *180*(1), 3-11.

The Mental Health Taskforce. (2016). *The Five Year Forward View for Mental Health* (pp. 4-67). NHS England. Retrieved from https://www.england.nhs.uk/wp-content/uploads/2016/02/Mental-Health-Taskforce-FYFV-final.pdf.

Thompson, A. R., & Russo, K. (2012) Ethical Dilemmas for Clinical Psychologists in Conducting Qualitative Research. *Qualitative Research in Psychology, 9*(1), 32-46, DOI: 10.1080/14780887.2012.630636.

Thompson, A., & Russo, K. (2012). Ethical Dilemmas for Clinical Psychologists in Conducting Qualitative Research. *Qualitative Research In Psychology*, *9*(1), 32-46. Doi: 10.1080/14780887.2012.630636.

Thorne, S. (2000). Data analysis in qualitative research. *Evidence Based Nursing*, *3*(1), 68-70. Doi: 10.1136/ebn.3.3.68.

Thornberg, R. (2012). Informed Grounded Theory. *Scandinavian Journal Of Educational Research*, *56*(3), 243-259. Doi: 10.1080/00313831.2011.581686.

Towl, G. (2003). *Psychology in Prisons* (pp. 18-92, 127-150, 230-247). Oxford: BPS Blackwell.

Tracy, S. (2013). *Qualitative research methods: collecting evidence, crafting analysis, communicating impact* (pp. 87-104, 227-250). West Sussex: Wiley-Blackwell.

Trafimow, D. (2014). Considering Quantitative and Qualitative Issues Together. *Qualitative Research in Psychology*, *11*(1), 15-24. Doi:10.1080/14780887.2012.743202.

Tyler, N., Miles, H. L., Karadag, B., & Rogers, G. (2019). An updated picture of the mental health needs of male and female prisoners in the UK: prevalence, comorbidity, and gender differences. *Social Psychiatry And Psychiatric Epidemiology*, *54*(1), 1143–1152. doi: 10.1007/s00127-019-01690-1.

Uhrig, N. (2016). *Black, Asian and Minority Ethnic disproportionality in the Criminal Justice System in England and Wales* (pp. 1-30). Ministry of Justice. Retrieved from http://www.justice.gov.uk/publications/researchand-analysis/moj.

UK Parliament. (2018). *Data Protection Act 2018*. Home Office. Retrieved from http://www.legislation.gov.uk/ukpga/2018/12/enacted.

Urquhart, C. (2013). *Grounded Theory for Qualitative Research: A Practical Guide* (1st ed., pp. 14-34). London: SAGE Publications Ltd.

Van Ginneken, E. F. J. C., Palmen, H., Bosma, A. Q., & Sentse, M. (2019). Bearing the Weight of Imprisonment: The Relationship Between Prison Climate and Well-Being. *Criminal Justice And Behavior*, *46*(10), 1385-1404. doi: 10.1177/0093854819867373.

Vennard, J., Sugg, D., & Hedderman, C. (1997). *Changing offenders' attitudes and behaviour: what works?* (pp. 1-52). Research and Statistics Directorate. Retrieved from http://library.college.police.uk/docs/hors/hors171.pdf.

Visher, C. A., Debus-Sherrill, S. A., & Yahner, J. (2011). Employment After Prison: A Longitudinal Study of Former Prisoners. *Justice Quarterly*, *28*(5), 698-718. doi: 10.1080/07418825.2010.535553.

Vishner, C., Debus, S., & Yahner, J. (2008). *Employment after Prison: A Longitudinal Study of Releasees in Three States* (pp. 1-9). Urban Institute Justice Policy Center. Retrieved from https://www.urban.org/sites/default/files/publication/32106/411778-Employment-after-Prison-A-Longitudinal-Study-of-Releasees-in-Three-States.PDF.

Wacquant, L. (2002). The curious eclipse of prison ethnography in the age of mass incarceration. *Ethnography*, *3*(4), 371–397. Retrieved from https://0-www-jstor-org.wam.city.ac.uk/stable/pdf/24047814.pdf?refreqid=excelsior%3A7a7f849b6cba46cf803cd324693f0e32.

Wallace, D., Fahmy, C., Cotton, L., Jimmons, C., McKay, R., Stoffer, S., & Syed, S. (2016). Examining the Role of Familial Support during Prison and after Release on Post-incarceration Mental Health. *International Journal Of Offender Therapy And Comparative Criminology*, *60*(1), 3-20. doi: 10.1177/0306624X14548023.

Ward, K., Hoare, K., & Gott, M. (2015). Evolving from a positivist to constructionist epistemology while using grounded theory: reflections of a novice researcher. *Journal of Research in Nursing*, *20*(6), 449–462. doi:10.1177/1744987115597731.

Wertz, F., Charmaz, K., McMullen, L., Josselson, R., Anderson, R., & McSpadden, E. (2011). *Five ways of doing qualitative analysis : phenomenological psychology, grounded theory, discourse analysis, narrative research, and intuitive inquiry* (1st ed., pp. 63-65, 228-240). London: The Guildford Press.

Wheatley, M. (2016). Drug misuse in prison. In Y. Jewkes, B. Crewe & J. Bennett, *Handbook on Prisons* (2nd ed., pp. 205-218). London: Routledge.

Wheeler, M. (2000). Episodic memory and autonoetic awareness. In E. Tulving & F. Craik, *The Oxford Handbook of Memory* (pp. 597-608). New York: Oxford University Press, Inc.

Widom, C. S., & College, J. J. (2017). Long-Term Impact of Childhood Abuse and Neglect on Crime and Violence. *Clinical Psychology: Science & Practice*, *42*(2), 186-202.

Wilfley, D., & Shore, A. (2015). Interpersonal Psychotherapy. In J. Wright, *International Encyclopedia of the Social & Behavioral Sciences* (2nd ed., pp. 631-636). Elsevier Ltd. Retrieved from https://www.sciencedirect.com/science/article/pii/B9780080970868210659?via%3Dihub.

Wilkins, P. (2003). *Person-Centred Therapy in Focus* (1st ed., pp. 8-18, 34-82, 90-99). London: SAGE Publications Ltd.

Williams, K., Papadopoulou, V., & Booth, N. (2012). *Prisoners' childhood and family backgrounds: Results from the Surveying Prisoner Crime Reduction (SPCR) longitudinal cohort study of prisoners* (pp. 1-25). MoJ. Retrieved from https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/278837/prisoners-childhood-family-backgrounds.pdf.

Willig, C. (2008). *Introducing Qualitative Research in Psychology: Adventures in theory and method* (2nd ed., pp. 15-51,149-161). Berkshire: Open University Press.

Willig, C. (2013). *Introducing Qualitative Research in Psychology* (3rd ed., pp. 14-48). Maidenhead: McGraw Hill/Open University.

Willig, C., & Stainton-Rogers, W. (2017). *The SAGE Handbook of Qualitative Research in Psychology* (pp. 240-256, 263-278). London: SAGE Publications Ltd.

Witcher, C. S. G. (2010). Negotiating Transcription as a Reflective Insider: Implications for Rigor. *International Journal Of Qualitative Methods*, *9*(2), 122-132. doi: 10.1177/160940691000900201.

Woodall, J., Dixey, R., & South, J. (2014). Control and choice in English prisons: developing health-promoting prisons. *Health Promotion International*, *29*(3), 474–482. doi: 10.1093/heapro/dat019.

Woodall, J., Dixey, R., & South, J. (2013). Prisoners' perspectives on the transition from the prison to the community: implications for settings-based health promotion. *Critical Public Health*, *23*(2), 188-200. doi: 10.1080/09581596.2012.732219.

World Health Organisation. (2013). *Investing in mental health: evidence for action* (pp. 10-15, 24-26). World Health Organisation. Retrieved from https://apps.who.int/iris/bitstream/handle/10665/87232/9789241564618_eng.pdf?sequence=1&isAllowed=y.

World Health Organisation. (2005). *Mental Health and Prisons Information Sheet* (pp. 1-5). World Health Organisation. Retrieved from https://www.who.int/mental_health/policy/mh_in_prison.pdf.

World Health Organisation. (2004). *World Health Organization. Promoting mental health: concepts, emerging evidence, practice (Summary Report)* (pp. 13-56). Geneva: World Health Organisation. Retrieved from https://www.who.int/mental_health/evidence/en/promoting_mhh.pdf.

Wright, R. (2018). UK prison workers stage walkout over levels of violence. *Financial Times.* Retrieved from https://0-search-proquest-com.wam.city.ac.uk/docview/2103986268?accountid=14510.

Wright, N., Jordan, M., & Kane, E. (2014). Mental health/illness and prisons as place: Frontline clinicians′ perspectives of mental health work in a penal setting. *Health & Place*, *29*(1), 179-185. doi: 10.1016/j.healthplace.2014.07.004.

Wu, C. V., & Beaunae, C. (2014). Personal reflections on cautions and considerations for navigating the path of grounded theory doctoral theses and dissertations: A long walk through a dark forest. *International Journal of Social Research Methodology, 17*(3), p. 249 – 265.

Yardley, L. (2000). Dilemmas in qualitative health research. *Psychology & health*, 15 (2), p. 215-228.

Zhang, L., Zhou, S. and Kwan, M. (2019). A comparative analysis of the impacts of objective versus subjective neighborhood environment on physical, mental, and social health. *Health & Place*, 59(1), pp.1-13.

Appendices

Appendix A – Ethics Form ETH1819-0098

Ethics ETH1819-0098: Florentine De Raaij (Medium risk)

Date	10 Oct 2018
Researcher	Florentine De Raaij
Project	How do individuals who suffer from mental health distress and have spent time in prison experience talk therapy?
School	School of Arts and Social Sciences
Department	Psychology

Ethics application

Risks

R1) Does the project have funding?
No

R2) Does the project involve human participants?
Yes

R3) Will the researcher be located outside of the UK during the conduct of the research?
No

R4) Will any part of the project be carried out under the auspices of an external organisation, involve collaboration between institutions, or involve data collection at an external organisation?
Yes

R5) Does your project involve access to, or use of, material that could be classified as security sensitive?
No

R6) Does the project involve the use of live animals?
No

R7) Does the project involve the use of animal tissue?
No

R8) Does the project involve accessing obscene materials?
No

R9) Does the project involve access to confidential business data (e.g. commercially sensitive data, trade secrets, minutes of internal meetings)?
No

R10) Does the project involve access to personal data (e.g. personnel or student records) not in the public domain?

No

R11) Does the project involve deviation from standard or routine clinical practice, outside of current guidelines?
No

R12) Will the project involve the potential for adverse impact on employment, social or financial standing?
No

R13) Will the project involve the potential for psychological distress, anxiety, humiliation or pain greater than that of normal life for the participant?
Yes

R15) Will the project involve research into illegal or criminal activity where there is a risk that the researcher will be placed in physical danger or in legal jeopardy?
No

R16) Will the project specifically recruit individuals who may be involved in illegal or criminal activity?
No

R17) Will the project involve engaging individuals who may be involved in terrorism, radicalisation, extremism or violent activity and other activity that falls within the Counter-Terrorism and Security Act (2015)?
No

Applicant & research team

T1) Principal Applicant

Name
Florentine De Raaij

Provide a summary of the researcher's training and experience that is relevant to this research project.
I am currently a third year student on the City University Counselling Psychology doctorate. As part of this course, I am required to carry out a research project as part of the thesis, which is part of my final portfolio. I have interest in pursuing a career as a counselling psychologist within forensic settings and feel that this research is appropriate associated to my interests. I have previously worked in a school with adolescents who had parents/caregivers in the prison system, and seeing the impact of this lifestyle on the mental health of the students further motivated me to pursue the doctorate and this particular research idea. I am also currently working as a trainee counselling psychologist at a low-security inpatient psychiatric hospital for adult males with severe and enduring mental health concerns as well as complex behaviour concerns. Seeing the impact of longer-term imprisonment has further motivated me to want to research this particular topic.

T2) Co-Applicant(s) at City

T3) External Co-Applicant(s)

T4) Supervisor(s)
Prof George Berguno

T5) Do any of the investigators have direct personal involvement in the organisations sponsoring or funding the research that may give rise to a possible conflict of interest?
No

T6) Will any of the investigators receive any personal benefits or incentives, including payment above normal salary, from undertaking the research or from the results of the research above those normally associated with scholarly activity?
No

T7) List anyone else involved in the project.
[redacted]

Project details

P1) Project title
How do individuals who suffer from mental health distress and have spent time in prison experience talk therapy?

P1.1) Short project title
Research exploring the experience of therapeutic support in prison

P2) Provide a lay summary of the background and aims of the research, including the research questions (max 400 words).
There is strong evidence that mental health (MH) is negatively impacted by imprisonment, with MH concerns considerably more prevalent within prison populations than the general population in the UK. Whilst there recently have been significant changes in legislation and service structures to better support incarcerated individuals suffering from MH concerns, the latest research suggests significant improvements are still needed in order for practice to match legislative visions.

Although there has recently been an increase in research carried out on this topic from a qualitative approach, most studies evidencing the negative impacts of imprisonment and the need for improvements have been carried out using quantitative analysis. As such, available research indicates there is a lack of exploration of the voices of those directly experiencing the phenomenon, resulting in a less comprehensive insight of how incarcerated individuals experience MH and support. Additionally, despite the increased use of talk-therapy (TT) as a MH intervention in prison, little qualitative research has explored the impact of the use of TT. In attempting to provide MH support which is appropriate and effective, substantially more qualitative research needs to be carried out

with a focus of gaining a better understanding of the current status of MH and the use of TT in prisons.

This research offers an exploration of how incarcerated individuals living with MH experience TT, with a focus on interviewing individuals after their experience of incarceration. This research study focuses specifically on exploring more commonly experienced symptoms, including depression, anxiety (generalised and social), panic, Obsessive Compulsive Disorder and Post-Traumatic Stress Disorder, as outlined by Nice Guidelines (2011). There are many types of treatments that can be considered when supporting these particular mental health concerns, however this research will solely focus on the use of TT, referring to therapeutic treatments in which individuals speak to a professional about their concerns. The review solely focuses on TT as there are already several recognised by the NHS and thus are also used in the NHS Improving Access to Psychological Therapies programme, which is available within prison settings.

P4) Provide a summary and brief explanation of the research design, method, and data analysis.

A qualitative research design will be used to conduct this research. An abbreviated version of the constructivist grounded theory will be used, with the aim of developing an explanatory theory of how individuals with mental health distress feel they were therapeutically supported whilst in prison.

Theoretical sampling will be used in the recruitment process and participant will be recruited through response of a posted advertisements at two mental health support services, who have agreed to advertise the study on their grounds. Specific inclusion and exclusion criteria have been established, which will be used within the recruitment process. Prior to interviews taking place, potential candidates will be contacted by phone for screening purposes, ensuring that the inclusion criteria of the study are met.

Once consent has been gathered and participants have been briefed, semi-structured interviews will be carried out, on a one-to-one basis. Participants will be briefed prior to taking part in the interview and debriefed upon completion. Participants will also be offered an informative leaflet on looking after mental health as part of debrief process.

One set of interviews will be carried out. The length of the interviews will be dependent on responses provided. Each interview is expected to last approximately an hour. All interviews will be digitally audio-recorded to ensure accurate transcription takes place.

P4.1) If relevant, please upload your research protocol.

P5) What do you consider are the ethical issues associated with conducting this research and how do you propose to address them?

There are some ethical issues associated to conducting this research which need to be considered and addressed.

The main ethical concern is that of lone-working, referring to recruitment of participants as well as carrying out one-to-one and face-to-face interviews in a room on university grounds. Concerns associated with this are the potential for: violent/threatening/intimidating behaviour, theft of personal property, risk of participants raising concerns around self-harm or harm to others, as well as accidents. All risk levels are considered to be low.

In regard to violent/threatening/intimidating behaviour, the following control measures are to be put in place:

-Researcher to give mobile number to both research supervisors and allocated safety person.

-Researcher has mobile number of both research supervisor.

-Researcher has given code word to research supervisors and allocated safety person in case of emergency.

-Researcher notifies supervisors and allocated safety person of date, time and location of each interview at University (names of participants will not be mentioned).

-Researcher notifies both supervisors of arrival and departure of each interview.

-Researcher will have easy access to emergency contact numbers in case of need.

-Participants will be met at university (Rhind building) during the psychology department staff hours (at least 1 supervisor will be present at time of each interview) (Wed-Fri 9am-5pm).

-Security at City University to be given information sheet with code which participants must verbally present when entering the building for interviews.

-Researcher will not keep personal belongings on her throughout the duration of interviews. The only assets in the room will be the researcher's audio-recording device, which will be put away immediately after completion of each interview.

-Researcher to position self nearest to door in interview room.

-Researcher has approved and updated DBS check prior to starting research.

-Inclusion/exclusion criteria for participation established to avoid interviewing individuals with violent crime offenses, and to avoid individuals with more severe mental health concerns, to minimise potential risk to researcher.

-Email address created specifically for research recruitment purposes so that no personal contactable information is available of researcher.

-Advertisement through 2 external organisations, both of which are based in London (recruitment not done in person).

-Participants will be provided with information sheet which includes details around participating in the study, including details around breaking confidentiality measures.

-Each participant will initial a consent form prior to taking part in the research project.

-Participants are briefed prior to the interview taking place and are informed of ability to stop the interview at any time without consequence.

-Participants to be given debriefing sheet with information regarding self-help, support services and hotlines available in London.

-Participants to be given leaflet, which will include advice on lifting mood, improving wellbeing, mindfulness techniques, and relaxation exercises.

Regarding potential theft of personal property, the same control measures as above are considered.

Regarding the risk of participants raising concerns around self-harm or harm to others: Considering the sensitivity of the research topic, there is a small chance that participants may in their responses to questions, disclose issues of concern (whether emotional, psychological, educational or health related). There is also potential for participants to experience increased levels of distress as they may

relive negative past experiences. In using semi-structured interviews, one also aims to allow opportunity for participants to disclose information they feel is important and relevant to the topic being studied, though interviews will be constructed to minimise the potential for such responses and reactions. A need for referral of a participant is unlikely due to the protective measures which will be put in place for all participating individuals.

Alongside control measures mentioned above for the other potential concerns, in case any distress is identified by the researcher or voiced by the participant (i.e. mention of suicidal ideation, thoughts or planning), the interview will be terminated and both research supervisors will be informed. Appropriate additional support will be offered to the participant. Within the briefing and debriefing, participants will be made aware of the purpose of the study, what is expected of participants and boundaries of the research as well as resources for self-help. They'll also be given information of local support services in the debrief as well as an informative leaflet around improving mental health, in case of need.

Regarding the potential for accidents, the same control measures as mentioned above will be considered.

P6) Project start date
31 Jan 2019

P7) Anticipated project end date
14 Feb 2020

P8) Where will the research take place?
City University, Rhind Building, during the psychology department staff hours

P9) If the research is taking place at a time or in a place that could potentially put the researcher at risk (e.g. research taking place in a participant's home) please provide details of the lone working policy you will be following.
There is minimal risk of physical harm to the researcher due to the protective measures put in place for any face-to-face contact with involved participants. For instance, the inclusion/exclusion criteria have been created with the important aim of minimising potential of harm. Also, interviews will be completed at City University in the Rhind Building (where the psychology department also sits), during the psychology department staff hours. Furthermore, upon completion of the participant recruitment process, a timetable with interview times and the location of interviews with participants will be created by the researcher and given to the research supervisors to ensure full transparency and awareness of the location of the researcher when active in the data collection process.

Further detail on available solutions for potential risks to the researcher are offered within the completed risk assessment form, which is attached.

P10) Is this application or any part of this research project being submitted to another ethics committee, or has it previously been submitted to an ethics committee?
Yes

P10.1) Please give details and justification for going to separate committees, details of the Secretary of the relevant authority/committee, and attach correspondence and details of the outcome of the application, including any conditions of approval or reasons for rejection.
It has previously been submitted to the City University Ethics committee (in the previous format). Amendments were offered, which have been addressed within this new submission.

External organisations

E1) Provide details of the external organisation/institution involved with this project.
Involvement of external institutions will be required for the participant recruitment process. A maximum of ten participants will be recruited on a voluntary basis through response of a posted advertisements via 2 mental health support services, based in London. Whilst organisations used will be identified, individuals participating in the study will not be identified to ensure confidentiality.

E2) If applicable, has permission to conduct research in, at or through another institution or organisation been obtained?
Yes

E2.1) Provide details and attach the correspondence.

Human participants: information and participation

The options for the following question are one or more of:
'Under 18'; 'Adults at risk'; 'Individuals aged 16 and over potentially without the capacity to consent'; 'None of the above'.

H1) Will persons from any of the following groups be participating in the project?
None of the above

H2) How many participants will be recruited?
10

H3) Explain how the sample size has been determined.
Due to the time constraints of carrying out this research study, an overall maximum of 10 participants will be interviewed. This amount of participants is also appropriate with the qualitative grounded theory methodology used.

H4) What is the age group of the participants?

