‘Helping not hurting’: Learning from the experiences of prisoner peer caregivers and care receivers in a UK prison to improve peer care practices in custodial contexts.

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This thesis is submitted in partial fulfilment of an Educational Doctorate degree programme undertaken at the School of Education, University of Brighton

Abstract

Over the past two decades the proportion of older prisoners has increased dramatically from 7% to 17% of the total prison population in England and Wales. This is problematic, as their needs are holistically different to their younger counterparts and prisons are not designed for issues associated with older adulthood. An increase in human frailty, disability and dependency has exposed problems within the local and national prison systems, and this has raised numerous financial and managerial issues for prison administrators. These issues are set against a backdrop of reduced funding, overcrowding, increasing violence, increasing self-harm and suicide.

The aim of this study is to contribute to new understandings that can mitigate the effects of an increasingly ageing and infirm population by developing the amount and quality of peer caregiving – namely, low-level, preventative peer social support. The research was undertaken in a Category B UK prison with a higher-than-average proportion of older prisoners.

The study investigates the factors that explain the current situation, inhibit the processes of peer caregiving and other factors that might promote better caregiver/receiver relations in a prison setting. Data was collected using mixed qualitative methods (participant observation and interview). The related literature was reviewed, and ethics of care, criminological theories of personal development and theories of social learning were used as theoretical frameworks to analyse the data. Analysis enabled the clustering of quotes, observations and researcher notes into the following emergent themes:

1. Immediate precarity and longer-term risks.
2. Expressions of care in prison.
3. Caregiving and personal development.
4. Learning to peer care.
5. Purpose and power: working relationships, official guidance, leadership.

Prisoner peer caregiving is identified as a relatively new discourse and practice that is in tension with better-established discourses and practices of security, control and managerialism. The current situation is explained in terms of dominant discourses and practices and neo-liberal imperatives in the fields of health and social care and justice. Developing models of horizontal care, supported by social forms of learning, are recommended as contributing to improving peer care practice in prisons.

Author declaration (Declaration of Authorship)

I, Warren Lee Stewart, declare that this thesis and the work presented in it, to be my own work, and it has been generated as the result of my original work.

Title: **'Helping not hurting': Learning from the experiences of prisoner peer caregivers and care receivers in a UK prison to improve peer care practices in custodial contexts.**

I confirm that:

1. This work was completed solely by me while undertaking research for the Educational Doctorate at University of Brighton, between 2017 and 2021.
2. Some of the work has been published in journal articles before submission.
3. I have acknowledged sources of support and help.
4. I have clearly referenced other sources of information.

Signed: Warren Lee Stewart
Date: July 2021

Dedication: To all of the staff and participants at the research site, specifically the onsite health care manager, without whom the whole experience would have been extremely difficult.

Acknowledgements: To Dr Nadia Edmond and Dr Lizzie Ward, the words 'thank you' will never be enough. Thank you for walking with me on this epic road, for your amazing 'super-vision', advice, humour, inspiration and comfort.
To my lovely family: Dawn, Arthur and Maisie. Thank you for your understanding and patience – know that I am so proud of each of you.
To my school for supporting me; the commitment has not been taken for granted.

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Part 1: Research context and preparation for undertaking the research

Chapter 1. Introduction and background

This thesis investigates the current provision of peer caregiving and the possibility of developing learning to peer care in an English prison. The research exposes and problematises existing practices and renders visible the influence of wider discourses and ideologies on practice. It is hoped that the research will prompt practitioners and administrators to think differently about how peer care is perceived and organised, for the betterment of the whole prison community.

The research stems from my professional involvement of organising care and learning in custodial settings (see Appendix 1.3. Reflective notes on the motivation to undertake the study, page 230). The work has evolved inductively, based on my experiences, observations, reading, critical reflection and reflexivity. In keeping with the idea of Tran et al (2018), I will adopt a strategy of using language that normalises rather stigmatises the participants. Refer to Appendix 1.1. Abbreviations and glossary of terms, page 226, for a full explanation of acronyms, definitions and key terms.

This chapter begins by establishing the context for the research and by setting out the aims of the study. It then discusses the main groups of participants, establishing a general picture of their health and social needs. It is my best hope that the following sections will help the reader to imagine life as an older and disabled adult incarcerated in later life.

Summary of the previous phases of research

The current study evolves from my involvement in two earlier phases of investigation, including a project initiated by the Department of Health and Social

Care (DHSC), followed by a pilot study for this thesis (for a full description of these phases of investigation and training, see Appendix 1.7. Earlier cycles of investigation and context of the current study, page 235). The pilot phase included a review of the literature on peer caregiving in prisons between 2000 and 2015 (see Stewart and Edmond, 2017) and an action research project designed to implement and evaluate peer care training interventions (see Stewart and Lovely, 2017; Stewart, 2018). The pilot was undertaken at the same research site, taking place over 25 working days, over a four-month period. This practical, fact-finding endeavour helped to establish the working relationships necessary for the thesis stage; however, the local staff did not feel confident to continue with the training after the pilot.

The findings from each of the previous phases coupled with the results from the recent literature review (Chapter 2, page 29) helped to shape and inform the aims and objectives of this thesis. The literature review made recommendations in relation to the inclusion of the recipients of caregiving and to the methodological approaches for the next stage of research.

Study aims

Although the pilot study was generally productive, it did not capture the views of the older and disabled prisoners (ODPs) or provide direct observations of caregiving practices. These omissions were noted in the preliminary pilot research and identified as a limitation of the work. It therefore became the intention of this research to generate new knowledge by extending and developing the aims of the pilot study, by investigating the factors that enable and impede peer caregiving processes, by giving visibility to the practices of the caregivers, and by gathering the perspectives of the peer caregivers, key informants and the ODPs themselves.

The study aims to derive a range of perceptions and meanings via the generation of observations and by giving voice to the participants, through sensitive descriptions and analysis, of the pains and gains associated with peer caregiving and receiving,

and by developing understandings of individual motivations for engaging with the role, including what difference they feel this may make to their futures.

The study is situated within a critical realist philosophical framework, making use of critical reflexivity in all aspects of the research. The study aims to establish peer care in prisons as an emerging social practice, and proposes the development of safe, effective caregiver training, and amendments to other organisational practices. It is hoped the study could contribute towards positive outcomes for other service users in the environment, and service users in similarly confined settings with similar populations, and generate original knowledge in the field.

Details of the research site and care dyads

The research site for this study will be known henceforth as Her Majesty's Prison (HMP) A. HMP A is classified as a security category 'B' training prison (Ministry of Justice (MOJ), 2017) (see Appendix 1: Research context, page 227, for a fuller description of the security classifications and the research site). HMP A is an amalgamation of two co-located prisons, occupying a substantial geographic footprint. It holds a population of 1,100 male prisoners over the age of 21 years who are regarded as vulnerable prisoners (VPs), on the basis of being convicted to life or lengthy sentences for sexual offences. Services are commissioned by Her Majesty's Prison and Probation Service (HMPPS), falling under the jurisdiction of the Ministry of Justice (MOJ).