Lower	Upper
18	

H5) Please specify inclusion and exclusion criteria.
Inclusion Criteria:

- A population with prior prison time has been chosen due to the challenges of accessing individuals currently incarcerated.

- An adult sample population (18+) has been chosen as research shows the memory of adults tends to be more vivid in recollection than those of adolescents and children.

- Participants must have been incarcerated for a minimum of 6 months to ensure participants have a thorough insight into the prison system

- Participants must have been incarcerated for a maximum of 2 years. --- Criminal events included will be: driving offences (where no loss of life or serious injury to a third party occurred), and failure to comply with a community order or a suspended sentence. During the screening phone call, participants will be asked to describe the nature of the offence.

- Participants must not be under probation supervision at time of recruitment, data collection or analysis process.

- In order to provide current findings and as studies of memory have evidenced that the quality of memories speedily decays over time, a time limit of 5 years since release has been decided.

- Due to the sensitive nature of mental health concerns, participants will be taken at their word in relation to experience or having experienced mental health distress. In the screening phone-call, clients will be asked to describe their symptoms, the onset of their symptoms and whether they still experience symptoms.

- In order to gather a fully representative view of inmate experience of suffering from mental health in prison, there is no requirement of attendance of talk-therapy during the period of incarceration to participate.

- Due to the method chosen, participants must be willing to being audio-recorded.

Exclusion Criteria:

- Individuals who are under the age of 18.

- Individuals who have served a sentence shorter than 6 months.

- Individuals who have served a sentence longer than 2 years.

- Individuals who have served a sentence which included death or injury to a third party (i.e. DUI with death or serious injury to a third party, GBH, ABH, assault by beating, rape, sexual assault, paedophilia).

- Individuals will be excluded if there is mention of symptoms related to psychosis or if there is a previous or current diagnosis of psychosis.

- Individuals who have been released from prison over 5 years ago.

- Individuals who are currently supervised under probation.

- Individuals who are unable to describe symptoms related to one of the mentioned mental health concerns (individuals will be taken at their word).

- Individuals who are not willing for interviews to be recorded.

Whilst the advertisement will provide all criteria, such information will be verified with participants prior to carrying out each interview cycle via a screening phone-call carried out by the researcher.

H6) What are the potential risks and burdens for research participants and how will you minimise them?

Considering the sensitivity of the research topic, there is a small chance that participants may in their responses to questions, disclose issues of concern (whether emotional, psychological, educational or health related). There is also potential for participants to experience increased levels of distress as they may relive negative past experiences. In using semi-structured interviews, one also aims to

allow opportunity for participants to disclose information they feel is important and relevant to the topic being studied, though interviews will be constructed to minimise the potential for such responses and reactions. A need for referral of a participant is unlikely due to the protective measures which will be put in place for all participating individuals.

Prior to participating in the interview, participants will be provided with information sheet which includes details around participating in the study, including details around breaking confidentiality measures. Each participant will initial a consent form prior to taking part in the research project, and participants will be briefed prior to the interview taking place and are informed of ability to stop the interview at any time without consequence. Alongside control measures mentioned above for potential concerns, in case any distress is identified by the researcher or voiced by the participant (i.e. mention of suicidal ideation, thoughts or planning), the interview will be terminated. At this point, the participant will be appropriately supported. During the debriefing process, participants are given a debrief sheet which provides information on resources for self-help, and contact information of MH organisations are also provided. They'll also be an informative leaflet on lifting mood, improving wellbeing, mindfulness techniques and relaxation exercises. The researcher will also have easy access to emergency contact numbers, in case of need.

In case of need to terminate interview, the research supervisor will also be informed of need and reason to terminate interview, with a follow-up discussion taking place to reflect on appropriateness of support offered.

H7) Will you specifically recruit pregnant women, women in labour, or women who have had a recent stillbirth or miscarriage (within the last 12 months)?
No

H8) Will you directly recruit any staff and/or students at City?
None of the above

H8.1) If you intend to contact staff/students directly for recruitment purpose, please upload a letter of approval from the respective School(s)/Department(s).

H9) How are participants to be identified, approached and recruited, and by whom?
A maximum of ten participants will be recruited on a voluntary basis through response of a posted advertisements at two external organisations, both based in London.

Theoretical sampling will be used in the recruitment process. Theoretical sampling is used as contributors to the study will have different subjective experiences of the phenomenon being studied and this isn't accounted for within the recruitment process. Potential participants will be provided with an information sheet prior to deciding to participate in the research.

Prior to interviews taking place, potential candidates who have expressed interest in participating in the study will be contacted by phone for screening purposes, ensuring that the inclusion criteria of the study are met.

H10) Please upload your participant information sheets and consent form, or if they are online (e.g. on Qualtrics) paste the link below.

H11) If appropriate, please upload a copy of the advertisement, including recruitment emails, flyers or letter.

H12) Describe the procedure that will be used when seeking and obtaining consent, including when consent will be obtained.

Participants will be provided information sheets through the involved external organisations, who will share the information sheets alongside the advertisement for the study. Participant information sheets can also be received via e-mail, through the e-mail address which was specifically created for this research and will be deleted when the thesis and viva process is completed.

Prior to interviews taking place, written informed consent will be gathered from the participant by the researcher. This is to ensure that all involved participants are fully aware of the aims of the research, what is expected per their involvement, the boundaries of the research and to ensure equality to all participants. Participants will be asked to sign two identical copies of the consent form. The participant will be able to take one home. The other copy of the consent form will be scanned in, with the digital copy stored on one-drive at the university, and the hard copy will be securely destroyed using official university procedures.

H13) Are there any pressures that may make it difficult for participants to refuse to take part in the project?

No

H14) Is any part of the research being conducted with participants outside the UK?

No

Human participants: method

The options for the following question are one or more of:
'Invasive procedures (for example medical or surgical)'; 'Intrusive procedures (for example psychological or social)'; 'Potentially harmful procedures of any kind'; 'Drugs, placebos, or other substances administered to participants'; 'None of the above'.

M1) Will any of the following methods be involved in the project:

None of the above

M2) Does the project involve any deceptive research practices?

No

M3) Is there a possibility for over-research of participants?

No

M4) Please upload copies of any questionnaires, topic guides for interviews or focus groups, or equivalent research materials.

M5) Will participants be provided with the findings or outcomes of the project?

Yes

M5.1) Explain how this information will be provided.

Participants will be notified via e-mail when the thesis has successfully completed the Viva process, through the e-mail address created specifically for this research. At this point, they will be offered a copy of the thesis, with the option of receiving it via e-mail or via post (if he or she feels comfortable sharing their address for the purpose of receiving a copy of the thesis).

M6) If the research is intended to benefit the participants, third parties or the local community, please give details.

A key focus of this research is to provide in-depth and clear data which confronts a gap observed in existing research and knowledge. Another aim of this research is to offer a marginalised group a chance to share their views and beliefs.

As counselling psychologists are focused on the wellbeing (including mental health - MH) of the people and supporting associated concerns in the most appropriate way, it seems appropriate to also emphasise the importance of researching how this research can have the potential to improve how the counselling practice functions within prison settings. Creating awareness and allowing for the opportunity for better understanding amongst the public and professional bodies could potentially ensure that in the future, more of those serving custodial sentences are provided with MH support which is not only highly appropriate but also vastly effective.

M7) Are you offering any incentives for participating?

Yes

M7.1) Please give details, justifying their type and amount.

My research explores how individuals who suffer from mental health distress and have spent time in prison experience talk therapy. In order to take part in this research, participants will be asked to travel to City University, to take part in an interview. In wanting to not discriminate against financial capability and in order to ensure that all willing individuals are offered an equal opportunity to take part in the study, I would like to offer travel compensation. Individuals who would like travel compensation will be expected to provide receipts of their journey.

Journeys covered will include those offered by Transport for London (TfL), including bus, tube, tram, DLR, Overground, TfL rail and National rail. Journeys not covered consist of those outside TfL services, such as taxi fares. The maximum spend per single fare (according to TfL) is £5.10 if using an Oyster Card or Contactless payment and £6 if using a cash-based fare. Based on the highest fares possible for travel to and from City University from any zone (£12 for a return journey), I will be requesting a total amount of £120 of financial support. It is not expected that all participants will be travelling based on this amount but this would ensure that the travel cost of each potential participant would be covered. A completed 'Research Student Request for Research Support Costs' form has been e-mailed to the Research Committee, and the request has been accepted.

M8) Does the research involve clinical trial or clinical intervention testing that does not require Health Research Authority or MHRA approval?

No

M9) Will the project involve the collection of human tissue or other biological samples that does not fall under the Human Tissue Act (2004) that does not require Health Research Authority Research Ethics Service approval?

No

M10) Will the project involve potentially sensitive topics, such as participants' sexual behaviour, their legal or political behaviour, their experience of violence?
No

M11) Will the project involve activities that may lead to 'labelling' either by the researcher (e.g. categorisation) or by the participant (e.g. 'I'm stupid', 'I'm not normal')?
No

Data

D1) Indicate which of the following you will be using to collect your data.
Interviews

D2) How will the the privacy of the participants be protected?
Any other method

D2.1) Provide details of 'any other method' used.
- Only the researcher will meet participants.

- Only the researcher and research supervisor will be able to review collected data.

- In order to make sure confidentiality is kept throughout, consent forms will be scanned in, with the digital copies stored on one-drive at City University, and the hard copies securely destroyed using official university procedures.

- Interviews will be recorded using an encrypted device, and these recordings will be deleted once they have been transferred to an encrypted USB stick, which will be stored within the researcher's home environment in a locked filing cabinet, alongside transcriptions of the interviews.

- Any use of quotes in the final report will be anonymised.

- The decision to participate and the information shared during the interview will not be shared with other organisations.

- Data will be kept safely for 10 years before being securely destroyed using the City University confidential waste management contract, which is in-line with institutional guidelines on retention rates as well as the 2018 Data Protection Act.

- If a participant decides to withdraw from the study, the recording of the interview will be immediately destroyed and the data will not be used in the final report.

D3) Will the research involve use of direct quotes?
Yes

D5) Where/how do you intend to store your data?
Data to be kept in a locked filing cabinet
Storage on encrypted device (e.g. laptop, hard drive, USB
Storage at City

D6) Will personal data collected be shared with other organisations?
No

D7) Will the data be accessed by people other than the named researcher, supervisors or examiners?
No

D8) Is the data intended or required (e.g. by funding body) to be published for reuse or to be shared as part of longitudinal research or a different/wider research project now or in the future?
No

D10) How long are you intending to keep the research data generated by the study?
Data will be kept for 10 years before being fully destroyed, which is in-line with institutional guidelines on retention rates.

D11) How long will personal data be stored or accessed after the study has ended?
Data will be kept for 10 years before being fully destroyed, which is in-line with institutional guidelines on retention rates as well as the 2018 Data Protection Act, which states a minimum of 10 years.

D12) How are you intending to destroy the personal data after this period?
Paper documents will be shredded and further destroyed via University's confidential waste management contract.

Health & safety

HS1) Are there any health and safety risks to the researchers over and above that of their normal working life?
Yes

HS2) How have you addressed the health and safety concerns of the researchers and any other people impacted by this project?
There are some potential health and safety risks associated to conducting this research which need to be considered and addressed.

One ethical concern is that of lone-working, referring to recruitment of participants as well as carrying out one-to-one and face-to-face interviews in a room on university grounds. Concerns associated with this are the potential for: violent/threatening/intimidating behaviour, theft of personal property, risk of participants raising concerns around self-harm or harm to others, as well as accidents. All risk levels are considered to be low.

In regard to violent/threatening/intimidating behaviour, the following control measures are to be put in place:

-Researcher to give mobile number to both research supervisors and allocated safety person.

-Researcher has mobile number of both research supervisor.

-Researcher has given code word to research supervisors and allocated safety person in case of emergency.

-Researcher notifies supervisors and allocated safety person of date, time and location of each interview at University (names of participants will not be mentioned).

-Researcher notifies both supervisors of arrival and departure of each interview.

-Researcher will have easy access to emergency contact numbers in case of need.

-Participants will be met at university (Rhind building) during the psychology department staff hours (at least 1 supervisor will be present at time of each interview) (Wed-Fri 9am-5pm).

-Security at City University to be given information sheet with code which participants must verbally present when entering the building for interviews.

-Researcher will not keep personal belongings on her throughout the duration of interviews. The only assets in the room will be the researcher's audio-recording device, which will be put away immediately after completion of each interview.

-Researcher to position self nearest to door in interview room.

-Researcher has approved and updated DBS check prior to starting research.

-Inclusion/exclusion criteria for participation established to avoid interviewing individuals with violent crime offenses, and to avoid individuals with more severe mental health concerns, to minimise potential risk to researcher.

-Email address created specifically for research recruitment purposes so that no personal contactable information is available of researcher.

-Advertisement through 2 external organisations, both of which are based in London (recruitment not done in person).

-Participants will be provided with information sheet which includes details around participating in the study, including details around breaking confidentiality measures.

-Each participant will initial a consent form prior to taking part in the research project.

-Participants are briefed prior to the interview taking place and are informed of ability to stop the interview at any time without consequence.

-Participants to be given debriefing sheet with information regarding self-help, support services and hotlines available in London.

-Participants to be given leaflet, which will include advice on lifting mood, improving wellbeing, mindfulness techniques, and relaxation exercises.

Regarding potential theft of personal property, the same control measures as above are considered.

Regarding the risk of participants raising concerns around self-harm or harm to others: Considering the sensitivity of the research topic, there is a small chance that participants may in their responses to questions, disclose issues of concern (whether emotional, psychological, educational or health related). There is also potential for participants to experience increased levels of distress as they may relive negative past experiences. In using semi-structured interviews, one also aims to allow opportunity for participants to disclose information they feel is important and relevant to the topic being studied, though interviews will be constructed to minimise the potential for such responses and reactions. A need for referral of a participant is unlikely due to the protective measures which will be put in place for all participating individuals.

Alongside control measures mentioned above for the other potential concerns, in case any distress is identified by the researcher or voiced by the participant (i.e. mention of suicidal ideation, thoughts or

planning), the interview will be terminated and both research supervisors will be informed. Appropriate additional support will be offered to the participant. Within the briefing and debriefing, participants will be made aware of the purpose of the study, what is expected of participants and boundaries of the research as well as resources for self-help. They'll also be given information of local support services in the debrief as well as an informative leaflet around improving mental health, in case of need. Additionally, considering the sensitive nature of the research topic, the researcher must ensure to maintain a high level of sensitivity, empathy and openness. The researcher must be constantly aware of the ability to influence interview questions and participant responses through verbal and nonverbal ways of communication.

Regarding the potential for accidents, the same control measures as mentioned above will be considered.

Additionally, regarding the researcher, due to the rigorous nature of the qualitative research and grounded theory methodology, there is the potential for the data collection and analysis process to become emotionally draining. As such, a reflective and open stance must be taken to carrying out this research. Furthermore, due to the interactive nature of grounded theory methodology as well as the critical realist ontology and constructivist epistemological position taken, a constant reflective stance is needed during the data collection and analysis process. Supportive and protected contexts such as personal therapy, supervision sessions and peer discussions will be used to ensure a reflective, open and sensitive stance is upheld whilst carrying out this research project and to ensure that a high quality of professional and ethical practice is thus maintained by the researcher at all times. This also ensure that the researcher remains aware of personal and emotional limitations which may arise and to ensure that these do not conflict with the research process. Additionally, supplementary measures commonly used within the grounded theory methodology will be used such as bracketing and memo-taking throughout the data collection, data analysis as well as the writing up process.

HS3) Are there hazards associated with undertaking this project where a formal risk assessment would be required?
Yes

HS3.1) Has a risk assessment been undertaken?
Yes

Appendix B – Ethics Approval ETH1819-0098

City, University of London

Dear Florentine

Reference: ETH1819-0098

Project title: How do individuals who suffer from mental health distress and have spent time in prison experience talk therapy?

Start date: 31 Jan 2019

End date: 14 Feb 2020

I am writing to you to confirm that the research proposal detailed above has been granted formal approval from the Psychology committee: medium risk. The Committee's response is based on the protocol described in the application form and supporting documentation. Approval has been given for the submitted application only and the research must be conducted accordingly. You are now free to start recruitment.

Please ensure that you are familiar with City's Framework for Good Practice in Research and any appropriate Departmental/School guidelines, as well as applicable external relevant policies.

Please note the following:

Project amendments/extension

You will need to submit an amendment or request an extension if you wish to make any of the following changes to your research project:

- Change or add a new category of participants;
- Change or add researchers involved in the project, including PI and supervisor;
- Change to the sponsorship/collaboration;
- Add a new or change a territory for international projects;
- Change the procedures undertaken by participants, including any change relating to the safety or physical or mental integrity of research participants, or to the risk/benefit assessment for the project or collecting additional types of data from research participants;
- Change the design and/or methodology of the study, including changing or adding a new research method and/or research instrument;

- Change project documentation such as protocol, participant information sheets, consent forms, questionnaires, letters of invitation, information sheets for relatives or carers;
- Change to the insurance or indemnity arrangements for the project;
- Change the end date of the project.

Adverse events or untoward incidents

You will need to submit an Adverse Events or Untoward Incidents report in the event of any of the following:

a) Adverse events

b) Breaches of confidentiality

c) Safeguarding issues relating to children or vulnerable adults

d) Incidents that affect the personal safety of a participant or researcher

Issues a) and b) should be reported as soon as possible and no later than five days after the event. Issues c) and d) should be reported immediately. Where appropriate, the researcher should also report adverse events to other relevant institutions, such as the police or social services.

Should you have any further queries relating to this matter, please do not hesitate to contact me. On behalf of the Psychology committee: medium risk, I do hope that the project meets with success.

Kind regards

Katy Tapper

Psychology committee: medium risk

City, University of London

Ethics ETH1819-0098: Florentine De Raaij (Medium risk)

Appendix C – Ethics Amendments Form ETH1920-0056

Ethics ETH1920-0056: Florentine De Raaij (Medium risk)

Date	08 Aug 2019
Researcher	Florentine De Raaij
Project	How do individuals who suffer from mental health distress and have spent time in prison experience talk therapy?
School	School of Arts and Social Sciences
Department	Psychology

Ethics application

Project amendments

SA1) Types of modification/s

Change or add a new category of participants

Change to the sponsorship/collaboration

Change the procedures undertaken by participants, including any change relating to the safety or physical or mental integrity of research participants, or to the risk/benefit assessment of the project or collecting additional types of data from research participants

Change project documentation such as protocol, information sheets, consent forms, questionnaires, recruitment materials (please upload the relevant files with highlighted changes)

SA2) Details of modification

Change or add a new category of participants

-Inclusion criteria of requiring to be on probation has been removed. No other criteria have been edited. The participant information sheets for all organisations have been edited to remove this criteria, and the screening phone call schedule has been edited to remove the question relating to this criteria.

Change to sponsorship/collaboration

- Two new organisations have been recruited. These include [redacted] and [redacted]. Written correspondence with both organisations documentation are provided.

Change the procedures undertaken by participants, including any change relating to the safety or physical or mental integrity of research participants, or to the risk/benefit assessment of the project or collecting additional types of data from research participants

- [redacted] has welcomed the opportunity to carry out interviews in a room at their hub location in [redacted]. They are willing to provide the researcher with a personal alarm for each interview and to allocate a staff member to be outside the room in which the interviews takes place. It has also been agreed that interviews will take place during office hours (documented on risk assessment form). A specific participant information sheet has been created for [redacted] to include the option of interview location.

Change project documentation such as protocol, information sheets, consent forms, questionnaires, recruitment materials (please upload the relevant files with highlighted changes)

- A specific participant information sheet has been created for [redacted] participants to include the option of interview location.

- Title of research has been edited. As such, titles on all forms have been edited to include the new title.

-Julianna Challenor no longer works at City University and so her contact information has been removed from the participant information sheets.

SA3) Justify why the amendment is needed

Change or add a new category of participants

-The inclusion criteria of requiring to be on probation has been removed based on further reading and conversation with managers of services wishing to be involved. Removing this criteria maximises participant recruitment whilst maintaining minimal risk.

Change to sponsorship/collaboration

- The original two organisations included with the ethics approval submission have not been able to provide the amount of participants required for this research. These two new organisations were recruited to maximise the participant recruitment process.

Change the procedures undertaken by participants, including any change relating to the safety or physical or mental integrity of research participants, or to the risk/benefit assessment of the project or collecting additional types of data from research participants

- Offering [redacted] participants the choice of where they would like to be interviewed can offer a less distressing experience, thus potentially also encouraging more participants to be willing to participate.

Change project documentation such as protocol, information sheets, consent forms, questionnaires, recruitment materials (please upload the relevant files with highlighted changes)

- New participant information sheets were created for [redacted] participants to ensure that all data provided is accurate.

-The title of the research has been edited to more accurately represent the method chosen and the aim of the research.

-Contact details of Julianna Challenor were removed to ensure that all information provided to participants are accurate.

SA4) Other information

SA5) Please upload all relevant documentation with highlighted changes

Appendix D – Ethics Approval ETH1920-0056

City, University of London

Dear Florentine

Reference: ETH1920-0056

Project title: How do individuals who suffer from mental health distress and have spent time in prison experience talk therapy?