The research was mostly conducted in four residential areas, referred to as house units (HUs), see Figure 1 below. HU1 is a modern building designated as the main social care area for the prison; it accommodates 28 ODPs located on the ground floor to assist with mobility issues. Six prisoner peer caregivers (referred to locally as buddies) were allocated to attend to this group's functional health and personal-care needs. HU2 is located adjacent to HU1, and it is known as the 'induction wing'. HU2 had two permanent peer caregivers supporting a low but variable number of ODPs (six at the time of data collection). HUs 3 and 4 are situated in the original Victorian

section of the prison, with gallery-style wings, built on five levels (with no lift facilities). HU3 has a maximum roll of 130 prisoners of mixed ages; it has 29 ground-floor cells occupied by ODPs. At the time of data collection there were four caregivers overseeing eight relatively dependent ODPs, and 21 less dependent ODPs. HU4 is a smaller wing attached to HU3. It has a maximum roll of 79 prisoners, with approximately six ODPs supported by two peer caregivers. In all locations in HMP A, the ODPs occupied single cells.

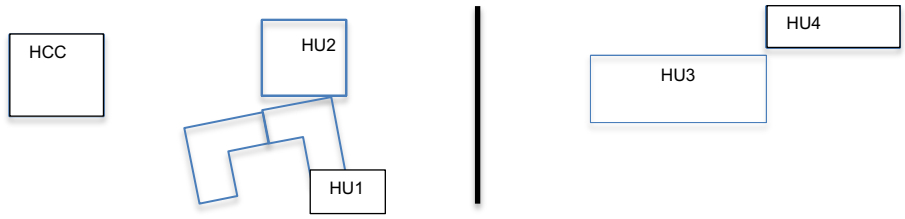


Figure 1: Visual representation of regularly visited buildings. The figures in this diagram are partially disguised in accordance with HMPPS security restrictions, (MOJ, 2021).

House unit	Total number of prisoners	No. of ODPs	No. of caregivers
1	88	28	6
2	60	6	2
3	130	8 (+21)	4
4	72	6	2

Table 1: Summary of the number of ODPs and caregivers by location

ODPs and social care in prisons

Older prisoners are the fastest rising sub-group in the prison demography. This trend is expected to continue, with figures predicted to rise from 13,616 in 2018 to 14,100 in 2022 (MOJ, National Statistics, 2018). The causes of this development are multifactorial, including an increase in life expectancy, higher custody rates, an increase in people committing crime in later life and targeted drives to retrospectively prosecute historic sex offences (Prisons and Probation Ombudsman (PPO), 2017; MOJ, 2018). Consequently, the number of older prisoners continues to increase,

both in numbers and as a proportion of the general prison population (PPO, 2017; MOJ, 2018). International research shows that other anglophone countries are also grappling with issues associated with ageing prisoner populations (Bureau of Justice Statistics, 2016). This issue is perhaps most acute in the US, where, if sentencing trends continue, older prisoners will account for one-third of the total prison population by 2030 (Rikard and Rosenberg, 2007).

From a UK perspective, the number of ODPs with social care needs is difficult to estimate (Lee et al., 2016). In 2014, the Association for Directors of Adult Social Services (ADASS) estimated there to be approximately 3,500 prisoners in England and Wales in need of social care (ADASS, 2014). A more recent national survey of social services managers (2016) identified 1,800 prisoners as having social care needs; of these, 1,600 were referred for assessment and 800 were deemed eligible for the provision of statutory care and support (Local Government Association, 2016). Despite such high incidences of age-related problems, prison administrators have been slow to respond to the social, physical and mental health needs of this sub-group of prisoners (Aday and Krabill, 2013; Forsyth et al., 2019).

The level of formal social care in UK prisons has received severe criticism in recent years (O'Hara et al., 2015; PPO, 2017; Her Majesty's Inspectorate of Prisons (HMIP) England and Wales, 2018; HMIP Scotland, 2019). The combination of increasing numbers of frail, ageing and disabled prisoners and insufficient social care (Tucker et al., 2018) presents significant practical, legal and economic challenges for prison managers (ADASS 2016; HMIP, 2018). Furthermore, social care in prisons falls short of the target of parity with community services, as set out in the Care Act (2014) (Tucker et al., 2018). Consequently, prison officers have come under pressure to provide social care, mental health care, palliative care, as well as their custodial role, and this is without adequate training and support (Brooke and Jackson, 2019; Turner and Peacock, 2017). Owing to the recent increase in publicity on older prisoners (BBC, 2019; Ford, 2019), it is a problem that cannot be overlooked by health and social care policymakers.

Policy

Despite repeated recommendations (HMIP 2004, 2008; Justice Select Committee, 2013), HMPPS has resisted calls for a dedicated national strategy for older prisoners; this has been justified by a perception of diversity within the older prisoner profile (Forsyth et al., 2019). This amounts to a view that prisoners should be managed on the basis of individual needs, not on the basis of age (MOJ, 2014). HMPPS has continued to pursue a policy of mainstreaming older adults into the general prison population, meaning both the regime and environment are undifferentiated by age and ability. Interestingly, the American Correctional Association also recommends that prisoners should be classified by level of physical impairment, regardless of age (Wick and Zanni, 2009). Consequently, many ODPs are housed in accommodation that is unsuited to their needs, increasing their vulnerability and making adaptation to the environment, culture and prison regime difficult (Turner and Peacock, 2017). Moreover, it is argued that this can lead to the exclusion of ODPs from services or activities (Wahidin and Aday, 2010; Crawley and Sparks, 2005).

Several authors highlight that a failure to provide appropriate adjustments to support this group could result in potential breaches of the Human Rights Act (1998), Prison Rules (1999), Equality Act (2010), United Nations Standard Minimum Rules for the Treatment of Prisoners (2015) and Care Act (2014) (Levy et al., 2019; Tucker et al., 2018; Forsyth et al., 2019). Prior to the Care Act (2014), the responsibility for the care of this group fell to local prison health care providers and prison administrators under a duty of care (Forsyth et al., 2019). This was regarded as contentious for several reasons, namely a reported near-absolute lack of social care and disputes over decision-making and funding for care interventions (Williams, 2012; Prison Reform Trust (PRT), 2014; Lee, 2016). In response to the Care Act, the National Offender Management Service (NOMS) produced three Prison Service Instructions (PSI): 15/2015 Adult Safeguarding in Prison, 16/2015 Adult Social Care and, most relevant in the context of this study, 17/2015 Prisoners Assisting Other Prisoners. More recently, but after data collection, the following document has been produced: Modes of Delivery – Older Prisoners, a guidance document (HMPPS, 2018).

Although these documents contribute towards guidance in respect of care of older, disabled and frail prisoners, there remains a policy grey area for the section of the population that have non-medical needs but do not qualify for statutory social care.

Defining ODPs

50 years of age was found to be the most widely utilised age for the recognition of older age and age-based interventions in prisons (Hayes et al., 2013; Age UK, 2019). This is a full 15 years lower than the equivalent for older age in the community and currently 16 years lower than the age of retirement for men (Department for Work and Pensions, 2017). Premature ageing among offenders is due to a complex range of factors, including socio-economic status, lifestyle choices, access to preventative health care and institutional stresses (Wahidin and Aday, 2010).

45% of prisoners over 50 years of age are convicted of sexual offences (PRT, 2017). The rate of imprisonment for sexual offending in the UK is 7.3%, compared with the European average of 3.7% (Council of Europe, 2017). The PRT identified four sub-groups of older prisoners, each with distinct characteristics: ‘repeat prisoners’ or revolving door prisoners sentenced for less serious offences; ‘grown old in prison’, those given a long sentence prior to the age of 50 who have aged in prison; ‘first-time prisoners given a short sentence’; and ‘first-time prisoners given a long sentence’ (PRT, 2016). The latter category most closely reflects the status of the participants in this study. As a generality, this group comes from different socio-economic backgrounds from the rest of the prison population, having a higher educational attainment, financial security and higher social status throughout their lives (Turner et al., 2018).

The number of older offenders being sentenced to custody is currently higher than the number being released, a statistic being driven by increases in sexual offence proceedings since 2012. This effect is compounded by more severe sentences, higher numbers of sentence recalls and an ageing lifer population (MOJ, 2018).

Nearly all those over 80 were sentenced when they were aged 70 or over and there are increasing numbers of the 'oldest old', those aged 85 and over (PRT, 2017). Older prisoners are at increased risk of intimidation because of their status, their frailty and because they are more likely to require medication, which is a sought-after commodity in prison (Turner et al., 2018).

Within the research site the number of ODPs in need of social support varied, depending on changes to the prison population. At the time of data collection, only two ODPs met the criteria for statutory funded social care. In accordance with the Care Act (2014), these prisoners had been assessed as having non-medical needs by externally based local authority (LA) social workers and received daily visits from external social carers. There were a further 70 ODPs who were referred for assessment but did not meet the threshold for statutory social care. However, these ODPs were considered to be in need of various adjustments, safeguards and levels of support to maintain their dignity, health and safety, as well as their activities of daily living (ADLs), such as cell cleaning and accessing activities. It is this group of prisoners who would most benefit from preventative, peer personal care. Administrators at the research site operated a policy of clustering the ODPs with the greatest need within specific areas of the prison (ground-floor corridors in HU1 and HU3) – the remaining ODPs were dispersed in various other residential wings.

ODPs as vulnerable research participants

By definition, prisoners are vulnerable; however, imprisoned sex offenders are deemed especially so (Riccardelli, 2014; Riccardelli & Spencer, 2014). The prisoners at the research site were males convicted of sexual offences (MCSOs); the function of the prison was essentially to rehabilitate sexual offenders. In this section, I discuss some of the factors that identify ODPs who have been convicted of sexual offences as a vulnerable sub-population.

Researching vulnerable and marginalised people is associated with the concept of 'sensitive research'; this is often undertaken with 'hidden' or 'hard-to-reach'

populations (Liamputtong, 2007). These groups of people are often ‘the silent, the hidden, the deviant, the tabooed, the marginalised and hence ‘invisible’ populations in society’ (Stone, 2003, p149). Campbell (2002) suggests that sensitive research focuses on the ‘difficult’ issues, such as abuse, trauma, illness, death and crime. Moore and Miller (1999, p1,034) contend that vulnerable individuals ‘lack the ability to make personal life choices, to maintain independence, and to self-determine’. These populations include people who are disenfranchised, impoverished or subject to discrimination, subordination and stigma (Nyamathi, 1998). Stone (2003) suggests that vulnerable individuals are people suffering from chronic physical and mental illness – significantly, in relation to the aims of the study, this includes the caregivers of the chronically unwell. All of the above sources of vulnerability are associated with the experience of older adulthood in prisons.

In male prisons, sex offenders are the most victimised group of prisoners (Riccardelli and Spencer, 2014). Researchers have used the expressions ‘ultramasculine’ (Sabo, Kupers and London, 2001) or ‘hypermasculine’ (Jewkes, 2004) to describe the expression of masculinity within male prisons. Sabo, Kupers and London (2001, p6) suggest these forms of masculinity enable ‘elite males to extend their influence and control over lesser-status males within inter-male dominance hierarchies’. This causes ‘secondary exclusion’ (Ievins and Crewe, 2014), which can serve to weaken support, increase their sense of insecurity and, hence, increase their vulnerability to stress, depression and other ill health (Melrose 2002).

Being categorised as a sex offender can subject one to hatred, scorn and persecution. Media representations often function as expressions of disdain and disgust for individuals with sex offending histories (Tolson and Klein, 2015). Sex offenders often report experiences of stigmatisation and isolation from their families and communities as a result of their labelled status. This leads them to be distrustful of outsiders, including researchers (Medlicott, 2004). As such, sex offenders are, ordinarily, extremely difficult to access for research, both in the community (Reeves 2010) and in prisons (Blagden and Pemberton, 2010). Although the prison conditions are relatively minimal, there were various salutogenic processes in the environment (for example, the provision of on-site health care services and opportunities for social

engagement). Moreover, while the participants are regarded as vulnerable, they had been convicted of perpetrating abuse to other, more vulnerable populations, at earlier stages in their lives.

All but three participants in the ODP sample were convicted of historic sexual offences in later life, indicating that the majority were convicted of crimes committed at some time in their distant past. Older adults being admitted into prison for the first time face specific problems adapting to the environment, a phenomenon termed as ‘entry shock’ (DH, 2007). Furthermore, they are considered to be particularly vulnerable to exploitation and victimisation (Crawley and Sparks, 2005; Mann, 2012). Marquart, Merianos and Doucet (2000) found that older inmates feared psychological, physical and financial exploitation from younger inmates, and they expressed a preference to be accommodated with inmates of broadly the same age. Taken together, such concerns can affect the well-being of ODPs and place them in positions where they feel the need to withdraw from social situations or decline opportunities for activity and involvement (Harrison, 2009; Aday and Krabill, 2013).

Additional problems can include developing new relations in prison, grief processes based on the loss of relationships and community, negative emotions in relation to their offences, fear related to their health, isolation, suicidal ideation, unrealistic expectations of health and care services in comparison to the community and difficulties adjusting to communal living (Aday and Krabill, 2013; Paluch, 2004). Other intrinsic fears and concerns can develop as they progress through their sentences, including the strain of separation, fears of outliving family members, concerns in relation to the skills needed for reintegration and a lack of appropriate prison activity to help maintain self-esteem (Chu, 2018). Increased worries can impact on their mood, elevate the risk of falls or injury or increase their fears for their personal safety, indicating a need for increased staff sensitivity to potential risks and the need for supportive interventions (Aday and Krabill, 2013).

Physical health needs of ODPs

The health and social care needs of older prisoners are complex and characterised by higher rates of mental disorders, learning disability, acute and chronic physical conditions, substance misuse, blood-borne viruses and communicable diseases (Justice Select Committee, 2013; NHS, 2016). Older prisoners are known to import a wide range of health and social care needs with them into prison and develop further problems while serving their sentences (Fazel et al., 2004; Ginn, 2012; House of Commons Justice Committee, 2013). For example, in a UK study of over 200 male prisoners aged 60 years and over, it was found that 83% reported a longstanding illness or disability (Fazel et al., 2004). This accords with evidence from the US by Sterns (2008), which shows that 45% of prisoners over 50 and 82% of prisoners over 65 have chronic health problems. In Canada, 46% of inmates over 50 are reported as having health problems at the time of entry to prison (Beckett, Peterneli-Taylor & Johnson, 2003). In comparison with their community peers, older male prisoners report a higher level of chronic conditions, including arthritis, hypertension, cardio-vascular disease, emphysema, diabetes and gastro-intestinal problems (Smyer and Gragert, 2006). Consequently, older prisoners generally require more medical care than younger prisoners (Cohn, 1999).