Start date: 31 Jan 2019

End date: 14 Feb 2020

I am writing to you to confirm that the research proposal detailed above has been granted formal approval from the Psychology committee: medium risk. The Committee's response is based on the protocol described in the application form and supporting documentation. Approval has been given for the submitted application only and the research must be conducted accordingly. You are now free to start recruitment.

Please ensure that you are familiar with City's Framework for Good Practice in Research and any appropriate Departmental/School guidelines, as well as applicable external relevant policies.

Please note the following:

Project amendments/extension

You will need to submit an amendment or request an extension if you wish to make any of the following changes to your research project:

- Change or add a new category of participants;
- Change or add researchers involved in the project, including PI and supervisor;
- Change to the sponsorship/collaboration;
- Add a new or change a territory for international projects;
- Change the procedures undertaken by participants, including any change relating to the safety or physical or mental integrity of research participants, or to the risk/benefit assessment for the project or collecting additional types of data from research participants;
- Change the design and/or methodology of the study, including changing or adding a new research method and/or research instrument;

- Change project documentation such as protocol, participant information sheets, consent forms, questionnaires, letters of invitation, information sheets for relatives or carers;
- Change to the insurance or indemnity arrangements for the project;
- Change the end date of the project.

Adverse events or untoward incidents

You will need to submit an Adverse Events or Untoward Incidents report in the event of any of the following:

a) Adverse events

b) Breaches of confidentiality

c) Safeguarding issues relating to children or vulnerable adults

d) Incidents that affect the personal safety of a participant or researcher

Issues a) and b) should be reported as soon as possible and no later than five days after the event. Issues c) and d) should be reported immediately. Where appropriate, the researcher should also report adverse events to other relevant institutions, such as the police or social services.

Should you have any further queries relating to this matter, please do not hesitate to contact me. On behalf of the Psychology committee: medium risk, I do hope that the project meets with success.

Kind regards

Tina Forster

Psychology committee: medium risk

City, University of London

Ethics ETH1920-0056: Florentine De Raaij (Medium risk)

Appendix E - Ethics Amendments Form ETH1920-1419

Ethics ETH1920-1419: Florentine De Raaij (Medium risk)

Date	15 Apr 2020
Researcher	Florentine De Raaij
Project	How do individuals who suffer from mental health distress and have spent time in prison experience talk therapy?
School	School of Arts and Social Sciences
Department	Psychology

Ethics application

Project amendments

SA1) Types of modification/s

Change the design and/or methodology of the project, including changing or adding a new research method and/or research instrument

Change project documentation such as protocol, information sheets, consent forms, questionnaires, recruitment materials (please upload the relevant files with highlighted changes)

SA2) Details of modification

Recruitment process: AMENDED BASED ON FEEDBACK

-The drug and alcohol recovery service is the sole participating organisation with remote recruitment.

-The manager of the organisation will inform relevant individuals of research study via email - Based on the request for further clarity and the emphasis mentioned around confidentiality, the manager will contact service users solely via email (not by telephone) to offer information on the study. This consists of emailing individuals the study advertisement and participant information sheet. The manager is aware of the inclusion criteria so will solely be contacting those he feels fit these criteria. However, he will not be informed of the individuals who participate in the screening interview or the research interview to ensure a level of confidentiality.

-Participant information sheet has been edited to reflect the study in its amended form for the service manager or myself, the researcher, to share with potential participants.

Data collection process:

-Skype account has been created specifically for the purpose of remotely interviewing participants. This account will be deleted once all interviews

have been completed.

-Debrief information and informative leaflet will be emailed to participants once the interview is completed.

-As there is potential to not be able to as quickly identify distress, participant wellbeing and safety will be emphasised prior to starting the interview and participants will be asked about their wellbeing sensitively throughout.

Written informed consent:

-Consent form to be emailed by researcher to participants using e-mail account specifically created for research purposes.

-Consent forms are to be signed by the participant and emailed to researcher either prior to the interview or at the start of the interview.

-Completed consent forms (with signature) will be deleted entirely from inbox once they have been scanned onto the City University one-drive.

-It is of utmost importance that informed consent protocols are kept - voluntary nature of research, confidentiality boundaries and any concerns shared by the participants will be discussed prior to starting the interview.

Participant Information Sheet:

-Removed expenses section as expenses were offered for travel to/from interview.

-Edited "What will happen if I take part?" section to include remote interviewing rather than interviews taking place at university or support service.

-Edited "Will my taking part in the study be kept confidential?" section to inform participants that their emailed completed consent forms will be deleted once scanned onto the City University one-drive.

SA3) Justify why the amendment is needed

Given the unprecedented times due to the current COVID-19 pandemic, I have had to change details of my research to accommodate remote recruitment and interviewing taking place.

SA4) Other information

All other aspects of the research will remain the same.

SA5) Please upload all relevant documentation with highlighted changes

Appendix F – Ethics Approval ETH1920-1419

City, University of London

Dear Florentine

Reference: ETH1920-1419

Project title: How do individuals who suffer from mental health distress and have spent time in prison experience talk therapy?

Start date: 31 Jan 2019

End date: 14 Feb 2020

I am writing to you to confirm that the research proposal detailed above has been granted formal approval from the Psychology committee: medium risk. The Committee's response is based on the protocol described in the application form and supporting documentation. Approval has been given for the submitted application only and the research must be conducted accordingly. You are now free to start recruitment.

Please ensure that you are familiar with City's Framework for Good Practice in Research and any appropriate Departmental/School guidelines, as well as applicable external relevant policies.

Please note the following:

Project amendments/extension

You will need to submit an amendment or request an extension if you wish to make any of the following changes to your research project:

- Change or add a new category of participants;
- Change or add researchers involved in the project, including PI and supervisor;
- Change to the sponsorship/collaboration;
- Add a new or change a territory for international projects;
- Change the procedures undertaken by participants, including any change relating to the safety or physical or mental integrity of research participants, or to the risk/benefit assessment for the project or collecting additional types of data from research participants;

- Change the design and/or methodology of the study, including changing or adding a new research method and/or research instrument;
- Change project documentation such as protocol, participant information sheets, consent forms, questionnaires, letters of invitation, information sheets for relatives or carers;
- Change to the insurance or indemnity arrangements for the project;
- Change the end date of the project.

Adverse events or untoward incidents

You will need to submit an Adverse Events or Untoward Incidents report in the event of any of the following:

a) Adverse events

b) Breaches of confidentiality

c) Safeguarding issues relating to children or vulnerable adults

d) Incidents that affect the personal safety of a participant or researcher

Issues a) and b) should be reported as soon as possible and no later than five days after the event. Issues c) and d) should be reported immediately. Where appropriate, the researcher should also report adverse events to other relevant institutions, such as the police or social services.

Should you have any further queries relating to this matter, please do not hesitate to contact me. On behalf of the Psychology committee: medium risk, I do hope that the project meets with success.

Kind regards

Tina Forster

Psychology committee: medium risk

City, University of London

Ethics ETH1920-1419: Florentine De Raaij (Medium risk)

Appendix G – Ethics Amendments Form ETH1920-1776

Ethics ETH1920-1776: Florentine De Raaij (Medium risk)

Date	08 Jun 2020
Researcher	Florentine De Raaij
Project	How do individuals who suffer from mental health distress and have spent time in prison experience talk therapy?
School	School of Arts and Social Sciences
Department	Psychology

Ethics application

Project amendments

SA1) Types of modification/s

Change to the sponsorship/collaboration

SA2) Details of modification

A new organisation has been recruited to support with the recruitment of participants. The organisation is [redacted]

SA3) Justify why the amendment is needed

The organisations used so far have not been able to provide the minimum amount of participants required for this research. The new organisation will support the participant recruitment process for the final participants.

SA4) Other information

SA5) Please upload all relevant documentation with highlighted changes

Attached files

Correspondence 1.png

Correspondence 2.png

Correspondence 3.png

Appendix H – Ethics Approval ETH1920-1776

Dear Florentine

Reference: ETH1920-1776

Project title: How do individuals who suffer from mental health distress and have spent time in prison experience talk therapy?

Start date: 31 Jan 2019

End date: 14 Feb 2020

I am writing to you to confirm that the research proposal detailed above has been granted formal approval from the Psychology committee: medium risk. The Committee's response is based on the protocol described in the application form and supporting documentation. Approval has been given for the submitted application only and the research must be conducted accordingly. You are now free to start recruitment.

Please ensure that you are familiar with City's Framework for Good Practice in Research and any appropriate Departmental/School guidelines, as well as applicable external relevant policies.

Please note the following:

Project amendments/extension

You will need to submit an amendment or request an extension if you wish to make any of the following changes to your research project:

- Change or add a new category of participants;
- Change or add researchers involved in the project, including PI and supervisor;
- Change to the sponsorship/collaboration;
- Add a new or change a territory for international projects;
- Change the procedures undertaken by participants, including any change relating to the safety or physical or mental integrity of research participants, or to the risk/benefit assessment for the project or collecting additional types of data from research participants;
- Change the design and/or methodology of the study, including changing or adding a new research method and/or research instrument;
- Change project documentation such as protocol, participant information sheets, consent forms, questionnaires, letters of invitation, information sheets for relatives or carers;
- Change to the insurance or indemnity arrangements for the project;
- Change the end date of the project.

Adverse events or untoward incidents

You will need to submit an Adverse Events or Untoward Incidents report in the event of any of the following:

a) Adverse events

b) Breaches of confidentiality

c) Safeguarding issues relating to children or vulnerable adults

d) Incidents that affect the personal safety of a participant or researcher

Issues a) and b) should be reported as soon as possible and no later than five days after the event. Issues c) and d) should be reported immediately. Where appropriate, the researcher should also report adverse events to other relevant institutions, such as the police or social services.

Should you have any further queries relating to this matter, please do not hesitate to contact me. On behalf of the Psychology committee: medium risk, I do hope that the project meets with success.

Kind regards

Tina Forster

Psychology committee: medium risk

City, University of London

Appendix I – Participant Demographic Information

Participant	Gender	Age	Sentence Length	Release Time	Nature of Offense	Mental Health Concerns	Mental Health Symptoms Information	Mental Health Diagnosis	Psychosis Diagnosis
1	M	Early 30's	6 Months	4.5 Years Ago	Shoplifting	Depression, PTSD	Started in prison, symptoms ongoing (less)	Depression	Yes
2	M	Late 40's	24 Months	Under 5 Years Ago	Theft & Fraud	Depression, Anxiety, Panic	Started prior to prison, symptoms ongoing (less)	Depression, Anxiety	No
3	M	51	17 Months	Under 5 Years ago	Non-violent	Anxiety	Started upon release, symptoms ongoing (less)	No	No
4	M	Mid 40's	20 Months	4.5 Years Ago	Commercial Burglary	Anxiety, PTSD	Started prior to prison, symptoms ongoing	PTSD	No
5	M	Early 50's	24 Months	2.5 Years Ago	Drug Dealing	Anxiety, Panic	Started prior to prison, symptoms ongoing (less)	Borderline Personality Disorder, Anxiety	No

Appendix J – Study Advertisement

Department of Psychology
City University London

PARTICIPANTS NEEDED FOR RESEARCH EXPLORING THE EXPERIENCE OF THERAPEUTIC SERVICES IN PRISONS

We are looking for volunteers to take part in a study which aims to explore what happens when individuals experience mental health distress whilst in prison.

You would be asked to take part a semi-structured interview, lasting approximately an hour.

For more information about this study, or to take part, please contact:
Florentine de Raaij at Therapyinprisonsthesis@gmail.com
George Berguno at George.Berguno@city.ac.uk

The Psychology Department
at
020 7040 0236 (direct line)

This study has been reviewed by, and received ethics clearance through the Psychology Department Research Ethics Committee, City University London [*ETH1920-1776*].

If you would like to complain about any aspect of the study, please contact the Secretary to the University's Senate Research Ethics Committee on 020 7040 3040 or via email: Anna.Ramberg.1@city.ac.uk

Appendix K – Participant Information Sheet 1

Title of study: **What happens when individuals experience mental health distress in prison?**

We would like to invite you to take part in a research study. Before deciding whether you would like to take part, it is important that you understand why the research is being done and what it would involve for you. Please take time to read the following information carefully and discuss it with others if you wish. Ask us if there is anything that is not clear or if you would like more information.

What is the purpose of the study?
The aim is to explore the experiences of those living with a mental health distress and who have spent time in prison. Based on the data given, a theory will be created on the current state of mental health support in prisons, with a specific focus on the use therapeutic support interventions.

This study is carried out as part of the Professional Doctorate in Counselling Psychology at City University and is overseen by an allocated research supervisors.

Why have I been invited?
You have been invited as you have expressed fitting the criteria needed to take part in this study. As such, you've stated that you:

- Are over the age of 18
- Have served a minimum prison sentence of six months
- Have served a maximum sentence of 2 years
- Offences included within this research are non-violence based offenses such as: driving offences (where there was no loss of life or serious injury to a third party), and a failure to comply with a community order or a suspended sentence
- Have been released from prison in the last five years
- Have experiencing mental health distress. The concerns focused on within this particular study include symptoms associated to anxiety (including social anxiety), depression, PTSD, panic, and OCD.
- You have also assured the researcher that you feel comfortable with your responses being audio-recorded.

Do I have to take part?
Participation in the project is entirely voluntary, and you can choose not to participate in part or all of the project. It is up to you to decide whether or not to take part. If you do decide to take part you will be asked to sign a consent form. If you decide to take part you are still free to withdraw within 2 months of the interview taking place, and without giving a reason. You are also not required to answer any question you feel uncomfortable with. Any such decision will not be punished and will not affect future treatment.

What will happen if I take part?
A maximum of ten participants will be interviewed on an individual basis. Each interview will be carried out by the researcher on a face-to-face basis at City University. One interview will take place per participant and interviews are estimated to last around one hour long. Once the interview is completed, it will be transcribed and analysed thoroughly to establish a theory.

Expenses:
You will be offered compensation for your travel to and back from City University. A receipt of travel will be required.

What do I have to do?
By agreeing to participate in this study, you agree to being asked questions regarding your experience of mental health concerns whilst incarcerated, and to describe your experience of talk-therapy support.

Semi-structured interviews will be carried out, meaning that although there will be some pre-set questions, the creation of questions mostly depends on the information given by you, the participant. For instance, the pre-set questions within the interview will briefly explore your personal background, your mental health background and whether you accessed talk-therapy while in prison but more questions may be asked depending on your responses.

What are the possible disadvantages and risks of taking part?
Although the interview questions do not aim to create distress, there is the possibility that you may feel higher levels of distress as you relive your past experiences. If at any time you do not want to answer a question, you do not have to, and you may also leave the interview at any time. Also, if any psychological distress of the participant is detected by the researcher at any time, the interview will be stopped. Upon finishing the interview (including if withdrawing from study), participants will be provided with a debrief sheet with information regarding self-help, support services and hotlines available in London. You will also be given an informative leaflet, which will include advice on lifting mood and overall wellbeing, mindfulness techniques and relaxation exercises.

What are the possible benefits of taking part?
The main aim of this study is to gather findings which can add to the (little) knowledge already available on the topic and so, create a path for better understanding and better awareness. It is also hoped that the findings will encourage renewed reflection on the current state of the prison mental health care system, and what can be done to more appropriately and suitably support those in prison and experiencing mental health distress.

Will my taking part in the study be kept confidential?
Your participation will be kept confidential by taking the following steps:

- Only the researcher will meet participants.
- Only the researcher and research supervisor will be able to review collected data.
- In order to make sure confidentiality is kept throughout, consent forms will be scanned in, with the digital copies stored on one-drive at City University, and the hard copies securely destroyed using official university procedures.
- Interviews will be recorded using an encrypted device, and these recordings will be deleted once they have been transferred to an encrypted USB stick, which will be stored within the researcher's home environment in a locked filing cabinet, alongside transcriptions of the interviews.
- Any use of quotes in the final report will be anonymised.
- Your decision to participate and the information you share during the interview will not be shared with other organisations.
- Data will be kept safely for 10 years before being securely destroyed using the City University confidential waste management contract, which is in-line with institutional guidelines on retention rates as well as the 2018 Data Protection Act.
- If you decide to withdraw from the study, the recording of your interview will be immediately destroyed and your data will not be used in the final report.
- Confidentiality measures can be broken if the participant reports imminent risk for self-harm or harm to others.
- Confidentiality measures will need to be broken if the participant discloses a crime which has not been reported to the police.

What should I do if I want to take part?
If you are interested in participating in the study, please contact one of the individuals listed in the 'Further information and contact details' section, provided on the following page.

What will happen to the results of the research study?
All of the data collected from the interviews will be transcribed verbatim in order for the appropriate analysis to be carried out, and the findings of the study will be published within the final report, to be submitted in early 2020. Confidentiality will be kept secure throughout and no identifiable information will be provided within the final report.

As a participant, you will be offered a copy of the initial findings and a copy of the final report. In order to receive these, you will need to inform the researcher at any time during the interview or within 2 months of the date of the interview.

What will happen if I don't want to carry on with the study?
As a voluntary participant, you are free to leave, without explanation or penalty, at any time during the interview. Due to the nature of the research method, your request for your data to be taken out must be done at any point during the interview or within 2 months of the interview taking place. Requests for data withdrawal after this timeframe will not be accepted.

Who has reviewed the study?
This study has been approved by City University London Psychology Department Research Ethics Committee, [*ETH1920-1776*].

Further information and contact details:
For any queries about the research, please contact:

Florentine de Raaij at Therapyinprisonsreseach@gmail.com
George Berguno at George.Berguno@city.ac.uk

The Psychology Department
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020 7040 0236 (direct line)

Data Protection Privacy Notice: What are my rights under the data protection legislation?
City, University of London is the data controller for the personal data collected for this research project. Your personal data will be processed for the purposes outlined in this notice. The legal basis for processing your personal data will be that this research is a task in the public interest, that is City, University of London considers the lawful basis for processing personal data to fall under Article 6(1)(e) of GDPR (public task) as the processing of research participant data is necessary for learning and teaching purposes and all research with human participants by staff and students has to be scrutinised and approved by one of City's Research Ethics Committees.

What if I have concerns about how my personal data will be used after I have participated in the research?
In the first instance you should raise any concerns with the research team, but if you are dissatisfied with the response, you may contact the Information Compliance Team at dataprotection@city.ac.uk or phone 0207 040 4000, who will liaise with City's Data Protection Officer Dr William Jordan to answer your query.

If you are dissatisfied with City's response you may also complain to the Information Commissioner's Office at www.ico.org.uk

What if there is a problem?
If you have any problems, worries or questions about this study, please ask to speak to a member of the research team. If you remain unhappy and wish to complain formally, you can do this through

the University complaints procedure. To complain about the study, you need to phone 020 7040 3040. You can then ask to speak to the Secretary to Senate Research Ethics Committee and inform them that the name of the project is: How do incarcerated individuals who suffer from mental health disorders and have spent time in prison experience talk-therapy?

You could also write to the Secretary at:
Anna Ramberg
Secretary to Senate Research Ethics Committee
Research Office, E214
City University London
Northampton Square
London
EC1V 0HB
Email: Anna.Ramberg.1@city.ac.uk

City University London holds insurance policies which apply to this study. If you feel you have been harmed or injured by taking part in this study you may be eligible to claim compensation. This does not affect your legal rights to seek compensation. If you are harmed due to someone's negligence, then you may have grounds for legal action.

Thank you for taking the time to read this information sheet.

Date of creation of participant information sheet: 10/01/2019, Version 4.

Appendix L – Participant Information Sheet 2

Title of study: **What happens when individuals experience mental health distress in prison?**

We would like to invite you to take part in a research study. Before deciding whether you would like to take part, it is important that you understand why the research is being done and what it would involve for you. Please take time to read the following information carefully and discuss it with others if you wish. Ask us if there is anything that is not clear or if you would like more information.

What is the purpose of the study?
The aim is to explore the experiences of those living with a mental health distress and who have spent time in prison. Based on the data given, a theory will be created on the current state of mental health support in prisons, with a specific focus on the use therapeutic support interventions.

This study is carried out as part of the Professional Doctorate in Counselling Psychology at City University and is overseen by an allocated research supervisors.

Why have I been invited?
You have been invited as you have expressed fitting the criteria needed to take part in this study. As such, you've stated that you:

- Are over the age of 18
- Have served a minimum prison sentence of six months
- Have served a maximum sentence of 2 years
- Offences included within this research are non-violence based offenses such as: driving offences (where there was no loss of life or serious injury to a third party), and a failure to comply with a community order or a suspended sentence
- Have been released from prison in the last five years
- Have experiencing mental health distress. The concerns focused on within this particular study include symptoms associated to anxiety (including social anxiety), depression, PTSD, panic, and OCD.
- You have also assured the researcher that you feel comfortable with your responses being audio-recorded.

Do I have to take part?
Participation in the project is entirely voluntary, and you can choose not to participate in part or all of the project. It is up to you to decide whether or not to take part. If you do decide to take part you will be asked to sign a consent form. If you decide to take part you are still free to withdraw within 2 months of the interview taking place, and without giving a reason. You are also not required to answer any question you feel uncomfortable with. Any such decision will not be punished and will not affect future treatment.

What will happen if I take part?
A maximum of ten participants will be interviewed on an individual basis. Each interview will be carried out by the researcher on a face-to-face basis at City University or at the [redacted] hub in Kennington, London. One interview will take place per participant and interviews are estimated to last around one hour long. Once the interview is completed, it will be transcribed and analysed thoroughly to establish a theory.

Expenses:
You will be offered compensation for your travel to and back from City University or the [redacted] hub location. A receipt of travel will be required.

What do I have to do?
By agreeing to participate in this study, you agree to being asked questions regarding your experience of mental health concerns whilst incarcerated, and to describe your experience of talk-therapy support.

Semi-structured interviews will be carried out, meaning that although there will be some pre-set questions, the creation of questions mostly depends on the information given by you, the participant. For instance, the pre-set questions within the interview will briefly explore your personal background, your mental health background and whether you accessed talk-therapy while in prison but more questions may be asked depending on your responses.

What are the possible disadvantages and risks of taking part?
Although the interview questions do not aim to create distress, there is the possibility that you may feel higher levels of distress as you relive your past experiences. If at any time you do not want to answer a question, you do not have to, and you may also leave the interview at any time. Also, if any psychological distress of the participant is detected by the researcher at any time, the interview will be stopped. Upon finishing the interview (including if withdrawing from study), participants will be provided with a debrief sheet with information regarding self-help, support services and hotlines available in London. You will also be given an informative leaflet, which will include advice on lifting mood and overall wellbeing, mindfulness techniques and relaxation exercises.

What are the possible benefits of taking part?
The main aim of this study is to gather findings which can add to the (little) knowledge already available on the topic and so, create a path for better understanding and better awareness. It is also hoped that the findings will encourage renewed reflection on the current state of the prison mental health care system, and what can be done to more appropriately and suitably support those in prison and experiencing mental health distress.

Will my taking part in the study be kept confidential?
Your participation will be kept confidential by taking the following steps:

- Only the researcher will meet participants.
- Only the researcher and research supervisor will be able to review collected data.
- In order to make sure confidentiality is kept throughout, consent forms will be scanned in, with the digital copies stored on one-drive at City University, and the hard copies securely destroyed using official university procedures.
- Interviews will be recorded using an encrypted device, and these recordings will be deleted once they have been transferred to an encrypted USB stick, which will be stored within the researcher's home environment in a locked filing cabinet, alongside transcriptions of the interviews.
- Any use of quotes in the final report will be anonymised.
- Your decision to participate and the information you share during the interview will not be shared with other organisations.
- Data will be kept safely for 10 years before being securely destroyed using the City University confidential waste management contract, which is in-line with institutional guidelines on retention rates as well as the 2018 Data Protection Act.
- If you decide to withdraw from the study, the recording of your interview will be immediately destroyed and your data will not be used in the final report.
- Confidentiality measures can be broken if the participant reports imminent risk for self-harm or harm to others.
- Confidentiality measures will need to be broken if the participant discloses a crime which has not been reported to the police.

What should I do if I want to take part?
If you are interested in participating in the study, please contact one of the individuals listed in the 'Further information and contact details' section, provided on the following page.

What will happen to the results of the research study?
All of the data collected from the interviews will be transcribed verbatim in order for the appropriate analysis to be carried out, and the findings of the study will be published within the final report, to be submitted in early 2020. Confidentiality will be kept secure throughout and no identifiable information will be provided within the final report.

As a participant, you will be offered a copy of the initial findings and a copy of the final report. In order to receive these, you will need to inform the researcher at any time during the interview or within 2 months of the date of the interview.

What will happen if I don't want to carry on with the study?
As a voluntary participant, you are free to leave, without explanation or penalty, at any time during the interview. Due to the nature of the research method, your request for your data to be taken out must be done at any point during the interview or within 2 months of the interview taking place. Requests for data withdrawal after this timeframe will not be accepted.

Who has reviewed the study?
This study has been approved by City University London Psychology Department Research Ethics Committee, [*ETH1920-1776*].

Further information and contact details:
For any queries about the research, please contact:

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What if I have concerns about how my personal data will be used after I have participated in the research?
In the first instance you should raise any concerns with the research team, but if you are dissatisfied with the response, you may contact the Information Compliance Team at dataprotection@city.ac.uk or phone 0207 040 4000, who will liaise with City's Data Protection Officer Dr William Jordan to answer your query.

If you are dissatisfied with City's response you may also complain to the Information Commissioner's Office at www.ico.org.uk

What if there is a problem?
If you have any problems, worries or questions about this study, please ask to speak to a member of the research team. If you remain unhappy and wish to complain formally, you can do this through the University complaints procedure. To complain about the study, you need to phone 020 7040

3040. You can then ask to speak to the Secretary to Senate Research Ethics Committee and inform them that the name of the project is: How do incarcerated individuals who suffer from mental health disorders and have spent time in prison experience talk-therapy?

You could also write to the Secretary at:
Anna Ramberg
Secretary to Senate Research Ethics Committee
Research Office, E214
City University London
Northampton Square
London
EC1V 0HB
Email: Anna.Ramberg.1@city.ac.uk

City University London holds insurance policies which apply to this study. If you feel you have been harmed or injured by taking part in this study you may be eligible to claim compensation. This does not affect your legal rights to seek compensation. If you are harmed due to someone's negligence, then you may have grounds for legal action.

Thank you for taking the time to read this information sheet.

Date of creation of participant information sheet: 10/01/2019, Version 4.

Appendix M – Participant Information Sheet Remote

Title of study: **What happens when individuals experience mental health distress in prison?**

We would like to invite you to take part in a research study. Before deciding whether you would like to take part, it is important that you understand why the research is being done and what it would involve for you. Please take time to read the following information carefully and discuss it with others if you wish. Ask us if there is anything that is not clear or if you would like more information.

What is the purpose of the study?
The aim is to explore the experiences of those living with a mental health distress and who have spent time in prison. Based on the data given, a theory will be created on the current state of mental health support in prisons, with a specific focus on the use therapeutic support interventions.

This study is carried out as part of the Professional Doctorate in Counselling Psychology at City University and is overseen by an allocated research supervisors.

Why have I been invited?
You have been invited as you have expressed fitting the criteria needed to take part in this study. As such, you've stated that you:

- Are over the age of 18
- Have served a minimum prison sentence of six months
- Have served a maximum sentence of 2 years
- Offences included within this research are non-violence based offenses such as: driving offences (where there was no loss of life or serious injury to a third party), and a failure to comply with a community order or a suspended sentence
- Have been released from prison in the last five years
- Have experiencing mental health distress. The concerns focused on within this particular study include symptoms associated to anxiety (including social anxiety), depression, PTSD, panic, and OCD.
- You have also assured the researcher that you feel comfortable with your responses being audio-recorded.

Do I have to take part?
Participation in the project is entirely voluntary, and you can choose not to participate in part or all of the project. It is up to you to decide whether or not to take part. If you do decide to take part you will be asked to sign a consent form. If you decide to take part you are still free to withdraw within 2 months of the interview taking place, and without giving a reason. You are also not required to answer any question you feel uncomfortable with. Any such decision will not be punished and will not affect future treatment.

What will happen if I take part?
A maximum of ten participants will be interviewed on an individual basis. Each interview will be carried out by the researcher on a remote basis through Skype. One interview will take place per participant and interviews are estimated to last around one hour. Once the interview is completed, it will be transcribed and analysed thoroughly to establish a theory.

What do I have to do?
By agreeing to participate in this study, you agree to being asked questions regarding your experience of mental health concerns whilst incarcerated, and to describe your experience of talk-therapy support.

Semi-structured interviews will be carried out, meaning that although there will be some pre-set questions, the creation of questions mostly depends on the information given by you, the participant. For instance, the pre-set questions within the interview will briefly explore your personal background, your mental health background and whether you accessed talk-therapy while in prison but more questions may be asked depending on your responses.

What are the possible disadvantages and risks of taking part?
Although the interview questions do not aim to create distress, there is the possibility that you may feel higher levels of distress as you relive your past experiences. If at any time you do not want to answer a question, you do not have to, and you may also leave the interview at any time. Also, if any psychological distress of the participant is detected by the researcher at any time, the interview will be stopped. Upon finishing the interview (including if withdrawing from study), participants will be provided with a debrief sheet with information regarding self-help, support services and hotlines available in London. You will also be given an informative leaflet, which will include advice on lifting mood and overall wellbeing, mindfulness techniques and relaxation exercises.

What are the possible benefits of taking part?
The main aim of this study is to gather findings which can add to the (little) knowledge already available on the topic and so, create a path for better understanding and better awareness. It is also hoped that the findings will encourage renewed reflection on the current state of the prison mental health care system, and what can be done to more appropriately and suitably support those in prison and experiencing mental health distress.

Will my taking part in the study be kept confidential?
Your participation will be kept confidential by taking the following steps:

- Only the researcher will meet participants.
- Only the researcher and research supervisor will be able to review collected data.
- In order to make sure confidentiality is kept throughout, consent forms will be scanned in, with the digital copies stored on one-drive at City University, and the completed consent form emailed to the researcher will be deleted once it has been scanned onto the one-drive.
- Interviews will be recorded using an encrypted device, and these recordings will be deleted once they have been transferred to an encrypted USB stick, which will be stored within the researcher's home environment in a locked filing cabinet, alongside transcriptions of the interviews.
- Any use of quotes in the final report will be anonymised.
- Your decision to participate and the information you share during the interview will not be shared with other organisations.
- Data will be kept safely for 10 years before being securely destroyed using the City University confidential waste management contract, which is in-line with institutional guidelines on retention rates as well as the 2018 Data Protection Act.
- If you decide to withdraw from the study, the recording of your interview will be immediately destroyed and your data will not be used in the final report.
- Confidentiality measures can be broken if the participant reports imminent risk for self-harm or harm to others.
- Confidentiality measures will need to be broken if the participant discloses a crime which has not been reported to the police.

What should I do if I want to take part?
If you are interested in participating in the study, please contact one of the individuals listed in the 'Further information and contact details' section, provided on the following page.

What will happen to the results of the research study?
All of the data collected from the interviews will be transcribed verbatim in order for the appropriate analysis to be carried out, and the findings of the study will be published within the final report, to be submitted in 2020. Confidentiality will be kept secure throughout and no identifiable information will be provided within the final report.

As a participant, you will be offered a copy of the initial findings and a copy of the final report. In order to receive these, you will need to inform the researcher at any time during the interview or within 2 months of the date of the interview.

What will happen if I don't want to carry on with the study?
As a voluntary participant, you are free to leave, without explanation or penalty, at any time during the interview. Due to the nature of the research method, your request for your data to be taken out must be done at any point during the interview or within 2 months of the interview taking place. Requests for data withdrawal after this timeframe will not be accepted.

Who has reviewed the study?
This study has been approved by City University London Psychology Department Research Ethics Committee, [*ETH1920-1776*].

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If you are dissatisfied with City's response you may also complain to the Information Commissioner's Office at www.ico.org.uk

What if there is a problem?
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You could also write to the Secretary at:
Anna Ramberg
Secretary to Senate Research Ethics Committee
Research Office, E214
City University London
Northampton Square
London
EC1V 0HB
Email: Anna.Ramberg.1@city.ac.uk

City University London holds insurance policies which apply to this study. If you feel you have been harmed or injured by taking part in this study you may be eligible to claim compensation. This does not affect your legal rights to seek compensation. If you are harmed due to someone's negligence, then you may have grounds for legal action.

Thank you for taking the time to read this information sheet.

Date of creation of participant information sheet: 10/01/2019, Version 4.

Appendix N – Screening Interview Schedule

All individuals will be asked the questions identified below, prior to starting the interview

I would like to ask you some questions to verify your suitability for participating in the study. How does this sound?

Q1: Can you please verify for me that you are above the age of 18?

Q2: Could you please confirm whether you have served a minimum sentence of 6 months and a maximum sentence of 2 years in prison?

Q3: Regarding your time served, were you released from prison within the last 5 years?

Q4: Could you please briefly describe the nature of the offence?

- If response is considered to be unclear, the participant will be asked to clarify if the offence was violence-based or sexual-based.

Q5: The mental health concerns focused on within this research are ones which are more-commonly experienced ones, including depression, anxiety (including social anxiety), panic, PTSD and OCD. Do feel that you are experiencing or have experienced symptoms which could be linked to one of these?

Q6: Would you be able to describe the symptoms for me?

Q7: When did you first begin to notice symptoms?

Q8: Do you feel that you currently still experience symptoms?

Q9: Have you ever been formally diagnosed with psychosis?

Q10: Have you ever been formally diagnosed with any other mental health concerns?

Inclusion criteria met: “Thank you for taking the time to answer these questions for me today. Based on your responses, I am happy to inform you that you appear to meet all of the criteria needed to participate in the research study. I will be in touch with you within the next week to set a date and time to meet for the interview to take place, how does this sound? Do you have any questions?”

Inclusion criteria not met at any point in the interview: “Thank you for taking the time to answer some questions for me today. Unfortunately, based on your responses, it appears that you do not meet the criteria needed to take part in the study. I sincerely apologise for this. Do you have any questions regarding the study or not meeting the criteria that I can assist with?”

Appendix O – Participant Consent Form

Title of Study: What happens when individuals experience mental health distress in prison?

Ethics approval code: [*ETH1920-1776*].

Please initial box

1.	I confirm that I have had the project explained to me, and I have read the participant information sheet, which I may keep for my records. I understand this will involve: • being interviewed by the researcher • allowing the interview to be audiotaped	
2.	This information will be held and processed for the following purpose(s): answering the research interview questions I understand that any information I provide is confidential, and that no information that could lead to the identification of any individual will be disclosed in any reports on the project, or to any other party. No identifiable personal data will be published. The identifiable data will not be shared with any other organisation. Confidentiality can be broken if I indicate concern around imminent risk of self-harm or harm to others. Confidentiality measures will be broken if I discloses a crime which has not been reported to the police.	
3.	I understand that my participation is voluntary, that I can choose not to participate in part or all of the project, and that I can withdraw at any stage during the interview or within 2 months of the interview taking place, without being penalized or disadvantaged in any way.	
4.	I agree to City recording and processing this information about me. I understand that this information will be used only for the purpose(s) set out in this statement and my consent is conditional on City complying with its duties and obligations under the General Data Protection Regulation (GDPR).	
5.	I agree to the arrangements for data storage, archiving, sharing.	
6.	I agree to the use of anonymised quotes in the final report. Confidentiality measures will be adhered to regarding the use of quotes.	
7.	I agree to take part in the above study.	

_____	_____	_____
Initials of Participant	Signature	Date
_____	_____	_____
Name of Researcher	Signature	Date

When completed, 1 copy for participant; 1 copy for researcher file.

Appendix P – Interview Schedule

The following interview questions will vary per interview cycle and the ones identified here are potential questions which may be included in the different interview cycles. The future construction of questions for the interview cycles will also depend on responses given in the interviews.

Q1: What was your overall experience of prison?

Q2: How were you effected by your experience of serving time?

Why and how?
Why not?

Q3: Did you seek support whilst in prison?

If so, how?
If not, why not?

Q4: What is your experience of talk-based therapeutic support whilst in prison?

Q5: Looking back on your experience of prison, did you feel that you were able to access the help you needed?

Yes – why and how?
No – why not?

Q6: Was there anything else that you found supported you whilst in prison?

Q7: Do you feel there were challenges in seeking support for your distress?

Q8: On reflection, was there anything that could have been helpful?

Appendix Q – Participant Debrief Form

What happens when individuals experience mental health distress in prison?

Thank you for taking part in this study. Now that it's finished we'd like to tell you a bit more about it!

In carrying out interviews with you, the participants, the aim was to gather a better understanding of the experiences of those suffering from mental health disorders whilst serving a prison sentence, with a specific focus on the use therapeutic interventions such as talk-therapies. Based on the data given, a theory will be created on the current state of mental health support in prisons from the perspective of those who have experienced this phenomena. As such, the overall aims of the study are to offer an opportunity for sharing your experience, to provide a basis for better understanding, and to raise awareness.

Although the interview questions do not aim to cause distress, there is the possibility that you may have felt or still feel higher levels of distress as you relived potentially negative experiences. Please don't hesitate to let the researchers know, as they will make sure you are given more psychological support in your local area. Also, please don't hesitate to contact your GP if you feel a need to do so, as they can give you more advice and/or a referral to a local NHS mental health service. Helplines for individuals in distress are also available, including Samaritans on 116-123, which is available 24 hours a day, Rethink on 0845 456 0455 from 10am-2pm on Monday to Friday, as well as Saneline on 0300 304 7000 from 430-1030pm daily.

For further information on supporting your wellbeing, including self-help guides, information on mental health services and how to access NHS support services, please refer to the following websites:

https://www.nhs.uk/conditions/stress-anxiety-depression/
https://www.mind.org.uk/
http://www.overcoming.co.uk/single.htm?ipg=4795
https://www.helpguide.org/
https://www.getselfhelp.co.uk/index.html

We hope you found the study interesting. If you have any other questions, please do not hesitate to contact us at the following:

Florentine de Raaij at Therapyinprisonsthesis@gmail.com
George Berguno at George.Berguno@city.ac.uk

Ethics approval code: [*ETH1920-1776*].

Informative Leaflet

Tips for looking after your mental health & overall wellbeing

Talk about your feelings
Keep active/exercise
Set realistic goals
Ask for help
Take a break
Do things you love
Accept who you are
Challenge negative thinking
Make time for yourself
Stay in touch with friends & family

Surround self with positive people
Eat a well-balanced diet
Keep learning
Get enough sleep
Keep track of positive moments

"You don't have to see the whole staircase, just take the first step"
-Martin Luther King Jr.

Relaxation Techniques

4-7-8 Breathing Exercise – Inhale through nose for 4 seconds, hold breath for 7 seconds, exhale through mouth for 8 seconds.

Visualisation Exercise– Sit down and relax, close your eyes. Imagine a scene where you feel at peace, free. Think about what you see, hear, smell, feel and taste. When ready, gently open eyes, come back to present.

Body Scan Exercise – lie on back, legs uncrossed and arms at sides, eyes closed. Start with deep breathing for several minutes. When ready, focus on right foot, noticing sensations you feel for 2 minutes. Slowly move to different parts of body, going from your feet to your shoulders. After completing scan and when ready, slowly open your eyes and stretch.

Appendix S – Excerpt of Participant Interview

R: So the first question I have for you is quite a broad question and they'll get a little bit more specific as we get along, the first question is what was your overall experience of prison when you were serving your sentence?

P: Uh, it's a madhouse

R: A madhouse

P: Yeah cause I was an addict, I come in ill, um… I come in ill and then I went onto the addict wing and it's a known fact that you go into an addict wing that its chaos, and I was on a script in there, um, I wanted to get off so I was detoxing while in there, um, it's quite a volatile place

R: Mmm

P: And to be hon-, honest, you got the addict wing and uh, there's a lot of honourable people in there, and me being one of them, uh, and you got people on there specifically to get other people's drugs and things like that

R: Right

P: So you get a lot of robberies and all that, um, and you have to defend yourself at first until you bed in

R: Mmm

P: But um, yeah it's not, it's not good, it's a shithole to be honest

R: Yeah… When you say chaotic, is that in the sense of what you were saying about, kind of, people wanting to get drugs off others

P: The whole thing, you know, you got ponces coming up to you all the time asking for ya, asking for stuff, um, you got to put boundaries in with them straight away, you know, you're full of fear as well, cause I've just got a sentence that I know that, I'm more concerned about my family…

R: Mmm

P: ...My kids, you know, and coming off drugs, I don't feel well, and then you've got to deal with trying to get some type of um, stra-, uh, need to know where, where you're going in your, in your sentence as well, and officers, they don't, they don't… you get some that care and some are just there just to open and shut doors

R: Mmm

P: That's the truth of it.

Appendix T – Process of Creating Focused Codes

Q3	
Lack of funding	Support/environment/resources
Lack of staff and resources	Support/resources/staff
Lack of good quality programs	Support/programs
Anxious around release	Mental health/stage of sentence – release
Need to take personal initiative	Taking initiative
Worry around medication	Mental health/medication
Worry of going back to prison	Mental health/stage of sentence – release
Suicidal thoughts	Mental health
Rare to find good programs	Support/programs
Some good programs	Support/programs
Box ticking exercises	Support/programs/environment
Some supportive staff	Support/staff
Q4	
Talk-therapy not available	Support/therapy
Austerity measures in place	Support/resources
Existing spice epidemic	Environment/health
Resources going to spice epidemic	Support/resources/health
A lot of emergencies	Mental health/environment/inmate needs
A lot of time locked in cells	Environment/structure
Q5	
Wanting to get off prescriptions	Support/health/medication
Doctors not agreeing with inmate requests	Support/health/doctors/inmate treatment
Need to convince doctors	Support/health/doctors
No access to services	Support
Being signposted	Support/referrals
No plan for release	Support/stage of sentence – release/inmate needs
Frustrating experience	Mental health
Demoralising experience	Mental health
Cycle of being signposted elsewhere	Support/referrals

Section B – The Publishable Paper

How do relationships influence access to support for mental health distress? An exploration of the experiences of male incarcerated individuals.