Explanations for poorer health include combinations of high-risk behaviours such as smoking, drug and alcohol use, poor diets, the stress associated with an abusive past, a lack of access to preventative health care, unhealthy lifestyles while in prison – including sleep disturbance and lack of exercise – and the harshness of prison life (Mann, 2012).

Functional health – activities of daily living

In line with the ‘age-crime curve’ concept (Mann, 2012), prisons are essentially designed to accommodate younger, active inmates, whereas older, disabled and frail prisoners are known to find the environment a challenge to their capabilities (Greene et al., 2018). Aday and Farney (2014) found that 89% of ODPs faced difficulties walking independently, 66% had problems ascending stairs, 49% needed ground-

level accommodation and 86% needed a lower bunk bed. Several ODPs also struggled with instrumental activities of living, such as managing their financial accounts and remembering when to take their medication. Furthermore, according to Liegey et al. (2013), older individuals faced challenges responding to various prison-specific processes dubbed as prison activities of daily living (PADLs); these included hearing and responding to verbal orders, understanding the need for security spot checks and difficulty collecting their meals at busy times.

However, it should be noted that not all older prisoners have impairments or long-term conditions (LTCs) and, additionally, some may thrive in the environment (Mann, 2012). Equally, some younger prisoners under the age of 50 have physical, cognitive and sensory impairments and require medical and personal care. Therefore, ODPs should be recognised as a diverse, heterogeneous group with mixed demographic backgrounds, offending histories and health-related needs.

Mental health needs of ODPs

In addition to higher rates of physical and sensory impairments, there is a higher prevalence of mental distress among older prisoners when compared with community equivalents (Fazel et al., 2016; National Audit Office, 2017; Forsyth, 2019). For those entering prison with fragmented external support networks or a lower sense of self-esteem, prison environments can serve as a source of stress, leading to further deteriorations in mental well-being (Aday and Krabill, 2013). Moreover, offending histories and sentence lengths may be a determinant of the stress faced while in prison.

According to the National Audit Office (2017), 31,328 UK prisoners reported some form of mental distress, while 7,917 had treatment for mental illness while in prison. Despite ambitious objectives for the management of mental illness (National Health Service (NHS) 2016; NHS England, 2016), both self-harm incidents (52,814) and self-inflicted deaths (120) continue to rise in prisons and are currently at the highest rates ever recorded (MOJ, 2019). Middle-aged offenders have been reported to

require more frequent treatment for depression, anxiety, substance abuse, personality disorders and schizophrenia. Problems with conditions such as depression are more likely to be somatised in older males (Age UK, 2019). More specifically, those of advanced age may require treatment for depression, anxiety, Alzheimer's disease and the dementias (Yarnell et al., 2017; Combalbert, 2018). Sterns (2008), suggests that older prisoners struggling with depression may simply reduce their levels of activity, withdrawing from social situations, becoming virtually invisible.

In the US, surveys have projected the numbers of geriatric inmates with mental illnesses to be in the range of 40% (James and Glaze, 2006). More recently in the UK, Forsyth et al. (2019) found 7% of their sample (or an estimated 953 prisoners in England and Wales) to have dementia or mild cognitive impairments. However, because of the increased frequency of comorbidity with other long-term conditions and the regimented lifestyle of prisons, that figure is expected to be much higher. Wilson and Barboza (2010) described some cases in which cognitively impaired prisoners could not recall the reasons why they are in prison.

End-of-life issues among ODPs

In 2019, there were 165 deaths in prisons via natural causes, excluding deaths by drug overdoses, homicide and suicide (MOJ, National Statistics, 2019). The average age of death from natural causes in prison is 56 compared with 81 in the community (Shaw et al., 2020). This can be compared with the 17,358 deaths in US correctional institutions between 2007 and 2010 (Bureau of Justice Statistics, 2015). The figures reflect the higher rate of imprisonment, higher population and more severe sentencing policies (for example, life without parole and the 'three strikes and you are out' policy.

Deaton, Aday and Wahidin (2009) report that older prisoners frequently engage with thoughts about dying. To many prisoners, the thought of dying in prison is extremely distressing and a source of bitter regret (Bolger, 2004). Release on compassionate

grounds or temporary licence are rare, with only 45 prisoners between 2009 and 2013 granted early release in England and Wales (PRT, 2014). While some prisoners die suddenly, for a range of reasons many prisoners elect to die in prison as opposed to hospices – these include the stigma associated with their offences, a lack of supportive community networks and a preference to die in familiar surroundings (Turner and Peacock, 2017). The combination of longer sentences and reduced use of compassionate release means many older prisoners are serving 'de facto' life sentences (Turner et al., 2018).

The cost of providing health and social care in prison

An increasingly vulnerable and dependent ageing prison population is likely to be one of the biggest issues facing the UK criminal justice system (Tucker et al., 2018; Lee et al., 2019).

Prisoners remain patients of the NHS while sentenced and are entitled to health services within prison or other services outside of prison (Turner and Peacock, 2017). However, internal prison health care services continue to receive criticism from a range of sources (Forsyth et al., 2019). In 2004, Fazel et al. found that a broad range of mental and physical health concerns had been reported but remained untreated in older prisoners. Aday and Wahidin (2009) found that existing symptoms are susceptible to further deterioration as prison health care services tend to lag behind mainstream medicine in terms of being able to offer the necessary treatment options. Stroller (2003, p2,263) suggests that access to health care in prisons is 'continually thwarted by rules, custodial priorities, poor health care management, incompetence and indifference'. Moreover, older prisoners have a very low utilisation of services and are unlikely to disclose their problems when treatments are available (Hooyman and Kiyak, 2011). When combined, the above factors can impact negatively on healthy ageing in older prisoners.

The increase in the amount of health and social care needs presents a costly and complex challenge for the prison service and other welfare services (Lee et al.,

2016). For example, in the UK the cost of a prison place is £37,543 per head, per year (MOJ, 2018). However, for prisoners over 60 years of age this could be expected to triple because of additional health-care needs (Mann, 2012). These figures are reflected in the US, where the cost is $34,135 per year for younger prisoners and, on average, $68,270 for older adults (Chettiar et al., 2012). These additional costs are set to a backdrop of austerity policies that have resulted in 20% real term cuts to HMPPS budget between 2009 and 2015 (Institute for Government, 2019; Ismail, 2020). There have been recent increases in spending, but this still falls short of pre-austerity spending levels (Institute for Government, 2019).

To offset the extra costs, £11.8 million of extra government money was made available to LAs to assist with the delivery of social care in prisons – with £6.5 million set aside for social care and £3.8 million for assessment (Justice Select Committee, 2013). However, this money is for an estimated number of between 1,800–3,500 ODPs, to be shared between 58 LAs (Local Government Association, 2014). As providing a statutory social care assessment costs, on average, £1,213 (Audit Commission, 2012) and providing home social care has a unit cost of between £131–£187 per visit (Health and Social Care Information Centre, 2013), many researchers have speculated that this is simply insufficient to cover the costs of prisons with large numbers of prisoners in need of assessment and social care (Lee, 2016).