Abstract: This paper presents one of the findings of a constructivist grounded theory study, which investigated what occurs when incarcerated individuals experience mental health distress. The experiences of five recently-incarcerated males with mental health concerns and addiction issues were explored through semi-structured interviews. One of the findings highlighted that the relationships which incarcerated individual have and are able to develop influences their ability to access mental health support services. This finding, alongside its implications, is thoroughly discussed, and practice recommendations are made to ensure that prisoners can be more appropriately supported within these settings.

Keywords: prison; incarceration; relationships; mental health support; support access; impact; rehabilitation.

The paper begins by offering a literature review, which starts with discussing the impact of imprisonment on the mental health of incarcerated individuals as well as the impact it has on their relationships. Following this, I discuss the importance of relationships more generally and identify the focus of this paper. The literature review is followed by a methodology section and a method section. Then, the findings of the study are described, followed by a discussion of the findings and a reflective

discussion of practice recommendations. To end the paper, concluding remarks are made, which addresses the limitations of the study as well as pathways for future research.

There are mixed opinions regarding the use of literature reviews in grounded theory studies (Dunne, 2011; Giles, King & de Lacey, 2013), though it is important to emphasise that the debate is not focused on whether an initial literature review should be completed, but rather when it should be done (Dunne, 2011). I have chosen to provide a brief initial literature review with the aim of contextualising the topic of this paper.

Impact of Incarceration on Mental Health and Relationships

It has been consistently evidenced that mental health is negatively impacted by imprisonment, with mental health concerns significantly more prevalent within the prison population than in the general population (Senior, 2015; Bradley, 2009; Prisons & Probations Ombudsman, 2016; World Health Organisation, 2005; Nagel 1976; Gee & Bertrand-Godfrey, 2014; Bowler, Phillips & Rees, 2018). In regard to the more commonly experienced mental health concerns, a recent study (Tyler et al., 2019) identified that the prevalence of incarcerated individuals suffering from anxiety, depression, and post-traumatic stress disorder symptoms is around five times higher than in the general population in the UK. The prevalence of mental health in prisons is important to reflect upon considering the research (Cohen et al., 2014; Cohen et al,, 2012; Austin et al., 1999) which has evidenced that deteriorating and serious mental health issues can impair one's ability to communicate, and thus acquire and sustain relationships within this environment. This lack of ability could have a detrimental

impact on one's ability to develop supportive relationships with other inmates and with staff, as well as the ability to access prison support services for mental health distress.

Research studies (Harding, Morenoff & Wyse, 2019; Goomany & Dickinson, 2015; Bowler, Phillips & Rees, 2018; Nurse, Woodcock & Ormsby, 2003) have evidenced that overcrowding in prison is strongly associated to mental health distress, alongside violence, lack of meaningful activity, isolation and a lack of privacy. Organisational factors, such as the reduction of funding provided throughout the years, has been strongly associated to the worsening of the prison environment, as they have led to a decrease in the amount of staff available as well as reduced resources (Nurse, Woodcock & Ormsby, 2003; Goomany & Dickinson, 2015). All of these factors are inter-related and associate to feelings of loss of independence and autonomy (Tyler et al., 2019), as well as increased levels of frustration, anxiety, and substance use (Harty et al., 2012; Bowler, Phillips & Rees, 2018).

Alongside these impacts, imprisonment has been evidenced to have a strong negative impact on an incarcerated individual's ability to maintain positive relationships with family members (Christian & Kennedy, 2011; Mowen & Visher, 2016) and romantic partners (Harman, Smith & Egan, 2007). A consequence of incarceration is that they are forcibly separated (Nurse, Woodcock & Ormsby, 2003; Harman, Smith & Egan, 2007), as it can increase economic difficulties (Braman, 2004; Christian & Kennedy, 2011) and result in negative emotional outcomes for family members and romantic partners (Western et al., 2015; Harman, Smith & Egan, 2007). The stress and distress caused by imprisonment can also cause significant ruptures

in these types of relationships (Harman, Smith & Egan, 2007; Christian & Kennedy, 2011).

It is important to note that close family bonds are especially important when an individual is released from prison, as they often lean on their family for support with navigating their way through re-entry into society (Mowen & Visher, 2016). Support from family during imprisonment and upon release has been evidenced to be associated to recidivism rates, with family conflict increasing the likelihood of reoffending (Mowen & Visher, 2015). The deterioration of these valuable relationships can have a hugely negative impact on the psychological wellbeing of the imprisoned individual (Harman, Smith & Egan, 2007; Christian & Kennedy, 2011; Mowen & Visher, 2016). As such, it is worth reflecting upon and reviewing ways in which this can be improved.

Other factors to consider includes the relationships between inmates as well as between staff and those incarcerated. Regarding inmate relationships, the available studies are divided in their findings. Research carried out by Goomany and Dickinson (2015) demonstrated that within prisons, there is atmosphere of bullying amongst inmates and worries of personal safety. Concern of personal safety generally appears to be strongest in those considered more vulnerable, such as those with poor health or mental health (Goomany & Dickinson, 2015). Additionally, the nature and structural aspects of the prisons leads to enforced interactions to take place between inmates, which can be challenging to manage in an environment that is considered volatile and compacted (Crewe, 2009; Wulf-Ludden, 2013). This can lead to inmates preferring to isolate themselves (Crewe 2009). In contrast to these findings, research (Crewe,

2009; Sykes, 1956) has suggested that the shared circumstance of being imprisoned can create social bonds. However, despite the strength of the relationship inmates may develop, it does not appear to be common for them to share personal details due to a lack of trust (Crewe, 2009), suggesting that the relationships developed are more superficial in prison.

Studies exploring the relationships between staff and prisoners have not provided encouraging findings. A study carried out by Nurse, Woodcock and Ormsby (2003) described the relationship between staff, such as prison officers and healthcare staff, and inmates as “a cycle of negative attitudes”. It has also been suggested by Liebling, Price and Elliott (2016) that the prison environment is not conducive to the development of positive relationships between staff and inmates. This is concerning, considering that the role of a prison officer is to manage and supervise the inmates, maintain a safe environment within the wings, and to support the prisoners by attending to their general needs. Alongside this, they also support prisoners by ensuring they receive appropriate treatment by contacting the relevant services when needed as well as to be admitted to courses. Taking into consideration the amount of interaction between the prison officer and prisoners, it is essential that there is opportunity for positive relationships to be developed. The same can be said for the need for positive relationships between healthcare staff and inmates, as the support provided by these staff is heavily relied upon by prisoners in relation to their overall wellbeing and mental health.

The Importance of Relationships

The ability to develop and maintain interpersonal relationships is known to have an impact on an individual's wellbeing and mental health throughout life (Erikson, 1982). An individual's mental health and wellbeing can also impact one's ability to develop and sustain interpersonal relationships (Tedgard, Rastam & Wirtberg, 2018). Research (Tedgard, Rastam & Wirtberg, 2018) has shown that the strength of these associations depends on the type of relationship, on stage of life an individual is in as well as the context in which one finds him or herself.

There are different types of interpersonal relationships, such as romantic, familial and platonic relationships. Overall, the level of closeness and support offered within these types of relationships are correlated with psychological wellbeing (Cramer & Donachie, 1999), though they can impact an individual's wellbeing and mental health in varying ways (Cramer & Donachie, 1999). For instance, it has been evidenced that supportive romantic relationships or marriages improve psychological wellbeing whilst stressful ones have a negative impact (Simon & Barrett, 2010; Williams, 2003; Ross, 1995). Additionally, the type and strength of the relationship one has with their family, such as parents and siblings, hugely influences psychological health (Campos et al., 2014), such as distress (Schwarts et al., 2010), wellbeing (Schwarts et al., 2010) and socialising behaviours (Campos et al., 2014). Supportive platonic relationships, such as friendships, have been evidenced to be associated with improved mental health as they allow for a feeling of connectedness and belonging (Cleary, Lees & Sayers, 2018).

The ability to develop and maintain relationships depends on a range of factors. For instance, research has shown that individuals who experience abuse, bullying or a lack of nurture in their childhood are more likely to develop mental health problems (Tedgard, Rastam & Wirtberg, 2018; Edwards et al., 2017; DeLara, 2019) and dysfunctional communication skills (Tedgard, Rastam & Wirtberg, 2018). Additionally, individual personality traits associated to attachment styles have been evidenced to influence the quality of developed relationships (Bowlby, 1969; Bowlby, 1982). Adult attachment styles have been associated through research to a range of interpersonal behaviours (Jenkins-Guarnieri, Wright & Hudiburgh, 2012), interpersonal communication (Kenny & Rice, 1995) and emotional functioning (Fraley & Shafer, 2000). Alongside this, research (Van Orden et al., 2008; Black et al., 2019) has showed that suffering from mental health distress, such as depression and/or anxiety also impacts communication skills, how one interacts with others and how one perceives relationships. For instance, when an individual in a romantic relationship suffers from symptoms associated to mental health disorders, this can impact a relationship in terms of the levels of closeness and intimacy (Brown, 2020). By the same token, mental health diagnoses can impact one's ability to develop and preserve close bonds with family members (Campos et al., 2014) and friends (Cleary, Lees & Sayers, 2018). These are just some of the factors which impact the ability to develop and maintain positive and supportive relationships.

Focus of the Article

The research study carried out focused on answering the established research question of what happens when individuals experience mental health distress in prison, through a constructivist grounded theory methodology. A key focus of this

piece was to provide in-depth and clear data, to fill the gap observed in existing research and knowledge. Another aim was to offer a marginalised and overlooked group a chance to share their views. I felt that carrying out this research would also allow for a better understanding of how relationships impact the mental health of prisoners and the ways in which it impacts therapeutic outcomes, amongst the public and health professionals. A final aim of this research was to investigate the mental health support structure in prisons and consider whether current policies and protocols allows for mental health needs of prisoners to be effectively addressed.

Four main categories were established through the analysis process. Participants expressed that the prison environment negatively affected them and their mental health, and that this impact led to needing support for a range of different needs. In relation to this, individual characteristics determined how they coped with their mental health distress whilst incarcerated, as well as the type and level of support they needed. Finally, it also became evident that receiving support throughout their sentence was strongly associated with the types of relationships the individual had and were able to develop, both inside and outside of the prison environment. Positive relationships were crucial in accessing consistent support.

I have chosen to focus on the relationships finding for two key reasons. Firstly, the research carried out evidenced that positive relationships play a vital role in the prisoner's ability to access consistent and appropriate support whilst incarcerated and upon release. Alongside this, I became aware that there is a significant lack of research which explores the value that positive relationships hold for incarcerated individuals. Adding to the knowledge base allows for a deeper understanding, which

can act as a basis for driving change within the prison environment as a whole as well as in mental health services such as psychological support. It can ensure that in the future, practitioners work in a way which more appropriately supports these individuals, thus improving the psychological experience of individuals whilst imprisoned and upon release.

Methodology

An abbreviated version of the constructivist grounded theory was used to carrying out this research. As such, one cycle of data collection and analysis was carried out. Key aspects of the analysis process such as initial coding, focused coding, memo-writing, continuous comparative analysis, negative case analysis, theoretical sensitivity, theoretical integration and continuous reflexive practice (Birks & Mills, 2015; Willig & Stainton-Rogers, 2017; Charmaz, 2006; Charmaz, 2014; Charmaz, 2017a; Willig, 2013) were utilised as to not deviate too far from the methodology. As the focus of the method strongly relies on the analysis strategies taken, I did not feel I was compromising the quality of the study significantly by only carrying out one interview cycle, although I did take into consideration that, as Willig (2013) states, this decision may limit the ability to develop a fully saturated theory or conceptual sufficiency.

For this research, a constructivist and critical-realist theoretical framework was used, which works in harmony with the methodology chosen. Taking a constructivist and critical realist approach, there was assumption throughout the data collection and analysis processes that experiences provided by participants are accurate, however that our perceptions of reality depends partially on our personal views and expectations (Willig, 2013; Bunge, 1993). Taking such a stance, there was also a

specific focus in the analysis on the meaning of language of produced data (Willig, 2008; Willig, 2013). Findings were perceived from these philosophies only, and as Charmaz (2017b) emphasises, it is important to note that other philosophical frameworks could potentially construct an alternative theory. Findings can also solely be considered as representative of the current realities of the participants as well as that of the researcher.

Method

Purposive sampling was used for this study, to collect data which appropriately responded to the research question. All of the participants were recruited from a drug and alcohol recovery services located in London, which agreed to support in the recruitment process. Potential participants were screened prior to interviews taking place, to ensure that those participating in the study fit the inclusion criteria. The inclusion criteria for this research were as follows:

- Over the age of 18
- Have served a minimum prison sentence of six months
- Have served a maximum sentence of 2 years
- Offences included within this research are non-violence based offenses such as: driving offences (where there was no loss of life or serious injury to a third party), and a failure to comply with a community order or a suspended sentence
- Have been released from prison in the last five years
- Have experiencing mental health distress. The concerns focused on within this particular study include symptoms associated to anxiety (including social anxiety), depression, PTSD, panic, and OCD

- You have also assured the researcher that you feel comfortable with your responses being audio-recorded.

Written informed consent was then gathered from all of the participants prior to interviews taking place (see Appendix O). Semi-structured interviews (see Appendix P) were carried out on a one-to-one basis, at City university of London or on the grounds of the recruitment organisation, with individuals who directly experienced the phenomenon being studied, ensuring the data collection and analysis was based on a primary data source (Payne, 2007). Whilst there is some debate around the use of semi-structured interviews, they are considered to be strongly compatible with qualitative research and the constructivist grounded theory methodology (Potter & Hepburn, 2005). This is as they allow for the potential emergence of new material and more detailed insight, through the analytical focus on language to describe experiences (Potter & Hepburn, 2005). Interviews were audio-recorded using an encrypted device, to ensure accurate transcription was able to take place. The interviews were transcribed verbatim for the purpose of carrying out the grounded theory analysis. The interviews also anonymised during the transcription process, to ensure confidentiality of those involved in the research.

The interviews were carried out with five male participants, aged between thirty and fifty-five years of age, who were previously-incarcerated for a maximum of two years and were released within the last five years. Participants were required to have experience of symptoms relating to a mental health concern. The mental health concerns I aimed to cover in the present study, based on the NICE guidelines descriptions of more commonly experienced mental health concerns (NICE, 2011),

include depression, anxiety, panic, post-traumatic stress disorder and obsessive-compulsive disorder. There was not a specific requirement for when their mental health symptoms were experienced. Participants were taken at their word in relation to their symptoms as I was not concerned with whether or not they had received a mental health diagnosis, but rather their self-report of having experienced such concerns, as is consistent with my paradigm. Anxiety was to be the most commonly experienced, followed by depression and post-traumatic stress disorder. One of the participants also shared experiences of symptoms associated to panic, whilst none expressed feeling symptoms associated to obsessive-compulsive disorder. Many also revealed having a professional diagnosis in relation to their symptoms. The table below presents the key demographic details of the participants who took part in the study.

	Gender	**Age**	**Ethnicity**	**Skin Colour**
P1	M	Early 30's	British	Black
P2	M	Late 40's	Irish	White
P3	M	Early 50's	British	White
P4	M	Mid 40's	British	Black
P5	M	Early 50's	British	White

Findings

A main category identified through the analysis was the importance of being able to develop and have relationships with individuals inside and outside of the prison

environment. Through the analysis process, it became clear that there was a strong emphasis on the need for positive relationships.

Participant responses indicated that having positive relationships with individuals inside and outside of the prison environment, strongly influenced how they coped whilst incarcerated and what would occur once released. This is as the relationships participants had and were able to develop whilst incarcerated tended to dictate what would occur when the individuals experienced mental health distress. It was preferable to have positive support systems in place, both inside and outside of prison, however this appeared to be rare.

With regard to the prison environment, prison officers appeared to be the most important individuals with whom to have a positive relationship with. The findings indicated that there is an inconsistency in how prison officers treat inmates; whilst some see it just as a job, others feel it is their duty to give the inmates the best support possible. Thus, knowing who was willing to help was an important factor in getting appropriate support. Participants also reflected in their responses that if they didn't have a positive relationship with a prison officer, they were then less likely to get the support or access to courses that they expressed they needed.

> "You got the screws, and if you're a bit of a wanker, they don't really have much to do with ya, and you know, if you, you know, if you're well, well, you're trying at least, they'll, they will help you out" (Daniel)

The same appeared to be relevant in relation to receiving support from healthcare teams, such as doctors and nurses, as well as therapists. In regard to the doctors and nurses, participants described that, at times, they felt that their needs were not taken

seriously and that they were not provided with appropriate care. One participant specifically shared an experience where this occurred, which resulted in him feeling and conveying a sense of frustration, which in turn was interpreted negatively by staff. When he shared his frustration, he was reprimanded for what was interpreted as violent behaviour, which further increased his distress.

> "I was on specific medication and uh, I've gone down for my meds and they're like, 'you can't get it here' …so you end up not having nothing, so then your mental status just goes up and you end up leaving there more frustrated, and then for myself, my anxiety goes, goes up even more, and that's where I start … end up swearing at officers and everything… and if it starts off, all of the sudden they'll just call an officer and say 'take him away' and then they go 'right, we're putting you on report" (Carl)

Regarding therapists, participants described that the lack of ability to develop positive relationships and trust, due to time constraints and not meeting with the same staff member for the sessions, was difficult to cope with. The lack of consistent and supportive care provided by the healthcare services was described as challenging to manage and often led to increased levels of distress.

> "It took them ages to get my medication sorted out, so that was a bit of a nightmare because I wasn't sleeping and stuff... it takes them ages to do anything in jail, you know, they drag their heels… it told me that they didn't care, I'm on my own" (George)

> "I had counselling there but then the counselling, um, that was for three weeks… for me to do counselling with someone, I need more than three weeks, you know, I can't just walk into a room and start discussing what's actually going on for myself and how I'm feeling… it's going to open up a couple of, a load of can of worms for me and then all of the sudden they are gone and I'm left with that can of worms open, and my head's going to be even more messed up" (Carl)

Relationships with other inmates was also an important factor relating to how they coped during their periods of incarceration as well as whether they were able to access support. Whilst most participants described feeling the need to isolate themselves from other prisoners for their own personal safety, some described being able to develop positive relationships with other incarcerated individuals. Interestingly, one of the participants highlighted however that even when he was able to develop positive relationships with other inmates, he still did not want to share his feelings of distress with them, as he did not want to place his burdens on others.

> "Some of them (inmates), but they've got their own problems as well so I wouldn't really go to them with my problems, you, you know, I'd keep it to myself most of the time." (George)

I became aware through the analysis process that some participants also found it more beneficial to seek advice from other inmates than from probation officers, especially about ways of accessing the healthcare services.

> "The challenge was getting heard and finding the people I need to speak to, So I would ask a lot of questions, 'who I need to speak to about this?' 'who do I need to speak to about that?'… speak to old-terms, the long-termers, that have been there, who know the system." (Daniel)

Participants shared that it was also helpful to have positive relationships and networks outside of the prison environment, with probation officers, family members and treatment facilities being most essential. As the participants in this research were all individuals who entered prison with addiction issues and were recruited through recovery treatment facilities, these positive relationships were deemed essential. Many participants reflected that moving to treatment centres upon release was due to having a supportive probation officer or a family member who had a connection to a

treatment facility, rather than being able to rely on support on staff within the prison environment. There were mixed descriptions of the support provided by the probation officers, with some stating that they were very helpful and others stating that they were not. When the probation officer was of no help, the ability to reach out to rehabilitation through a family member was crucial.

> "Support for in there for getting, for getting treatment centres and everything like that, no, you don't get no support. I had to do it all myself, i.e. by reaching out and, and speaking to my probation officer… because the prison system, they don't do any of that, you know…" (Carl)

I found it interesting to hear the participants describe how their relationships significantly impacted the type and level of support received in prison. It became evident to me how important positive relationships were for these individuals. I noticed that it is not just about the availability of services, as even though they do exist, a specific type of relationship is needed in order to access them.

Discussion

Since prison officers most often interact with prisoners, there is huge value placed on these relationships (Galanek, 2014; Beijersbergen et al., 2016). To a large extent, prison officers act as gatekeepers to support services. The relationship between prisoners and prison officers can thus influence whether and to which extent they are supported (Reed & Lyne, 2000; Galanek, 2014) and can hugely impact mental health support outcomes (Beijersbergen et al., 2016). A study carried out by Skogstad, Deane and Spicer (2006) was able to identify that a negative relationship between the inmate and prison officer makes it less likely for prisoners to seek support or receive quick and appropriate support. Unfortunately, the ability for incarcerated individuals to

form positive relationships with staff is challenging due to a lack of staff and a lack of proper staff training (Nurse, Woodcock & Ormsby, 2003; Kinman, Clements & Hart, 2017), as well as inefficient management of staff (Liebling, Price & Schefer, 2011). Research (Nurse, Woodcock & Ormsby, 2003; Liebling, Price & Schefer, 2011) has also evidenced that prison staff suffer from high levels of stress due to the environment and the demanding nature of the role, which has led to a fast turnover of staff (Kinman, Clements & Hart, 2017). The challenges regarding the ability to develop positive relationships with prison officers, mentioned above, were invariably described by the participants of the current study.