Moreover, the cost of making adaptations to the fabric of prisons to meet the needs of disabled prisoners also presents an extreme economic challenge given that many prisons were built in the early part of the 19th century. An example of the cost to changes to the environment to meet the needs of ODPs is the purpose-built ‘older prisoner unit’ that was built at HMP Norwich in 2004. At a cost of £1.5 million for 15 spaces, this demonstrates the potentially exponential cost of separate accommodation for the ageing population (HMPPS, 2020).

The impact of these costs may vary from region to region; some LAs do not have prisons in their jurisdiction, whereas others may have more than one. The capacity and function of the prison can also influence the amount and type of expenditure. For

example, a ‘local’ prison (see glossary at Appendix 1: Research , page 227) may have a high prisoner churn and may need to organise more social needs assessments, whereas a ‘training’ prison may have a lower churn but need to spend more on the delivery of personal care (Skills for Care, 2014). To complicate matters, health care and social care are commissioned from separate budgets, so deciding who pays for what is a complex task that can lead to service users’ needs falling between budgetary gaps. In regions with higher-than-average demographics of older adults, there is evidence to suggest the increased financial pressure has led to the criteria for social care becoming more variable (Lee et al., 2016). In summary, there is little clarity regarding how LAs will fund prisons with large numbers of ODPs, leading many to speculate that HMPPS will struggle to implement changes expected under the Care Act (Lee et al., 2019).

Prisoner peer caregiving

In response to the above challenges, there have been changes to local and national policies in support of the development of peer interventions. In 2009, staff at the research site created a ‘buddy’ system, whereby small numbers of carefully selected prisoners were paid to provide peer support to fellow prisoners with functional health needs. However, their work was not informed by training and it was supervised by a prison officer as opposed to a health or social care professional. The caregivers at the research site were risk assessed and employed under HMPPS regulations (PSI 6/2012) and their roles defined by PSI (17/2015), which delineates between ‘personal’ and ‘intimate’ levels of care, (see Appendix Table C, page 262, for a hyperlink to this document). There were differences in the composition of the buddy teams between the residential areas; however, in general, the caregivers were younger (ages 29–60) and more physically able than the ODPs. Other peer-support programmes, such as the ‘prison listener scheme’ and ‘advice and guidance champions’ ran concurrently at the research site.

Peer workers are prisoners who have earned trust ‘through their conduct on the landings and they are given more autonomy than standard prisoners’ (Nixon, 2020,

p44). They are in a liminal position, as they are neither ordinary prisoners nor staff. Clarke et al. (2016) suggest that peer working is a new concept that did not exist before the turn of the century; however, historically, prisoner trustees have long been employed in more responsible roles. Unlike other prison-based peer programs (for example, the prison listener scheme), the peer caregivers are not backed by a national charity or consumer group (aside from limited support from the charity Recoop in the south-west of England).

It is known that prisoner peer caregiving activity has developed in various areas of the country; however, this is felt to be in an uncoordinated and piecemeal fashion (Moll, 2013). Although academics have found it difficult to estimate the economic value of peer care (Bagnall et al., 2015), it is reported that 87% of prisons have schemes to promote peer care (Forsyth et al., 2019). This is relevant in the context of suboptimal government spending on prisons (Emmerson, Johnson and Stockton, 2019).

The range of activities delivered by peer workers in prisons has increased over recent years. According to South, Bagnall and Woodall (2017), this increase has the potential to improve health and reduce risks. Recently, South et al. (2017) attempted to impose a typology on the arrangements of peer interventions in prisons. Their categories of ‘peer education, peer support, peer mentoring and bridging roles’ (p217) were developed with the intention of developing the evidence base for a diverse range of practices. The peer work in this research is most closely aligned to the peer-support category which can be defined as ‘a wide range of roles or schemes by which people offer direct practical help and support to other prisoners, either in a paid or unpaid capacity’ (Edgar et al., 2011, p14). However, for the purpose of this thesis, this definition will be extended beyond the notion of ‘support’ to ‘care’ on the basis that peer caregivers’ duties involve providing care at social, emotional and physical levels.

Peer care activities include practical assistance, such as befriending, fetching meals, the negotiation of administrative processes and assistance with matters of hygiene

and cleanliness (Stewart, 2011). Some of the benefits of prisoner peer caregiving can been identified as follows:

- More accessible, lower cost, low-level personal care.
- Greater levels of choice with the potential for the provision of culturally responsive peer social care (HMIP, 2016).
- Increased relational factors between staff and prisoners, and an increased sense of community within establishments (Stewart and Lovely, 2018).
- The development of social capital through education and socially meaningful activity (Cowman and Walsh, 2013; Loeb et al., 2013; Collica, 2013).
- Compliance with the Care Act (2014).
- Peer caregiving mitigates the effects of institutionalisation and improves the ability of the ODPs to adapt to the prison culture, environment and regime.
- It can help to equip prisoners with transferable skills that may assist with resettlement and reduce reoffending on release (Toch, 2012).

Befriending and home help-style social care can promote social contact, increase well-being and save downstream costs (Clark, Dyer and Horwood, 1998). Furthermore, it is reported that some prisoners actively seek opportunities to engage in altruistic or generative activities in order to perform transformative or redemptive narratives (Cloyes, Rosenkranz and Wold, 2014). As such, there would appear to be both the need for increased peer support and the potential within the inmate population to provide it. It is for the above reasons that peer support could be seen as an efficient way of contributing towards the delivery of social care in prisons (Lee et al., 2016).

Chapter summary

The combination of harsher sentencing, people living longer and the pursuit of historic sex offences has resulted in greater numbers of older, frail and disabled people in UK and other Western prisons. The ageing tenure of the prison estate, along with reduced staffing and financial cuts, intensifies the disadvantage

experienced by this group. Furthermore, a lack of education and training on disability and ageing, as well as inadequate guidance and leadership, increases the challenges of delivering and improving practice. These issues are compounded by conflicting professional paradigms of security, managerialism and care (Lee et al., 2016; Ismail, 2020).

Perspectives on imprisonment, older adulthood, frailty, disability and vulnerability combine with public perceptions of sex offenders, to stigmatise and exclude this population. These factors serve to limit their voice, visibility and accessibility. Yet, peer caregiving represents an opportunity to meet the practical and relational needs of the ODPs and provides an opportunity to develop the peer caregivers.

Organisation of this thesis

The thesis is divided into three main sections and 11 chapters. Part 1 lays the foundation for the rest of the thesis by discussing the research context, synthesising the relevant literature, setting out the theoretical positions and methodological strategies for the research. Part 2 contains a chapter for each of the five themes, featuring selected extracts of data, with reflective discussion and analysis. Part 3 presents a discussion of the findings, bringing together the conclusions and setting out the recommendations of the research.

In the following chapter, the process, results and synthesis of the literature review are presented, followed by the research questions.

Chapter 2. Literature review

Chapter introduction

Literature reviews have become central to scholarly inquiry and an expectation of research degrees (Holbrook et al., 2007). Stern (1980) argues against the inclusion of literature reviews, suggesting that they risk a closure of ideas and concerns, whereas other authors argue in favour of a concise or limited review (Speziale and Carpenter, 2003). This means that questions are raised in relation to the depth of the searching and appraisal of the literature. As a doctoral student, I have adopted a structured approach to searching, but have also allowed myself to be guided by the results throughout the process.