Exploratory research on prisoner perceptions of prison officers (Liebling, Price & Schefer, 2011; Tait, 2008) has identified that the views of inmates generally falls into several categories. Overall, these studies (Tait, 2008; Liebling, Price & Schefer, 2011) have identified that prisoners only view a small number of staff as 'good' and that those will take their time to support inmates but that a large number of staff view their role as a 'job' and were less likely to support inmates but did view them as 'human beings'. Finally, a small proportion of staff were seen as 'bad' and could be vindictive towards inmates (Liebling, Price & Schefer, 2011). These findings indicate that there is no consistency in staff attitudes towards inmates, which will influence the likelihood that an incarcerated individual reaches out for support for their mental health distress. This inconsistency and the related impact was powerfully described by the participants of the current study as well.

The evidence described above is backed by the findings of the current research and the deterioration of mental health due to these factors was certainly something to

which the participants could relate. The lack of research into the importance of relationships, from the perspective of the previously incarcerated individual, makes the findings of this research study of huge significance. This is as it improves our understanding of the prisoner experience. The findings identifies important aspects which need to be addressed, regarding the prisoners ability to develop positive relationships with prison officers. It is clear however that more research needs to be carried out on this topic, as there is not a substantial amount of research available to further evaluate the research findings.

A few studies have also explored the impact of inmate-on-inmate relationships, the support of family as well as the existing healthcare teams in prisons, and how these impact the likelihood of seeking support for mental health needs. These studies (Skogstad, Deane & Spicer, 2006; Armitage & Conner, 2001; Mills & Kendall, 2016) have evidenced that prisoners who are not encouraged to seek support by their support system, such as other inmates, family members and healthcare teams in prison, are less likely to reach out to supportive services. This is due to a worry of not being appropriately helped and of not being accepted or understood (Skogstad, Deane & Spicer, 2006; Armitage & Conner, 2001; Mills & Kendall, 2016). Some prisoners may also not seek support due to their fear of coming across as vulnerable or weak in relation to others as well as a lack of trust in the prison healthcare system (Mills & Kendall, 2016; Cobb & Farrants, 2014; Howerton., et al, 2007; Skogstad, Deane & Spicer, 2006; De Viggiani, 2003). Something that I found particularly interesting in my findings is that whilst inmate support and healthcare attitudes were commonly declared by participants as influencing the likelihood of seeking support, the influence of family members was not mentioned. The findings of previous studies are in line with

the research findings of this study, except for the existing literature which highlights the importance of supportive family members. Overall, I believe that the current study explore the meaning and impact of these relationships more profoundly than previous research has done.

The relationship between prisoners and therapists are also crucial when addressing prisoner mental health needs. Non-prison related research has consistently evidenced the value that the therapeutic alliance between a therapist and client holds. A strong therapeutic relationship, both in short and long term therapeutic work, offers a pathway to predicting change (Bordin, 1979; Renik, 2000), positively impacts client engagement (Ross, Polaschek & Ward, 2008) and is more likely to lead to positive treatment outcomes as a whole (Cailhol et al., 2009). These findings can be transferred to prison settings, and it could be said that the therapeutic alliance is even more important in such settings. The findings of the current research indicates that due to a lack of staff, a lack of opportunity to access therapeutic support, not being seen by the same healthcare professional, as well as the time-limited duration of therapeutic support, it is challenging to build positive relationships with therapists. It would be fundamental to address these issues considering the positive impact that a strong therapeutic alliance can have on the outcomes of mental health distress outcomes.

With regards to relationships outside the prison environment, it is important to have positive relationships with the probation officer and treatment facilities, so that upon release of prison, the ex-prisoner can be appropriately and consistently supported. Participants highlighted that a connection with a treatment facility through

a family member was also essential to ensuring they received appropriate support post release. They highlighted that this was especially important when a positive relationship with the probation officer was not possible or when the probation officer was not appropriately supportive.

Access to appropriate and consistent support upon release, such as treatment facilities and a support network, have a substantial impact on recidivism rate (Chamberlain et al., 2017; Batty, 2020). They also increase the likelihood of positive outcomes for previously incarcerated individuals with mental health distress (Hopkin et al., 2018). As such, it is fundamental that those with mental health distress are consistently supported upon release and have access to support services if needed. Probation officers play a very important role in the lives of prisoners who have recently been released from prison on probation. They are said to play a dual role, one of support and of ensuring that their clients adhere to the terms of the probation (Chamberlain et al., 2017; Cnaan & Woida, 2019). Considering the characteristics of the sample population of the current study, a key aspect of the supportive role of probation officers would be to find appropriate treatment centres. Participants had mixed opinions of their probation officers, with some describing them as helpful whilst others described them as not being supportive or accommodating.

Minimal research has explored the importance of the relationship between the previously incarcerated individual and the probation officer. Additionally, the majority of research on this topic has been from the view of the probation officer, rather than that of the prisoner on probation. However, studies that have been carried out (Chamberlain et al., 2017; Klockars, 1972) clearly demonstrate that probation officers

play a crucial role in the re-entry into society process of a previously incarcerated individuals as well as the impact on the likelihood of reoffending in the future. Additionally, the parolee's willingness to comply with the conditions of their probationary contract and willingness to speak openly with their probation officers is strongly dependent on their relationship (Chamberlain et al., 2017; Bonta et al., 2008; Robinson, 2005). In relation to this, a recent study carried out by Cnaan and Woida (2019) has evidenced that a negative relationship can lead to the client feeling higher levels of anxiety and distress alongside lower levels of self-efficacy. The impacts of a positive or negative relationship were described in more detail by the participants of the current study than previous research, thus contributing to the existing knowledge base in a meaningful way.

Alongside probation officers, family support has been evidenced, by both quantitative and qualitative research studies, to play a huge role in the lives of those who have recently been released from prison (Mowen, Stansfield & Boman, 2018). Whilst the contributors of the current study solely discussed the importance of family support and access in relation to gaining access to treatment facilities post-release, further research has identified several other important reasons. Consistent family support can have a far reaching impact on those who have recently been released as it can positively increase reintegration outcomes (Boman & Mowen, 2017; Berg & Huebner, 2011; Vishner, Debus & Yahner, 2008; Grieb et al., 2014; Wallace et al., 2016). For instance, it can impact reoffending behaviours (Grieb et al., 2014), mental health (Wallace et al., 2016) and job employment prospects (Boman & Mowen, 2017; Berg & Huebner, 2011; Vishner, Debus & Yahner, 2008). In relation to this, the findings

of the current study on the importance of family connections can be considered to be an original contribution which adds to the pre-existing knowledge base.

Practice Recommendations

Based on the findings of the current study, several practice recommendations can be made, both to the prison system as a whole as well as to prison mental health support services such as psychological interventions. Whilst I appreciate that the changes outlined below requires an increased commitment to prisons and prisoners from the authorities, I believe it would be worthwhile and vital, as it would ensure that incarcerated individuals are included in the political discourses which surround mental health provisions. It would also ensure that the mental health needs of prisoners are more appropriately considered and addressed in the future.

A key aspect which needs to be addressed is the inconsistent behaviour by prison officers towards prisoners. A previous research study (Beijersbergen, Dirkzwager, van der Laan & Nieuwbeerta, 2016), alongside the current findings, has identified that the treatment of inmates by prison staff has been strongly correlated to psychological distress experienced by inmates. Prison officers most commonly interact with the inmates and to a large degree, act as gatekeepers to receiving mental health support. I believe that there are two strategic ways of addressing this issue, including increasing staff numbers and providing additional training, such as consistent mental health training for all prison officers.

Participants consistently mentioned that a lack of prison staff and a lack of appropriate training led to a lack of appropriate support. They also stated that mental

health needs and associated behavioural issues tended to be interpreted incorrectly and thus inappropriately managed, leading to increased acts of violence. These factors made it challenging for incarcerated individuals to develop positive relationships inside the prison environment. Increasing the amount of prison officers and offering appropriate training can have far-reaching positive impacts. Appropriate training can reduce the rate of staff turnover, as it will ensure that they are better equipped to cope with the demanding nature of the job. This can, alongside increased staff numbers, improve the ability for incarcerated individuals to develop positive relationships with staff. A reduced staff turnover rate and appropriate mental health training can also ensure that prisoners are better supported in the long run, as they will be appropriately referred to mental health support services.

Another aspect to review is the current healthcare system and how it responds to mental health distress. This includes reviewing the standard of psychological services, reviewing the number of services available as well as the suitability of referral procedures. Based on the findings of this study, it is clear that there currently are not enough mental health support services available compared to the demand and that support offered is time-limited. This inevitably has a negative impact on the mental health of inmates as they have a lack of necessary access and are unable to develop strong alliances with healthcare staff, such as therapists. One way of addressing this issue would be to increase the number of healthcare and psychological staff. Appropriate training for healthcare staff would also be essential as this would impact the staff turnover rates, improve the ways in which healthcare staff responds to the mental health distress of inmates, and allow for longer-term therapy. I also believe that longer-term therapy would positively support incarcerated individuals due to the

severity and complexity of mental health distress, and as it would increase the likelihood of developing trusting bonds between inmates and therapists.

It would also be important to review and reflect on the suitability of the psychological approaches taken by psychologists and therapists to support prisoners with mental health distress. One particular approach which I believe could be of huge support to incarcerated individuals with mental health distress is the person-centred approach. I sense that this approach, considering that it is non-confrontational, could offer a space which contrasts the current the prison processes and could offer a positive effect on the overall prison environment. The inherent components of person-centred therapy, which consist of offering unconditional positive regard, empathy, openness and focuses on social justice, can offer an environment which facilitates the development of positive therapeutic alliances (Rogers, 1980; Sandvik & McCormack, 2018; Wilkins, 2003) as well as recovery (Mearns, Thorne & McLeod, 2013; Rogers, 1963; Jacobs et al., 2017).

The use of any approach as well as the length of therapy would depend on the individuals' preferences and needs as well as the length of their sentence. This would need to be appropriately and thoroughly assessed prior to starting therapy. Comprehensive mental health and assessment training would support staff in being able to identify which approach would be most suitable for the incarcerated individual. I believe that hiring additional therapists, more specifically, counselling psychologists, could also be constructive due to their holistic and client-focused approach. Counselling psychologists are also trained in a range of approaches, places high

importance on the therapeutic alliance and have thorough knowledge of assessing client needs.

Finally, the impact of the environment on support-seeking strategies as well as the prevalence of mental health and substance misuse, indicates that it would be constructive to promote the awareness of mental health and substance-abuse in prison. Promotion could take the form of workshops for instance; which could be carried out by internal or external individuals with expertise on this topic. These workshops could focus on factors associated to mental health deterioration, triggers for mental health distress and ways of improving mental health within prison settings. Mental health focused workshops, like the ones mentioned above, are already offered in some prisons in England through, for instance, peer support groups, and have shown to be effective in supporting prisoners with their health and mental health (Bagnall et al., 2015; South, Woodall, Kinsella & Bagnall, 2016). Alongside workshops, I believe that offering more consistent training for staff from mental health experts can promote a more conscientious environment which focuses on looking after the mental health needs of inmates. As evidenced by several studies (Walsh & Freshwater, 2009; Booth et al., 2017; Melnikov & Kigli-Shemesh, 2017), such promotion could encourage prisoners to access support services in the long-term and encourage the development of supportive relationships between inmates as well as between staff and inmates.

Concluding Remarks

Whilst grounded theory offers a strong methodology, it is important to note that it only offers one theory and model (Willig, 2008), being that the application of the theory can be used in different ways. I am also aware that my preconceived views of the prison

mental health system and my experience of working within forensic healthcare settings inevitably influenced the findings. Alongside this, I recognise that I was solely reliant on the grounded theory methodology and the inclusion of other methodologies may have resulted in different findings or another theory.

I recognise a limitation of this study is that I did not use the full grounded theory model. Using an abbreviated version of the grounded theory methodology also meant that I was not able to use theoretical sampling as a recruitment strategy. The inability to use theoretical sampling consequently resulted in not being able to carry out follow-up interviews on concepts which arose from the interviews and analysis or to request feedback from the participants on the findings gathered. Another limitation of this study related to the sample size and sample population of the current study. The sample population, whilst it had a broad age range, solely consisted of the male prison population and mainly consisted of white British individuals, all of whom had a background associated to addiction.

Regarding future research, the review of existing literature and relevant empirical research carried out highlighted the lack of exploratory research that exists on the topic of relationships for incarcerated individuals. It would be of benefit if the findings of this research were accompanied by supplementary research, to address the gaps in my study and tentatively constructed theory. This would allow the opportunity to better evaluate the findings of the current study. Additional research would also provide a stronger basis for encouraging and implementing practice changes, to better support incarcerated individuals with mental health distress.

References

Armitage, C. J. and Conner, M., 2001. Efficacy of the theory of planned behaviour: a meta-analytic review. *British Journal Of Social Psychology*, [online] 40(4), pp.471-499. Available at: <https://0-doi-org.wam.city.ac.uk/10.1348/014466601164939> [Accessed 23 October 2020].

Austin, M., Mithcell, P., Wilhelm, K., Parker, G., Hickie, I., Prodaty, H., Chan, J., Eyers, K., Milic, M. and Hadzi-Pavlovic, D., 1999. Cognitive function in depression: a distinct pattern of frontal impairment in melancholia?. *Psychological Medicine*, [online] 29(1), pp.73-85. Available at: <https://0-www-cambridge-org.wam.city.ac.uk/core/journals/psychological-medicine/article/cognitive-function-in-depression-a-distinct-pattern-of-frontal-impairment-in-melancholia/18A967BDEBFD8C06B7F8344C64139568> [Accessed 25 October 2020].

Bagnall, A., South, J., Hulme, C., Woodall, J., Vinall-Collier, K., Raine, G., Kinsella, K., Dixey, R., Harris, L. and Wright, N., 2015. A systematic review of the effectiveness and cost-effectiveness of peer education and peer support in prisons. *BMC Public Health*, [online] 15(1). Available at: <https://bmcpublichealth.biomedcentral.com/articles/10.1186/s12889-015-1584-x> [Accessed 5 June 2021].

Batty, E., 2020. Without the Right Support Network I'd Probably Be Either Dead or in the Prison System': The Role of Support in Helping Offenders on their Journey to

Desistance. *The Howard Journal Of Crime And Justice*, [online] 59(2), pp.174-193. Available at: <https://0-onlinelibrary-wiley-com.wam.city.ac.uk/doi/full/10.1111/hojo.12355> [Accessed 23 October 2020].

Beijersbergen, K. A., Dirkzwager, A. J. E., van der Laan, P. H. and Nieuwbeerta, P., 2016. A social building? prison architecture and staff-prisoner relationships. *Crime & Delinquency*, [online] 62(7), pp.843-874. Available at: <https://0-heinonline-org.wam.city.ac.uk/HOL/Page?lname=&handle=hein.journals/cadq62&collection=&page=843&collection=journals> [Accessed 23 October 2020].

Berg, M. and Huebner, B., 2011. Reentry and the Ties That Bind: An Examination of Social Ties, Employment and Recidivism. *Justice Quarterly*, [online] 28(2), pp.382-410. Available at: <https://0-www-tandfonline-com.wam.city.ac.uk/doi/full/10.1080/07418825.2010.498383> [Accessed 23 October 2020].

Birks, M. and Mill, J., 2015. *Grounded Theory: A Practical Guide*. 2nd ed. London: SAGE Publications Ltd, pp.1-15, 49-124.

Black, J., Bond, M. A., Hawkins, R. and Black, E., 2019. Test of a clinical model of poor physical health and suicide: The role of depression, psychosocial stress, interpersonal conflict, and panic. *Journal of Affective Disorders*, [online] 257(1), pp.404-411. Available at: <https://0-www-sciencedirect-com.wam.city.ac.uk/science/article/pii/S0165032719300394?via%3Dihub> [Accessed 24 October 2020].

Boman, J. H. and Mowen, T. J., 2017. Building the Ties That Bind, Breaking the Ties That Don't: Family Support, Criminal Peers, and Reentry Success. *Criminology & Public Policy*, [online] 16(3), pp.753–774. Available at: <https://0-heinonline-org.wam.city.ac.uk/HOL/Page?lname=&handle=hein.journals/crpp16&collection=&page=753&collection=journals> [Accessed 23 October 2020].

Bonta, J., Rugge, T., Scott, T., G, B. and Yessine, A., 2008. Exploring the Black Box of Community Supervision. *Journal Of Offender Rehabilitation*, [online] 47(3), pp.248-270. Available at: <https://0-www-tandfonline-com.wam.city.ac.uk/doi/full/10.1080/10509670802134085> [Accessed 23 October 2020].

Booth, A., Scantlebury, A., Hughes-Morley, A., Mitchell, N., Wright, K., Scott, W. and McDaid, C., 2017. Mental health training programmes for non-mental health trained professionals coming into contact with people with mental ill health: a systematic review of effectiveness. *BMC Psychiatry*, [online] 17(1). Available at: <https://link.springer.com/article/10.1186/s12888-017-1356-5> [Accessed 5 June 2021].

Bordin, E. S., 1979. The generalizability of the psychoanalytic concept of the working alliance. *Psychotherapy: Theory, Research And Practice*, [online] 16(3), pp.252−260. Available at: <http://0-web.a.ebscohost.com.wam.city.ac.uk/ehost/detail/detail?vid=0&sid=6d472bb9-d719-4367-aed5-4d99fb0e749b%40sdc-v-

sessmgr02&bdata=JnNpdGU9ZWhvc3QtbGl2ZQ%3d%3d#AN=1980-23666-001&db=pdh> [Accessed 23 October 2020].

Bowlby, J., 1969. *Attachment And Loss: Vol. 1. Attachment*. 1st ed. New York: Basic Books, pp.177-350.

Bowlby, J., 1982. Attachment and loss: Retrospect and prospect. *American Journal of Orthopsychiatry*, [online] 52(4), pp.664–678. Available at: <http://0-web.a.ebscohost.com.wam.city.ac.uk/ehost/detail/detail?vid=0&sid=62df320a-5979-494f-8a87-291f3b833f73%40sdc-v-sessmgr01&bdata=JnNpdGU9ZWhvc3QtbGl2ZQ%3d%3d> [Accessed 24 October 2020].

Bowler, N., Phillips, C. and Rees, P., 2018. The association between imported factors and prisoners' mental health: Implications for adaptation and intervention. *International Journal Of Law And Psychiatry*, [online] 57(1), pp.61-66. Available at: <https://0-www-sciencedirect-com.wam.city.ac.uk/science/article/pii/S0160252717301255?via%3Dihub> [Accessed 25 October 2020].

Bradley, K., 2009. *Lord Bradley'S Review Of People With Mental Health Problems Or Learning Disabilities In The Criminal Justice System*. The Bradley Report. [online] Department of Health, pp.16-21, 28-50, 90-112. Available at: <http://webarchive.nationalarchives.gov.uk/20130107105354/http://www.dh.gov.uk/p

rod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_098698.pdf>
[Accessed 25 October 2020].

Braman, D., 2004. *Doing Time On The Outside: Incarceration And Family Life In Urban America*. 1st ed. Ann Arbor: University of Michigan Press, pp.41-96.

Brown, B., 2020. Intimate citizenship and mental ill health: Informal carers' accounts of romantic relationship difficulties of people with mental health problems. *Sexualities*, [online] 0(0), pp.1-19. Available at: <https://0-journals-sagepub-com.wam.city.ac.uk/doi/10.1177/1363460720957212> [Accessed 24 October 2020].

Bunge, M., 1993. Realism and Antirealism in Social Science. *Theory and Decision*, [online] 35(3), pp.207-235. Available at: <https://link.springer.com/article/10.1007/BF01075199> [Accessed 21 October 2020].

Cailhol, L., Rodgers, R., Burnand, Y., Brunet, A., Damsa, C. and Andreoli, A., 2009. Therapeutic alliance in short-term supportive and psychodynamic psychotherapies: A necessary but not sufficient condition for outcome?. *Psychiatry Research*, [online] 170(2-3), pp.229-233. Available at: <https://0-www-sciencedirect-com.wam.city.ac.uk/science/article/pii/S0165178108003442?via%3Dihub>
[Accessed 23 October 2020].

Campos, B., Ullman, J. B., Aguilera, A. and Dunkel-Schetter, C., 2014. Familism and psychological health: The intervening role of closeness and social support. *Cultural Diversity and Ethnic Minority Psychology*, [online] 20(2), pp.191-201. Available at:

<http://0-web.a.ebscohost.com.wam.city.ac.uk/ehost/detail/detail?vid=0&sid=18d5f3b8-8f3e-4fb9-9b08-b75420515866%40sdc-v-sessmgr01&bdata=JnNpdGU9ZWhvc3QtbGl2ZQ%3d%3d#AN=2014-14452-003&db=pdh> [Accessed 24 October 2020].