In this chapter, I present the key points from my review of the relevant literature. I begin with a summary of the pilot literature review, before describing the steps taken during the searching and selection process for the current literature review (a fuller description of the searching process can be found at Appendix 2, page 241). The retrieved papers were summarised, synthesised and clustered into themes, and their relevance to the research is discussed (see Appendix 3, Table B, page 247, for the search results).

The literature review is followed by an outline of the selected theoretical perspectives, suggesting how they might be useful to the analysis of the data.

Summary of the pilot literature review

As outlined in Chapter 1, a pilot project and literature review was conducted in 2015/2016 to inform the research for this thesis. In this phase the literature was searched over a 15-year period (2000–2015), to take account of major changes to policy and practice, such as the transfer of prison health care commissioning from the Home Office to the NHS. Several primary research papers were retrieved that related directly to practices associated with peer caregiving in prisons and on

conducting research in prisons (see Stewart and Edmond, 2017). As the results of the pilot literature review helped to inform and evolve the aims of the current literature review and study, the main points of learning are summarised below.

Key papers were retrieved by the following authors: Townsend (2001); Wright and Bronstien (2007); Hoffman and Dickinson (2011); Stewart (2011); Stone et al. (2012); Loeb et al. (2013); and Cloyes et al. (2014). Most papers were published between 2011 and 2015, indicating a recent increase in the amount of research interest on prison-based, peer care interventions. Remarkably, five papers related to studies undertaken in male prisons in the US, all of which discuss peer caregiving in prison hospice facilities. These findings were consistent with the high numbers of ageing and dying male prisoners in US prisons and reflect the more advanced state of peer programming in North American prisons. Of the two remaining papers, the paper by Townsend (2001) provided an outline of an action research study undertaken in a Malaysian prison, based on peer support for people living with human immunodeficiency virus (HIV). The final paper, by Stewart (2011), evaluated training interventions in three prison sites in England, focusing on personal care for ODPs. Five out of seven retrieved papers adopted qualitative methodological strategies; two papers made use of mixed methods, namely surveys and interviews.

To summarise, the review established the phenomenon of prisoner peer caregiving as a legitimate activity, and the papers offered some information on methods of evaluating peer care and the benefits to participants. However, the review also highlighted gaps in the literature: few papers focus directly on personal care for elderly prisoners with disabilities; none of the studies gathered the views and perspectives of care recipients; the information on training is under-reported; and few of the papers made reference to underpinning theories of education or care. These omissions became aims for the current research.

Current literature review

A narrative literature review and content analysis of the retrieved papers was undertaken to satisfy the primary question: '*What can be learned from the experiences of prisoner peer caregivers and care receivers in a UK prison, and how can peer care practices be enhanced?*' The literature review aimed to bring my knowledge of prison-based peer care interventions up to date, to search for educational processes that support peer interventions and develop an understanding of suitable theoretical perspectives by which to analyse the data. My aim was to situate the findings in the context of what is already known, filling gaps and developing new lines of inquiry, rather than restating previous findings or existing arguments.

To enhance the specificity of the searches the research question was deconstructed to elicit key search terms, such as 'caregiving', 'learning', 'peer working', 'older/disabled prisoners' and 'prisons'. These terms were used for the development of synonyms and subsequent search strings, which were added to relevant health, criminal justice, social care and educational databases. This process was supported by reference list or 'snowball' searching, which helped to increase the number of relevant papers. The synonyms and antonyms were reformatted to construct an inclusion and exclusion criteria; this tool helped to sift the retrieved papers, reducing the risk of drift.

The literature review elucidated several informative themes in response to the research question: peer care, end-of-life care, dementia care, learning to peer care and supporting theories. There is sufficient evidence to suggest that each of these areas could represent a topic for separate literature reviews; therefore, this strategy represented a thorough and ambitious approach to reviewing the available literature. The retrieved literature includes primary and secondary research papers, literature reviews and other influential thematic reports from a broad range of academic disciplines. The review summarises the findings of the retrieved papers, extracts information that is useful to the current study and finishes by stating which gaps my research aims to fill.

Summary of retrieved papers

In the following sections I have clustered the retrieved papers into the aforementioned themes (where authors have produced more than one paper from a single study, I have discussed the paper with the greatest relevance to this study). This will be followed by a section discussing the most relevant theoretical perspectives to underpin the study.

Peer care and wider social care issues in prisons

A service evaluation of prison peer caregiving in Victoria, Australia, by Webber and Evans (2020), possibly represents the nearest match to the aims of this study. It makes several recommendations for peer carer training, including locating the work in the context of a skills framework and the development of a skills workbook. Unsurprisingly, several papers by Stewart and Edmond (2017); Stewart and Lovely (2017); and Stewart (2018), featured prominently within the searches. This research presents guidance on the infrastructure needed to support peer care, learning materials and templates for the training. A qualitative study by Einat (2017) describes unspecified ‘practical support’ for prisoners with mental and physical vulnerabilities. It captures and analyses the benefits to the caregivers in the context of underpinning transformative theories of learning.

Forsyth et al. (2017) provide an evaluation of a comprehensive health and social care assessment and planning framework for elderly adult prisoners that aimed to support improvements in functional and cognitive health. Their system was found to be difficult to implement, as prison officers were viewed as lacking in the competence and capacity needed to complete the assessments. Significantly, the report recommends that institutions undertake an analysis of training needs and combine prisoner and staff training. Pertinently, the paper recommends a focused ethnography to assess how the environment, officers and ordinary prisoners interact to affect the lived experience of ODPs.

An illuminating paper by Tucker et al. (2018) featured a discussion of the financial costs of social care in prisons. The paper discusses concerns on the process of referral to formal services, a lack of standardised training for peer caregivers and a lack of parity between community and prison standards. Levy et al. (2018) present a review of the state of social care for offenders in Scotland – in prisons and on release. It suggests power imbalances can affect communication between groups, meaning frail and disabled prisoners lack voice and are unlikely to seek help from peers or officers. The paper recommends the development of co-produced learning modules and the use of ex-offenders as peer-support workers. A literature review by Lee et al. (2019) discusses emerging social care practices in prisons, including peer working, referring to the potential for intrinsic gains, increased compassion, a reduction in medical appointments and behavioural problems. Their review highlights staff and managerial resistance to peer working based on the differing imperatives of security and care. Pertinently, the review discusses the issue of caregiver burnout in the context of inadequate training.

It is apparent that there has been an increase in papers reporting on peer care and social care in prisons from a growing number of countries. The literature reflects a broader range of perspectives, extending the scope of the literature, for example, questions are raised in relation to the distribution of formal care and the financial costs. The papers reveal relevant points of learning in relation to the experiences of older prisoners, notably in relation to a lack of voice and power differentials. Gaps in officer knowledge and competence are identified in the context of reduced staff resources and concerns are expressed about caregiver knowledge and well-being. The papers describe new approaches to the implementation and evaluation of peer care and make useful recommendations on researching the issues, for example, adopting an ethnographic approach. Few papers refer to underpinning theories of learning or care, forming an aim of this research.

End-of-life peer interventions

Peer care for dying prisoners has a more specific focus in comparison to generic personal care. However, several issues relating to the implementation of interventions and training overlap with the aims of this study.