Charmberlain, A., Gricius, M., Wallace, D., D, B. and Ware, V., 2017. Parolee–Parole Officer Rapport: Does It Impact Recidivism?. *International Journal Of Offender Therapy And Comparative Criminology*, [online] 62(11), pp.3581-3602. Available at: <https://0-journals-sagepub-com.wam.city.ac.uk/doi/10.1177/0306624X17741593> [Accessed 23 October 2020].

Charmaz, K., 2006. *Constructing Grounded Theory: A Practical Guide Through Qualitative Analysis*. London: SAGE Publications Ltd, pp.1-12, 177-183.

Charmaz, K., 2014. *Constructing Grounded Theory*. 2nd ed. London: SAGE Publications Ltd, pp.1-16, 225-240.

Charmaz, K., 2017a. Constructivist grounded theory. *The Journal of Positive Psychology*, [online] 12(3), pp.299-300. Available at: <https://0-www-tandfonline-com.wam.city.ac.uk/doi/full/10.1080/17439760.2016.1262612> [Accessed 21 October 2020].

Charmaz, K., 2017b. Special Invited Paper: Continuities, Contradictions, and Critical Inquiry in Grounded Theory. *International Journal Of Qualitative Methods*, [online]

16(1), pp.1-8. Available at: <https://journals.sagepub.com/doi/full/10.1177/1609406917719350> [Accessed 21 October 2020].

Christian, J. and Kennedy, L. W., 2011. Secondary narratives in the aftermath of crime: Defining family members' relationships with prisoners. *Punishment & Society*, [online] 13(4), pp.379–402. Available at: <https://0-journals-sagepub-com.wam.city.ac.uk/doi/pdf/10.1177/1462474511414781> [Accessed 25 October 2020].

Cleary, M., Lees, D. and Sayer, J., 2018. Friendship and Mental Health. *Issues in Mental Health Nursing*, [online] 39(3), pp.279-281. Available at: <https://0-www-tandfonline-com.wam.city.ac.uk/doi/pdf/10.1080/01612840.2018.1431444?needAccess=true> [Accessed 24 October 2020].

Cnaan, R. A. and Woida, K., 2019. Power, anxiety, and relationships between returning citizens and parole officers. *Journal Of Social Work*, [online] 20(5), pp.576-598. Available at: <https://0-journals-sagepub-com.wam.city.ac.uk/doi/10.1177/1468017319852692> [Accessed 23 October 2020].

Cobb, S. and Farrrants, J., 2014. Male prisoners' constructions of help-seeking. *Journal Of Forensic Practice*, [online] 16(1), pp.46-57. Available at: <https://0-www-emerald-com.wam.city.ac.uk/insight/content/doi/10.1108/JFP-01-2013-0005/full/html> [Accessed 23 October 2020].

Cohen, A. S., Najolia, G. M., Kim, Y. and Dinzeo, T. J., 2012. On the boundaries of blunt affect/alogia across severe mental illness: Implications for Research Domain Criteria. *Schizophrenia Research*, [online] 10(1-3), pp.41-45. Available at: <https://0-www-sciencedirect-com.wam.city.ac.uk/science/article/pii/S0920996412003933?via%3Dihub> [Accessed 25 October 2020].

Cohen, A. S., McGovern, J. E., Dinzeo, T. J. and Covington, M. A., 2014. Speech Deficits in Serious mental Illness: A Cognitive Resource Issue?. *Schizophrenia Research*, [online] 160(0), pp.173–179. Available at: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4310829/> [Accessed 25 October 2020].

Cramer, D. and Donachie, M., 1999. Psychological Health and Change in Closeness in Platonic and Romantic Relationships. *The Journal of Social Psychology*, [online] 139(6), pp.762-767. Available at: <https://0-www-tandfonline-com.wam.city.ac.uk/doi/pdf/10.1080/00224549909598255?needAccess=true> [Accessed 24 October 2020].

Crewe, B., 2009. *The Prisoner Society: Power, Adaptation And Social Life In An English Prison*. 1st ed. Oxford: Oxford University Press, pp.301-364.

DeLara, E. W., 2019. Consequences of Childhood Bullying on Mental Health and Relationships for Young Adults. *Journal of Child & Family Studies*, [online] 28(9),

pp.2379-2389. Available at: <http://0-web.a.ebscohost.com.wam.city.ac.uk/ehost/detail/detail?vid=0&sid=23a70dc4-652e-45a0-a5d8-d1b780ff9dff%40sessionmgr4007&bdata=JnNpdGU9ZWhvc3QtbGl2ZQ%3d%3d#AN=137992385&db=a9h> [Accessed 24 October 2020].

De Viggiani, N., 2003. *(Un)Healthy Prison Masculinities: Theorising Men's Health In Prison (Phd)*. [online] University of Bristol, pp.15-77, 121-196. Available at: <https://www.researchgate.net/publication/277862762_Unhealthy_prison_masculinities_Theorising_men's_health_in_prison> [Accessed 23 October 2020].

Dunne, C., 2011. The place of the literature review in grounded theory research. *International Journal Of Social Research Methodology*, [online] 14(2), pp.111-124. Available at: <https://0-www-tandfonline-com.wam.city.ac.uk/doi/full/10.1080/13645579.2010.494930> [Accessed 25 October 2020].

Edwards, A. C., Lonn, S. L., Karriker-Jaffe, K. J., Sundquist, J., Kendler, K. S. and Sundquist, K., 2017. Time-specific and cumulative effects of exposure to parental externalizing behavior on risk for young adult alcohol use disorder. *Addictive Behaviors*, [online] 72, pp.8–13. Available at: <https://0-www-sciencedirect-com.wam.city.ac.uk/science/article/pii/S0306460317301053?via%3Dihub> [Accessed 24 October 2020].

Erikson, E. H., 1982. *The Life Cycle Completed*. 1st ed. London: W. W. Norton & Company, pp.7-84.

Foucault, M., 1977. *Discipline And Punish: The Birth Of The Prison*. Harmondsworth: Penguin, pp.73-170.

Fraley, R. C. and Shafer, P. R., 2000. Adult romantic attachment: Theoretical developments, emerging controversies, and unanswered questions. *Review of General Psychology*, [online] 4(2), pp.132-154. Available at: <https://0-journals-sagepub-com.wam.city.ac.uk/doi/10.1037/1089-2680.4.2.132> [Accessed 24 October 2020].

Galanek, J. D., 2014. Correctional Officers and the Incarcerated Mentally Ill: Responses to Psychiatric Illness in Prison. *Medical Anthropology Quarterl*, [online] 29(1), pp.116–136. Available at: <https://0-anthrosource-onlinelibrary-wiley-com.wam.city.ac.uk/doi/full/10.1111/maq.12137> [Accessed 22 October 2020].

Gee, J. and Bertrand-Godfrey, B., 2014. Researching the psychological therapies in prison: considerations and future recommendations. *International Journal Of Prisoner Health*, [online] 10(2), pp.118-131. Available at: <https://0-www-emerald-com.wam.city.ac.uk/insight/content/doi/10.1108/IJPH-06-2013-0030/full/html> [Accessed 25 October 2020].

Gideon, L., & Sung, H. (2011). *Rethinking Corrections: Rehabilitation, Reentry, and Reintegration* (1st ed., pp. 19-46). London: SAGE Publications, Inc.

Giles, T., King, L. and de Lacey, S., 2013. The Timing of the Literature Review in Grounded Theory Research: An Open Mind Versus an Empty Head. *Advances In Nursing Science*, [online] 36(2), pp.29-40. Available at: <http://0-ovidsp.dc2.ovid.com.wam.city.ac.uk/ovid-a/ovidweb.cgi?QS2=434f4e1a73d37e8c9c8be07760ee3a7a1b638968b4eca24638c4205dedf72444a4a5b855c7ef670572cbc73fc893c7a42adacac17abc1f4ff66b889afcc0b45179dd79ea6258e34739a0efc21c85e57f7c0b080609ced2821b37c19588373bcc0c3eaadadf4ae61d5ea703f553803d34d4c4c53fe449903cb3ecabdaf303091f40539660b0ab0b90f5735bc71603f3eff809b88ecadb9de5421f5f89c1eb55de6bf5aa718fca0473e47dbdc33b6e12687c842a02bf38b3cb0f42e36e9ab3c0f4c749fb518ca30cd6d3a857ab5ec8020a2419124240c113aeac24e3f9c496d80d74c341668634013eb9f8bc61d5e93207ae621b4ceab2122c> [Accessed 25 October 2020].

Godderis, R., 2006. Dining in: the symbolic power of food in prison. *The Howard Journal of Crime and Justice*, [online] 45(3), pp.255 - 267. Available at: <https://0-doi-org.wam.city.ac.uk/10.1111/j.1468-2311.2006.00420.x> [Accessed 22 October 2020].

Goomany, A. and Dickinson, T., 2015. The influence of prison climate on the mental health of adult prisoners: a literature review. *Journal Of Psychiatric And Mental Health Nursing*, [online] 22(6), pp.413–422. Available at: <https://0-onlinelibrary-wiley-com.wam.city.ac.uk/doi/full/10.1111/jpm.12231> [Accessed 25 October 2020].

Grieb, S., Crawford, A., Fields, A., Smith, J., Harris, R. and Matson, P., 2014. The Stress Will Kill You': Prisoner Reentry as Experienced by Family Members and the

Urgent Need for Support Services. *Journal Of Health Care For The Poor And Underserved*, [online] 25(3), pp.1183-1200. Available at: <https://0-muse-jhu-edu.wam.city.ac.uk/article/552193> [Accessed 23 October 2020].

Harding, D. J., Morenoff, J. D. and Wyse, J. J. B., 2019. *On The Outside: Prisoner Reentry And Reintegration*. 1st ed. London: The University of Chicago Press, pp.215-242.

Harman, J. J., Smith, V. E. and Egan, L. C., 2007. The Impact of Incarceration on Intimate Relationships. *Criminal Justice and Behavior*, [online] 34(6), pp.794-815. Available at: <https://0-journals-sagepub-com.wam.city.ac.uk/doi/pdf/10.1177/0093854807299543> [Accessed 25 October 2020].

Harty, M., Jarrett, M., Thornicroft, G. and Shaw, J., 2012. Unmet needs of male prisoners under the care of prison Mental Health Inreach Services. *The Journal Of Forensic Psychiatry & Psychology*, [online] 23(3), pp.285-296. Available at: <https://0-www-tandfonline-com.wam.city.ac.uk/doi/full/10.1080/14789949.2012.690101> [Accessed 25 October 2020].

Hopkin, G., Evans-Lacko, S., Forrester, A., Shaw, J. and Thornicroft, G., 2018. Interventions at the Transition from Prison to the Community for Prisoners with Mental Illness: A Systematic Review. *Administration And Policy In Mental Health*, [online] 45(4), pp.623–634. Available at: <https://0-link-springer-

com.wam.city.ac.uk/article/10.1007/s10488-018-0848-z> [Accessed 23 October 2020].

Howerton, A., Byng, R., Campbell, J., Hess, D., Owens, C. and Aitken, P., 2007. Understanding help seeking behaviour among male offenders: qualitative interview study. *The British Medical Journal*, [online] 334(7588), pp.303-313. Available at: <https://0-www-bmj-com.wam.city.ac.uk/content/334/7588/303> [Accessed 23 October 2020].

Jacobs, G., van Lieshout, F., Borgg, M. and Ness, O., 2017. Being a Person-Centred Researcher: Principles and Methods for Doing Research in a Person-Centred Way. In: B. McCormack, S. van Dulmen, H. Eide, K. Skovdah and T. Eide, ed., *Person-Centred Healthcare Research*, 1st ed. Chichester: John Wiley & Sons Ltd, pp.51-60.

Jenkins-Guarnieri, M. A., Wright, S. L. and Hudiburgh, L. M., 2012. The relationships among attachment style, personality traits, interpersonal competency, and Facebook use. *Journal of Applied Developmental Psychology*, [online] 33(6), pp.294-301. Available at: <https://0-www-sciencedirect-com.wam.city.ac.uk/science/article/pii/S0193397312000706?via%3Dihub> [Accessed 24 October 2020].

Kenny, M. E. and Rice, K. G., 1995. Attachment to parents and adjustment in late adolescent college students: Current status, applications, and future considerations. *The Counseling Psychologist*, [online] 23(3), pp.433-456. Available at: <https://0-journals-sagepub-

com.wam.city.ac.uk/doi/abs/10.1177/0011000095233003> [Accessed 24 October 2020].

Kinman, G., Clements, A. and Hart, J., 2017. Working conditions, work-life conflict, and well-being in u.k. prison officers: The role of affective rumination and detachment. *Criminal Justice And Behavior*, [online] 44(2), pp.226-239. Available at: <https://0-heinonline-org.wam.city.ac.uk/HOL/Page?lname=Kinman&handle=hein.journals/crmjusbhv44&collection=&page=226&collection=journals> [Accessed 5 June 2021].

Klockars, C. B., 1972. A theory of probation supervision. *The Journal Of Criminal Law, Criminology and Police Science*, [online] 63(4), pp.550-557. Available at: <https://0-www-jstor-org.wam.city.ac.uk/stable/1141809?pq-origsite=summon&seq=1#metadata_info_tab_contents> [Accessed 22 October 2020].

Liebling, A., Price, D. and Elliott, C., 2016. Appreciative Inquiry and Relationships in Prison. *Punishment & Society*, [online] 1(1), pp.71-98. Available at: <https://0-journals-sagepub-com.wam.city.ac.uk/doi/pdf/10.1177/14624749922227711> [Accessed 25 October 2020].

Liebling, A., Pricer, D. and Schefer, G., 2011. *The Prison Officer*. 2nd ed. Abingdon: William Publishing, pp.63-120.

Mearns, D., Thorne, B. and McLeod, J., 2013. *Person-Centred Counselling In Action*. 4th ed. London: SAGE Publications Ltd, pp.1-128.

Melnikov, S. and Kigli-Shemesh, R., 2017. Nurses Teaching Prison Officers: A Workshop to Reduce the Stigmatization of Prison Inmates With Mental Illness. *Perspectives In Psychiatric Care*, [online] 53(1), pp.251–258. Available at: <http://web.a.ebscohost.com/ehost/detail/detail?vid=0&sid=a34b79c4-f6ed-4159-b08e-9d0d60e57eb2%40sessionmgr4006&bdata=JnNpdGU9ZWhvc3QtbGl2ZQ%3d%3d#AN=125612966&db=ccm> [Accessed 5 June 2021].

Mills, A. and Kendall, K., 2016. Mental health in prisons. In: Y. Jewkes, B. Crewe and J. Bennett, ed., *Handbook on Prisons*, 2nd ed. London: Routledge, pp.187-199.

Mowen, T. J. and Visher, C. A., 2015. Changing the Ties That Bind: How Incarceration Impacts Family Relationships. *Criminology & Public Policy*, [online] 15(2), pp.503-528. Available at: <https://0-heinonline-org.wam.city.ac.uk/HOL/Page?handle=hein.journals/crpp15&id=505&collection=journals&index=> [Accessed 25 October 2020].

Mowen, T. J., Stansfield, R. and Boman, J. H., 2018. Family Matters: Moving Beyond “If” Family Support Matters to “Why” Family Support Matters during Reentry from Prison. *Journal Of Research In Crime And Delinquency*, [online] 56(4), pp.483-523. Available at: <https://0-journals-sagepub-com.wam.city.ac.uk/doi/10.1177/0022427818820902> [Accessed 23 October 2020].

Nagel, W., 1976. Environmental influences in prison violence. In: A. Cohen, G. Cole and R. Bailey, ed., *Prison Violence*. Massachusetts: Lexington Books, pp.135-146.

NICE, 2011. *Common Mental Health Problems: Identification And Pathways To Care*. [online] NICE, pp.13-40, 58-90. Available at: <https://www.nice.org.uk/guidance/cg123/resources/common-mental-health-problems-identification-and-pathways-to-care-pdf-35109448223173> [Accessed 25 October 2020].

Nurse, J., Woodcock, P. and Ormsby, J., 2003. Influence of environmental factors on mental health within prisons: focus group study. *British Medical Journal*, [online] 327(7413), pp.1-5. Available at: <https://0-www-bmj-com.wam.city.ac.uk/content/327/7413/480> [Accessed 23 October 2020].

Payne, S., 2007. Grounded theory. In: E. Lyons and A. Coyle, ed., *Analysing qualitative data in psychology*, 2nd ed. [online] London: Sage Publications Ltd, pp.119-146. Available at: <http://0-methods.sagepub.com.wam.city.ac.uk/book/analysing-qualitative-data-in-psychology?utm_source=ss360&utm_medium=discovery-provider> [Accessed 22 October 2020].

Potter, J. and Hepburn, A., 2005. Qualitative interviews in psychology: problems and possibilities. *Qualitative Research in Psychology*, [online] 2(4), pp.281-307. Available at: <https://0-www-tandfonline-

com.wam.city.ac.uk/doi/pdf/10.1191/1478088705qp045oa?needAccess=true> [Accessed 22 October 2020].

Prisons and Probation Ombudsman, 2016. *Learning From PPO Investigations: Prisoner Mental Health*. [online] London: Prisons and Probation Ombudsman, pp.5-37. Available at: <http://www.ppo.gov.uk/app/uploads/2016/01/PPO-thematic-prisoners-mental-health-web-final.pdf> [Accessed 25 October 2020].

Reed, J. and Lyne, M., 2000. Inpatient care of mentally ill people in prison: results of a year's programme of semistructured inspections. *The British Medical Journal*, [online] 320(7241), pp.1031-1034. Available at: <https://0-www-bmj-com.wam.city.ac.uk/content/320/7241/1031> [Accessed 23 October 2020].

Renik, O., 2000. Discussion of the Therapeutic Alliance. In: S. Levy, ed., *The Therapeutic Alliance*. [online] Madison: International Universities Press, pp.95-108. Available at: <http://0-www.pep-web.org.wam.city.ac.uk/document.php?id=zbk.073.0095a#p0095> [Accessed 24 October 2020].

Robinson, G., 2005. What Works in Offender Management?. *Howard Journal of Crime and Justice*, [online] 44(3), pp.307-318. Available at: <http://0-web.a.ebscohost.com.wam.city.ac.uk/ehost/pdfviewer/pdfviewer?vid=1&sid=01becc80-ac11-4637-b4dd-b15be52b8f8e%40sdc-v-sessmgr03> [Accessed 23 October 2020].

Rogers, C. R., 1980. *A Way Of Being*. New York: Houghton Mifflin Company, pp.5-26, 113-126.

Rogers, C. R., 1963. The actualizing tendency in relation to “motives” and to consciousness. In: M. R. Jones, ed., *Nebraska symposium on motivation*, 11th ed. Lincoln: University of Nebraska Press, pp.1-24.

Ross, C. E., 1995. Reconceptualizing Marital Status as a Continuum of Social Attachment. *Journal of Marriage and the Family*, [online] 57(1), pp.129-140. Available at: <https://0-www-jstor-org.wam.city.ac.uk/stable/353822?pq-origsite=summon&seq=1#metadata_info_tab_contents> [Accessed 24 October 2020].

Ross, E. C., Polaschek, D. L. L. and Ward, T., 2008. The therapeutic alliance: A theoretical revision for offender rehabilitation. *Aggression & Violent Behaviour*, [online] 13(6), pp.462-480. Available at: <https://0-www-sciencedirect-com.wam.city.ac.uk/science/article/pii/S1359178908000499?via%3Dihub> [Accessed 23 October 2020].

Sandvik, B. M. and McCormack, B., 2018. Being person-centred in qualitative interviews: reflections on a process Critical Reflection on Practice Development. *International Practice Development Journal*, [online] 8(2), pp.1-8. Available at: <https://www.fons.org/library/journal/volume8-issue2/article8> [Accessed 23 October 2020].

Schwartz, S. J., Weisskirch, R. S., Hurley, E. A., Zamboanga, B. L., Park, I. J. K., Kim, S. Y., Umana-Taylor, A,, Castillo, L. G., Brown, E. and Greene, A. D., 2010. Communalism, familism, and filial piety: Are they birds of a collectivist feather?. *Cultural Diversity and Ethnic Minority Psychology*, [online] 16(4), pp.548–560. Available at: <http://0-web.a.ebscohost.com.wam.city.ac.uk/ehost/detail/detail?vid=0&sid=90cd41df-6070-454d-b1a0-83b15e69a6bb%40sdc-v-sessmgr02&bdata=JnNpdGU9ZWhvc3QtbGl2ZQ%3d%3d#AN=2010-22619-012&db=pdh> [Accessed 24 October 2020].

Senior, J., 2015. Mental health in prisons. *Trends In Urology & Men's Health*, [online] 6(1), pp.9-11. Available at: <https://wileymicrositebuilder.com/trends/wp-content/uploads/sites/13/2015/01/Mental-health-in-prisons.pdf> [Accessed 25 October 2020].