Cloyes et al. (2017) describe an inmate-led peer care and vigil service, acknowledging the positive outcomes on the wider organisational culture. Loeb et al. (2018) provide an evaluation of a care pathway for dying prisoners, highlighting organisational challenges, such as costs and sustainability. Positive endorsements from senior staff are viewed as essential, as sensitive projects benefit from strong leadership and visible champions. Prost, Tripodi and Lacasses (2019) produce an interesting sequence of quantitative studies that set out to examine interrater reliability between peer caregivers and their patients on aspects of quality of life. The participants' characteristics are assessed with the prospect of enhancing the matching processes between caregivers and care receivers.

Numerous papers referred to the emotional consequences of peer caregiving. Specifically, Supiano et al. (2018) found volunteers were able to access support from peers and use individual methods of coping, such as self-reflection and spiritual contemplation. Depner et al. (2017, 2018) produced two papers on peer hospice workers, focusing on the benefits of personal growth and social bonding in the context of increased stress levels. Turner and Peacock (2017) produced several papers based on an end-of-life care study in the north-west of England. They adopt the perspective of Wacquant (2010) and others, by viewing prisons and criminal justice policy through a neo-liberal analytic lens. Significantly, connections are made between austerity measures and lower levels of officer/older prisoner interaction.

Other papers from this theme were retrieved from Canada (Burles, Peternelj-Taylor and Holtslander, 2016) and Switzerland (Richter and Hostettler, 2017), providing useful contextual information from countries other than the US and the UK.

Again, a greater number of papers from a broader range of countries suggests greater interest in the field. Several points of interest are relevant to the satisfaction of the research question. For example, visible support and attention to careful matching of carers and care receivers are identified as aspects of good practice. Several papers focus on ethical questions and concerns relating to caregiver resilience, although, interestingly, few papers suggest how such support can be implemented. New theoretical perspectives are discussed, namely the experience of older adults in the context of macroeconomic changes and organisational limitations.

Dementia care

A plethora of retrieved papers referred to the mental health needs of incarcerated older people – see Cambalbert et al. (2017); Yarnell et al. (2017). The following selected papers provide useful contextual information and relevant points of learning:

Tracey, Haggith and Darshana Wickramasinge (2019) evaluated the implementation of 'dementia-friendly community' principles in a custodial setting, alongside user-friendly study materials. The authors conclude that government underfunding and a high turnover of staff impacted the aims of their study and led to a de-prioritisation of ODPs' needs in favour of more difficult to manage ordinary prisoners. Di Lorito et al. (2020) undertook a systematic literature review of interventions to support ageing prisoners, concluding that although there have been some promising initiatives, care for older prisoners remains inconsistent.

Similarly, Du Toit et al. (2019) undertook a systematic review to elicit the best care options for ODPs with dementia, including a recommendation for increased peer care. Brooke and Jackson's (2019) qualitative study identifies gaps in the officers' knowledge of health-related issues, suggesting a need to challenge the officers' views that their role is simply to keep older prisoners safe. In common with the papers above, the authors recommend multi-disciplinary team (MDT) training, and the monitoring of caregivers' stress levels. A paper by Chu (2016) is one of the few studies in which a lone researcher conducted participant observations and interviews

with ageing prisoners, although, notably, the participants were less likely to need support with ADLs. Forsyth et al. (2019) found under-recognised levels of cognitive impairment and mild dementia in the prisoner population. The authors suggest multi-agency working is limited by poor information sharing and siloed working, and locally developed support initiatives were likely to fail.

At this stage in the review, the increase in research activity and need for better training and support for peer caregivers can be seen as cross-cutting themes. Information in relation to the barriers to implementing peer caregiving are also prominent within this section, these are, underfunding, reduced staffing, gaps in knowledge and staff attitudes.

Learning to be a peer worker and theories of learning

This subsection presents a summary of the recent literature, featuring learning in relation to peer care in prisons and its meaning in relation to the study.

Brooke and Rybacka (2019) discuss the evaluation of older people's mental health awareness training for prisoners and staff. The findings suggest the workshops were well received and helped to offset various misconceptions related to the effects of ageing. The results suggest training alone is insufficient to improve current care practices, and environmental factors, such as the provision of quiet, uncrowded spaces, also require attention. Papers by Perrin, Frost and Ware (2018) and Behan (2014) discuss training for peer mentors, suggesting the work is characterised by emotional problem-solving, reciprocal emotional support, reducing anxiety and linking the effects of learning to a reduction in reoffending. Kitt-Lewis et al. (2019) evaluated a computer-based, end-of-life care learning module for prisoners and staff groups. Some essential pedagogic content is provided and the importance of culturally competent care in prisons is emphasised.

Buck (2018) confirms peer programmes are increasingly a feature of the penal landscape. Drawing on the ideas of Carl Rogers (1961), she identifies the 'core

states' of criminal justice peer mentors, positing these as 'caring, listening and encouraging small steps'. Based on a study of sexual health peer educators in female prisons, Collica-Cox (2018) discusses the effects of positive attachments between prisoners, explaining the results with reference to attachment theory and theories of crime desistance. Her results suggest peer work can coalesce in profound internal change, shifts in self-identity and gains in purpose and meaning, suggesting aspects of peer working validates the transition to a desired 'good self'.

In summary, several papers refer to the difficulties of sustaining formal training over the longer term, and highlight a dearth of educational research in this area. The relationship between learning, peer working and the potential for reduced reoffending forms a visible theme. Although computer-based learning was not viable at the research site, attention to culturally competent care appears to be a relevant aim. The papers outlined in this section lean towards a combination of theories of self-development from a criminological framework, and social theories of learning would appear to have utility given the informal nature of learning and team approaches to caregiving.

Theories of care in criminal justice settings

As identified above, few of the papers referred to the application of underpinning theories of care. Therefore, reference lists were checked for relevant papers and the search parameters were extended to retrieve a wider sample of papers (see Appendix 2 page 241). The literature in this section draws from a cross-section of academic disciplines, including public health, philosophy, probation, forensic psychology and third-sector studies.

Several papers refer to 'security' versus 'care' tensions, for example, Adshead (2000) and Walsh (2009). A number of papers were rejected on the basis that they were too specific to be of relevance to the study – for example, Nolan and Walsh (2012) discuss intersubjectivity in the process of care and develop a theoretical model, but this does not extend to peer care.

From the philosophical tradition, papers by Brown Coverdale (2017, 2020) and Tronto (2010) suggest that ethics of care can facilitate the recognition of harm and poor practice in justice settings and institutional care. The paper by Tronto (2010) helpfully describes the problems associated with power differentials in care settings, suggesting that institutions need moral, ethical and political rhetorical spaces to interpret conflict and struggle.

From the field of probation, Gregory (2010) uses ethics of care to illuminate a shift in criminal justice working, from relational to technical-rational approaches to engagement. Gregory suggests that the positions of ethics of care and phronesis sit comfortably together and are distinct from technical-rational conceptions of self and care. Ward and Salmon (2011) suggest ethics of care can help professionals to view offenders more holistically. Interestingly, in the context of learning to care, the authors describe the practice of peer working as an activating agent for transformative learning.

In summary, few papers discuss theories of care; however, some papers discuss tensions between discourses of care, security and managerialism. Ethics of care (or care ethics) appears to have the versatility to assist the analysis of micro-level practices and macro-level influences on peer care. (See page 42 below for a justification of the selection of theoretical perspectives).