Skogstad, P., Deane, F. P. and Spicer, J., 2006. Social-cognitive determinants of help-seeking for mental health problems among prison inmates. *Criminal Behaviour And Mental Health*, [online] 43(59), pp.43-57. Available at: <https://0-onlinelibrary-wiley-com.wam.city.ac.uk/doi/pdfdirect/10.1002/cbm.54> [Accessed 23 October 2020].

Simon, R. W. and Barrett, A. E., 2010. Nonmarital Romantic Relationships and Mental Health in Early Adulthood: Does the Association Differ for Women and Men?. *Journal of Health and Social Behavior*, [online] 51(2), pp.168-182. Available at: <https://0-www-jstor-

org.wam.city.ac.uk/stable/pdf/27800379.pdf?refreqid=excelsior%3A85cc28abd7504bbeabb5110c047b9a28> [Accessed 24 October 2020].

Smith, C., 2002. Healthy Prisons': A Contradiction in Terms. *The Howard Journal of Crime and Justice*, [online] 39(4), pp.339-353. Available at: <https://0-doi-org.wam.city.ac.uk/10.1111/1468-2311.00174> [Accessed 22 October 2020].

South, J., Woodall, J., Kinsella, K. and Bagnall, A., 2021. A qualitative synthesis of the positive and negative impacts related to delivery of peer-based health interventions in prison settings. *BMC Health Services Research*, [online] 16(1), pp.2-8. Available at: <https://0-www-proquest-com.wam.city.ac.uk/docview/1825036713?pq-origsite=summon> [Accessed 5 June 2021].

Stiles, W., Barkham, M., Mellor-Clark, J., & Connell, J. (2008). Effectiveness of cognitive-behavioural, person-centred, and psychodynamic therapies in UK primary-care routine practice: replication in a larger sample. *Psychological Medicine*, *38*(5), 677 - 688. doi: 10.1017/S0033291707001511.

Sykes, G., 1956. Men, merchants and toughs: A study of reactions to imprisonment. *Social Problems*, [online] 10(4), pp.130–138. Available at: <https://0-www-jstor-org.wam.city.ac.uk/stable/799118?pq-origsite=summon&seq=1#metadata_info_tab_contents> [Accessed 25 October 2020].

Tait, S., 2008. Care and the prison officer: beyond ‘turnkeys and ‘care bears’. *Prison Service Journal*, 180(1), pp.3-11.

Tedgard, E., Rastam, M. and Wirtberg, I., 2018. An upbringing with substance-abusing parents: Experiences of parentification and dysfunctional communication. *Nordic Studies on Alcohol and Drugs*, [online] 36(3), pp.223-247. Available at: <https://journals.sagepub.com/doi/10.1177/1455072518814308> [Accessed 24 October 2020].

Tyler, N., Miles, H. L., Karadag, B. and Rogers, G., 2019. An updated picture of the mental health needs of male and female prisoners in the UK: prevalence, comorbidity, and gender differences. *Social Psychiatry And Psychiatric Epidemiology*, [online] 54(1), pp.1143–1152. Available at: <http://0-web.a.ebscohost.com.wam.city.ac.uk/ehost/detail/detail?vid=0&sid=ca145114-c8d7-40ef-8758-da8fd60abd7c%40sessionmgr4006&bdata=JnNpdGU9ZWhvc3QtbGl2ZQ%3d%3d#AN=138414974&db=a9h> [Accessed 25 October 2020].

Van Orden, K. A., Witte, T. K., Gordon, K. H., Bender, T. W. and Joiner, T. E., 2008. Suicidal desire and the capability for suicide: tests of the interpersonal-psychological theory of suicidal behavior among adults. *Journal of consulting and clinical psychology*, [online] 76(1), pp.72-83. Available at: <http://0-web.a.ebscohost.com.wam.city.ac.uk/ehost/detail/detail?vid=0&sid=26dcec7c-a493-4af1-b62a-7a541e4310df%40sdc-v-

sessmgr01&bdata=JnNpdGU9ZWhvc3QtbGl2ZQ%3d%3d#AN=2008-00950-010&db=pdh> [Accessed 24 October 2020].

Vishner, C., Debus, S. and Yahner, J., 2008. *Employment After Prison: A Longitudinal Study Of Releasees In Three States*. [online] Urban Institute Justice Policy Center, pp.1-9. Available at: <https://www.urban.org/sites/default/files/publication/32106/411778-Employment-after-Prison-A-Longitudinal-Study-of-Releasees-in-Three-States.PDF> [Accessed 23 October 2020].

Wacquant, L., 2002. The curious eclipse of prison ethnography in the age of mass incarceration. *Ethnography*, [online] 3(4), pp.371–397. Available at: <https://0-www-jstor-org.wam.city.ac.uk/stable/pdf/24047814.pdf?refreqid=excelsior%3A7a7f849b6cba46cf803cd324693f0e32> [Accessed 22 October 2020].

Wallace, D., Fahmy, C., Cotton, L., Jimmons, C., McKay, R., Stoffer, S. and Syed, S., 2016. Examining the Role of Familial Support during Prison and after Release on Post-incarceration Mental Health. *International Journal Of Offender Therapy And Comparative Criminology*, [online] 60(1), pp.3-20. Available at: <https://0-journals-sagepub-com.wam.city.ac.uk/doi/10.1177/0306624X14548023> [Accessed 23 October 2020].

Walsh, E. and Freshwater, D., 2009. Developing the Mental Health Awareness of Prison Staff in England and Wales. *Journal of Correctional Health Care*, [online] 15(4),

pp.302-309. Available at: <https://0-journals-sagepub-com.wam.city.ac.uk/doi/abs/10.1177/1078345809341532> [Accessed 5 June 2021].

Western, B., Braga, A. A., Davis, J. and Sirois, C., 2015. Stress and hardship after prison. *American Journal of Sociology*, [online] 120(5), pp.1512-1547. Available at: <https://0-www-jstor-org.wam.city.ac.uk/stable/10.1086/681301?seq=1#metadata_info_tab_contents> [Accessed 25 October 2020].

Wilkins, P., 2003. *Person-Centred Therapy In Focus*. 1st ed. London: SAGE Publications Ltd, pp.8-18, 34-82, 90-99.

Williams, K., 2003. Has the Future of Marriage Arrived? A Contemporary Examination of Gender, Marriage, and Psychological Well-Being. *Journal of Health and Social Behavior*, [online] 44(4), pp.470-487. Available at: <https://0-www-jstor-org.wam.city.ac.uk/stable/1519794?pq-origsite=summon&seq=1#metadata_info_tab_contents> [Accessed 24 October 2020].

Willig, C., 2008. *Introducing Qualitative Research In Psychology: Adventures In Theory And Method*. 2nd ed. Berkshire: Open University Press, pp.15-51,149-161.

Willig, C., 2013. *Introducing Qualitative Research In Psychology*. 3rd ed. Maidenhead: McGraw Hill/Open University, pp.14-48.

Willig, C. and Stainton-Rogers, W., 2017. *The SAGE Handbook Of Qualitative Research In Psychology*. London: SAGE Publications Ltd, pp.240-256, 263-278.

Woodall, J., Dixey, R. and South, J., 2014. Control and choice in English prisons: developing health-promoting prisons. *Health Promotion International*, [online] 29(3), pp.474–482. Available at: <https://0-academic-oup-com.wam.city.ac.uk/heapro/article/29/3/474/760763> [Accessed 22 October 2020].

World Health Organisation, 2005. *Mental Health And Prisons Information Sheet*. [online] World Health Organisation, pp.1-5. Available at: <https://www.who.int/mental_health/policy/mh_in_prison.pdf> [Accessed 25 October 2020].

Wulf-Ludden, T., 2020. Interpersonal relationships among inmates and prison violence. *Journal of Crime and Justice*, [online] 36(1), pp.116-136. Available at: <https://0-www-tandfonline-com.wam.city.ac.uk/doi/full/10.1080/0735648X.2012.755467> [Accessed 25 October 2020].

Appendices

Appendix A – The Howard Journal of Crime and Justice Notes for Authors

The Howard Journal of Criminal Justice
Notes for Authors

Editorial Office: Institute of Criminology, University of Cambridge, Sidgwick Avenue, Cambridge, CB3 9DA 01223 511810
Editors: Prof. D Wilson, Birmingham City University; Prof. J. R. Lilly, Northern Kentuky University, USA.
Managing Editor: Ms. F. Crook, The Howard League
Book Review Editor: Prof. L. Gelsthorpe, University of Cambridge
Publishing Editor: Mrs. B.C. McWilliams, Freelance Publishing Editor
Publisher: Blackwell Publishers, Oxford

I. Nature of the Journal

The Howard Journal of Criminal Justice welcomes articles related to any aspect of the law enforcement, criminal justice and penal processes, as well as those dealing with the prevention of crime through social policy, community action, etc. It is keen to publish work not only on the UK but taking an international perspective, especially international comparative research.

The Journal aims to attract readers from the professions concerned with criminal justice, the penal services and crime prevention, from academics, and from interested lay people and voluntary workers. Contributions are welcomed from persons belonging to any of these groups. The agreed policy of the Howard League and the Editors is for a Journal which aims to publish material of good academic standard, but written so far as possible in a non-technical style, not overburdened with statistical tables or unnecessary jargon. Articles by a specialist in one field should be readily intelligible to those in other fields and hence to the interested general reader (who may be a criminal justice practitioner or Howard League member).

Authors should note that the members of the Editorial Advisory Group (EAG) are committed to a policy of anti-racism and anti-sexism in respect of the terminology used in the Journal. The aim of the EAG is to have submissions peer-reviewed in a timely manner. The Journal also utilizes an ‘early view’ publication system. Authors can follow electronically how often their article has been cited.

While published in conjunction with the Howard League, the editorial policy of the Journal is independent of the League.

II. Article Submission

ScholarOne Manuscripts Papers should be submitted to The Howard Journal of Criminal Justice online using ScholarOne Manuscripts. Benefits of online submission include:

- Fast decisions on your paper. Submission, review and communication are all handled online.

- Easy. Write your paper on any word processor. Simply save text as RTF or Word. Graphics can be uploaded separately in any popular format including tiff, EPS and Excel.

- Convenient. Submit from any computer with an Internet connection. No software needs to be installed. All you need is a Web browser, Acrobat Reader and email.

- Responsive. Decisions sent by email, revisions made online. The moment a decision is taken, an email is dispatched. You can respond to the comments and submit a revised version online.

- Transparent. Track your manuscripts online. Return to the site at any time to see the current status of your submission. To make a submission, please visit http://mc.manuscriptcentral.com/HOJO

III. General notes on copy

1. Short articles are welcome, but up to 8,000 words is acceptable.

2. Articles should be double spaced, and with good margins. Each new paragraph should be indented, except after headings, tables or quotations.

3. The article should be headed as in the following example:

PEOPLE TALKING ABOUT PUNISHMENT MICHAEL HOUGH
Professor of Social Policy, South Bank University

Titles should be kept as short as possible, while indicating the general theme of the article.

4. An abstract of not more than 100 words must follow the title.

5. To assist in accurate indexing of the article, please list at least four keywords (which may be short phrases) after the abstract.

6. The article should be broken up into sections with appropriate subheadings. These headings should be typed in the centre of the page, not underlined, with initial letters of main words in capitals.

7. If a quotation of more than a couple of lines is included in the text, it should be indented and typed single space. If italics appear in a quotation you should indicate in parentheses after the quotation whether the italics are in the original, or added by you: i.e. (italics in original) or (italics added). Please remember to indicate the original page numbers of all quotations, whether or not long enough to require separate indentation.

8. Authors should seek to avoid terminology which may be offensive to minority ethnic groups. Likewise neither male nor female pronouns, whether used consistently or alternately, should stand alone to refer to persons of both sexes; the preferred form where both sexes are named or implied is ‘he or she’, ‘his or hers’ etc. If authors are in any doubt the editors should be contacted for clarification.

9. Articles will normally only be accepted for publication on the understanding that they are not published elsewhere. (It is acceptable for authors to submit to the Howard Journal and another journal simultaneously, but on receipt of an acceptance from the Howard Journal it is expected that the author will immediately either withdraw all submissions elsewhere, or withdraw from the Howard Journal). Authors are required to sign an Exclusive Licence Form (ELF), which will be sent upon acceptance of an article.

IV. Tables and graphs

1. Statistical Tables should be kept to a minimum, but where they are essential to an article they are permissible. If tables are included they should be clearly marked up so that non-technical readers can understand them. A table should always be headed TABLE 1 (etc.) in capitals, then have a subject heading in capitals and lower case, italics, all at the top of the table. At the foot, there should be a note in parentheses giving the source of the data if the source is other than the author’s own data. An example is given below.

2. Horizontal rules may be used in the table (as in the example shown below), but no vertical rules may be used.

3. Each table should be prepared on a separate sheet, and gathered together at the end of the article. The position of the table in the article should be indicated by a short gap in the text with the legend:

(Insert Table 1 about here)

TABLE 3
The Relationship Between Length of Time at APEX Job and Type of Reconviction Record During Ten Years After Release

	Left APEX job				
	Within one month	Within three months	Within one year	Still working in APEX job after one year	Total

Frequent *and* serious	8	6	2	-	16
Serious but *not* frequent	3	-	1	-	4
Frequent but *not* serious*	3	4	1	-	8
Neither *frequent nor* serious*	8	12	6	9	35
	22	22	10	9	63

(*Note*: * Men who were not reconvicted during the ten-year follow-up period are included in this category.)
(*Source*: Soothill and Holmes 1981, p.32, *Table 3*.)

4. Wherever possible statistical material should be presented in tabular rather than graphical form. Where it is essential to use a figure, authors must bear in mind that it is the figure which they supply to the editors which will appear in a photographed form in the journal. Clear black drawings on plain A4 paper are essential, and as they will be shrunk to either one-half or one-quarter of that size when they appear in the journal they should be boldly drawn and titled.

V. Footnotes and references

The Journal draws a basic distinction between footnotes and references.

Footnotes are normally used only for explaining something additional to the text. Such footnotes should be kept to a minimum, and where used be gathered together at the end of the article (before the list of references) in a list headed Notes. This list should be in single spacing, but with a double space between each note.

N.B. Notes should not be placed at the foot of a page.

References are in the 'Harvard' system of referencing. This system gives the author and date in the text of the article whilst the full reference is cited in an alphabetical list at the end of the article, after the Notes. Full details of the referencing system are given in the next section.

VI. Details of referencing

1. *References in the text of the article*
   a. Normal references are in the following forms:

i. Various authors have shown (Walker 1969; Thomas 1970) that sentencing is .....

or ii. As Nigel Walker (1969) writes .....

or iii. This was confirmed in a further study (Walker 1969, p.69), where it was found .....

iv. If more than three authors, cite Walker et al. 1968; if three or less, cite all authors.

b. Where the same reference has been quoted more than once, repeat the form given in (a) above. Please do not use the expressions '*ibid;* or *'op. cit*.'.

c. Where you have cited more than one work by the same author published in the same year, add a lower case letter of identification: (Walker 1969a), (Walker 1969b).

d. Please do not use the number form of references, i.e. Walker (1) has written .....

e. Some references cannot easily be reduced to the above forms, such as newspapers, parliamentary debates, etc. In such cases it is usually permissible to put the reference in the text (in parentheses if appropriate) without any listing in the list of references at the end; e.g. (*The Times*, 31 July 1977). References to legal cases should usually appear in this way – e.g. *Shaw v. DPP* ([1962] AC220); *In Re Gault* ([1967] 387 USI).

Where the length of such an insertion would make it too unwieldy to place in the text, it may be given in the notes at the end of the article: e.g. in the case of references to unpublished historical manuscripts.

2. *List of references at the end of the text (see examples in (3) below*)

a. The list is alphabetical by author's surname (in lower case). This should be followed by author's initial(s) (*not* full forename(s)) and then by the year of publication in parentheses.

b. Where more than one work by the same author has been cited, list these chronologically.

c. Where you have cited more than one work by the same author published in the same year (see 1(c) above) list them with the author's name followed by each work in alphabetical title order.

d. If the name used in the text is that of an editor, e.g. of a collection of papers, it should appear in the *text* as (Ruck 1951), but in the list of references it becomes: Ruck, S.K. (Ed.) (1951).

e. If a work has two authors (or editors) use '(x) and (y)' e.g. Walker, N.D. and McCabe, S. (1973) .....

or Jones, B.S. and Smith, J. (Eds.) (1973).....

f. Please list all authors in references list (i.e. do not use *et al*.).

g. In the case of a *book or pamphlet*, the author's name and year of publication should be followed by:

the title of the book (in italics and with initial letters in capitals), the edition or volume (if appropriate), the place of publication, the publisher. (See examples 3(a), 3(b), and 3(c) below, which also show the appropriate punctuation).

h. In the case of a *pamphlet* or *occasional paper* which is part of a series put the name of the series and the number of the paper in brackets after the title. (See example 3(d) below). N.B. This instruction applies to pamphlets in the Home Office Research Studies, which should appear under author's name and *not* under 'Home Office'.

i. In the case of a *journal article*, the author's name and year of publication should be followed by: the title of the article (*in single inverted commas*, with initial letters in lower case except for that of the first word), the full name of the journal (in italics), the volume number (in italics), the first and last page numbers of the article. (See example 3(e) below, which also shows the appropriate punctuation).

N.B.

i. Do *not* use 'pp.' with page numbers in listing journal articles, etc.
ii. Do *not* put the issue number after volume number except for articles from weekly periodicals. (See example 3(g) below). If you prefer you may use the date of the weekly rather than the issue number, *as long as first and last pages of the article are recorded.*
iii. The format for citation varies slightly if it is an article in a book or pamphlet. (See example 3(f) below).

j. British Official Publications should be listed by the name of the department, e.g. Home Office. (See example 3(h) below).

or by the name of the author (especially with Research Studies, cf. 2(h) above)

or by the name of the report if obviously well known, e.g. Kilbrandon Report (1964)

N.B. Advisory Council papers should be listed under Advisory Council and not as Home Office (see example 3(i) below).

These publications should be followed by the 'Command Number' if appropriate (see example 3(h)), or, if not a Command Paper, as 'London: HMSO.' (See example 3(i)). Please note that HMSO is a publisher and *not* an author.

k. *Foreign Official Publications*: list by the *name of the country or state*, followed by the name of the issuing agency, e.g. United States, Federal Bureau of Prisons. These should include place of publication and publisher, e.g. Washington, DC.: GPO. (See example 3(j) below).

l. *Unpublished theses, papers, etc.:* The title should be in single inverted commas, and at the end state in *parentheses* the source: e.g. (unpublished PhD thesis, University of Manchester); (unpublished address to Howard League Annual General Meeting, October 1976). *This should normally include the word 'unpublished', so that librarians do not waste time searching for the item among published sources.*

3. *Examples of references*
   a. Walker, N.D. (1969) *Sentencing in a Rational Society*, London: Allen Lane.

   b. Walker, N.D. (1972) *Sentencing in a Rational Society*, 2nd edn, Harmondsworth: Penguin.

   c. Walker, N.D. and McCabe, S. (1973) *Crime and Insanity in England*, vol. II, Edinburgh: Edinburgh University Press.

   d. Walker, N.D. *et al.* (1970) *The Violent Offender; Reality or Illusion?* (Oxford University Penal Research Unit Occasional Paper No. 1), Oxford: Blackwell.

   e. Wenk, E., Robinson, J. and Smith, G.W. (1972) 'Can violence be predicted?', *Crime and Delinquency, 18*, 393–402.

   f. Walker, N.D. (1968) 'Hospital orders and psychopathic disorders', in: D.J. West (Ed.), *Psychopathic Offenders*, Cambridge: Institute of Criminology.

   g. Walker, N.D. (1968) 'The choice of sentence', *New Society*, 12(312), 404–6.

   h. Home Office (1969) *People in Prison*, Cmnd. 4214.

   i. Advisory Council on the Penal System (1977) *The Length of Prison Sentences*, London: HMSO.

   j. The Netherlands, Ministry of Justice (1985*) Society and Crime: A Policy Plan for the Netherlands*, 's-Gravenhage, The Netherlands: Ministerie van Justitie.

For further examples see recent issues of *The Howard Journal of Criminal Justice*.

VII. Proofs
Proofs of accepted articles are sent to authors for correction via email. Authors should take particular care with proof corrections; the Editors cannot accept responsibility for any errors or omissions which authors fail to rectify.

Alterations to the text (other than corrections) at the proof stage are *very costly, and will not normally be allowed*, Authors should therefore take particular care to ensure that their final manuscript is free from errors.

In the case of authors who may be unavailable at the time when the proofs need to be checked, we usually expect the author to allow the Editors to carry out proof-reading in order to save production time. If this is not acceptable the author *must* advise the Editorial Office of where they may be contacted at proof stage.

VIII. Authors' copies and offprints
According to the terms of our contract with the Publishers, authors receive a pdf of their article.

Offprints, if required, can be ordered at proof stage on the order form, which will be sent to authors with the proofs of their article.

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