Government reports and pressure group papers

In the next stage of searching, national policies, government reports and criminal justice ombudsman thematic reports were collated, and several documents were found to allude to peer interventions for ODPs, see Appendix Table C: Government inspection and other recommendations papers 2015–2021 page 262.

In 2004, HMIP produced the thematic review ‘No Problems, Old and Quiet’, this was followed up in a review paper in 2008. In 2007, the Department of Health (DH)

produced the guidance paper ‘A Pathway to Care for Older Prisoners’. Older prisoners were the subject of the Justice Select Committee (2013), inclusive of subsequent sessions through to the Justice Select Committee’s Fifth Report, ‘Older Prisoners’ (2020–2021).

Between 2016 and 2019 there have been six further government thematic and advisory reports relating to the needs of older prisoners. Two HMIP reports directly allude to issues affecting older prisoners, these are, ‘HMIP and the Care Quality Commission, Social Care in Prisons in England and Wales: a thematic report’ (2018) and HMIP (Scotland), the thematic review ‘Who Cares? The Lived Experience of Older Prisoners in Scotland’s Prisons (2019)’. Indirect government policies impacting on older prisoners’ well-being include the National Service Framework for Older People (DH, 2001); the Care Act (2014) and the Equality Act (2010). Moreover, there have been several influential reports published by pressure groups, including briefing papers by the PRT (2003, 2008), Age UK (2011, 2019) and Recoop (2018), highlighting the difficulties experienced by older adults in prison. The *BBC*, *The Times* and *The Guardian* articles are presented at Appendix Table D: Summary of the grey literature and popular media, page 239. The effects of the COVID-19 pandemic on older and vulnerable groups in prisons are visible in these articles.

Characteristics of the retrieved studies

The following section describes the characteristics and patterns within the retrieved papers before going on to present a general synthesis of the literature. The retrieved papers and government reports contribute to the study by providing a point of comparison between policy and practice and assist with the overall analysis.

In comparison with the pilot literature review, there has been a discernible upturn in the number of government thematic and advisory papers, research papers, literature/scoping reviews, pressure group activity and media coverage, indicating an increase in public and political concern as well as a need for sustainable solutions for social care in prisons, adding impetus for this study. The retrieved papers were

drawn from a range of overlapping disciplines, for example, health and social care, medicine, gerontology, criminology and education. Several studies were not easy to pigeonhole, as they span more than one theme. Ambiguous language presented an additional source of complexity – for example, in some papers the usage of the term 'care' is applied conceptually, whereas in others it is applied performatively.

The results of this review continue to show a concentration of interest on issues related to end-of-life and dementia care for older prisoners. There has been a corresponding increase in the number of publications problematising social care in prisons; however, few papers evaluate supportive interventions for ageing, frail and disabled prisoners. This is an important point given that higher numbers of prisoners either have or will develop LTCs and struggle with ADLs rather than be diagnosed with dementia or die in prison (Fazel and Baillargeon, 2010). This represents an overlooked area in the literature and justifies the motives for undertaking the study.

Before 2015, most of the academic interest in peer caregiving interventions came from the US, where tougher sentencing has been in place for a longer period. There is new evidence for an increase in research from a broader range of Western nations, for example, Australia (Webber and Evans, 2020); Germany (Ghanem et al., 2019; Kenkmann et al., 2020); Spain (Ordonez, 2021); Israel (Einat, 2018); Scotland (Levy et al., 2019); and England and Wales (Forsyth et al., 2017, 2019).

Research interest in the identified domains appears to be dominated by clusters of academics from specific regions. For example, there are a high number of papers from academics at the University of Manchester relating to the development of prison health and social care systems, and several papers have been developed by academics at Leeds Beckett University on peer health promotion. In the US, both Cloyes et al. and Loeb et al. continue to publish on end-of-life care in prisons. Such clustering may be reflective of the attainment of research grants or groupings of academics with similar research interests – notably, the University of Manchester hosts the Offender Health Research Network.

In comparison with the pilot study, there are noticeable differences in the methodological strategies of the retrieved papers. While qualitative methods remain dominant, there has been an upturn in the number of mixed-method and quantitative studies. The increase in papers and increasingly complex research designs are possibly an indication of greater maturity of this field. Nonetheless, several studies acknowledge the need for more robust methodological quality, for example, Kitt-Lewis et al. (2020); Lee et al. (2019); Tracey et al. (2019). Buck (2018) and Walker and Mawson (2019) question the appropriateness of quantitative strategies to assess the value of peer interventions. Several papers recommend evaluating future peer caregiver interventions using methodological approaches untested in this context (for example, ethnographic methods).

Synthesis of the retrieved papers

In conclusion, a high number of empirical papers from a broad range of disciplines were retrieved and summarised. The papers provide useful contextual information in which it has been possible to locate this study. This review outlines what is and, importantly, what is not reported, and evidences other points of learning needed to support this study.

The sample includes several suggestions relating to the practical arrangements and infrastructure requirements needed to support peer caregiving (see Stewart and Lovely, 2017; Tracey et al., 2019); the value of careful matching between prisoner patients and peer caregivers (see Prost, Tripodi and Lacasses, 2019); and the need for support from senior officials, as evident in Loeb (2018).

Numerous papers referred to ethical concerns in respect of negative emotional states and risks of caregiver burnout, specifically Depner et al. (2017) and Supiano (2018). Several papers discussed the barriers and limitations to implementing peer interventions – these include organisational impediments and resourcing issues, Tracey (2019) and Forsyth (2017); socio-material issues, Forsyth et al. (2017) and Stewart (2018); and problems relating to a conflicting ideological of principles (Brown

Coverdale, 2020; Walsh, 2009). Concerns about the knowledge and competence levels of officers and resistance to peer caregiving was expressed by O'Hara et al. (2015) and Lee et al. (2019); issues relating to the prioritisation of younger prisoners' needs was addressed by Forsyth et al. (2017, 2019) and Tracey (2019); and the influence of macroeconomic policies on resources was the focus of Lee et al. (2019), Turner et al. (2018), Ismail (2020) and Tucker et al. (2018).

From an educational perspective, papers by Kitt-Lewis et al. (2019), Collica-Cox (2018) and Brooke and Rybacka (2020) all evaluate training interventions for prisoners and staff; most papers position learning as a separate, didactic process. A lower number of studies underpinned their discussions with reference to pedagogic theories – this is likely to be because peer programmes are diverse and, in most cases, there is not a standardised approach. From a theoretical perspective, papers by Collica-Cox (2018), Perrin et al. (2018) and Behan (2014) referred to theories of self-development drawn from criminological literature. These papers helpfully explain the motivation of peer caregivers and account for drives to attain personal change. Papers by Stewart (2018) and Cloyes (2017) suggest attending to socially transmitted learning processes within communities of caregivers; therefore, theories of social learning and criminological theories of self-development are put forward as suitable analytic perspectives for the research.

Papers by Brown Coverdale (2020), Gregory (2010) and Ward and Salmon (2011) all referred to the application of ethics of care in justice settings. Ethics of care views care as a moral, relational activity, and it enables challenges to contemporary neo-liberal political and macroeconomic ideals. For these reasons, ethics of care appears to have a high level of utility for the study and is put forward as an appropriate theoretical lens to assist with the analysis of the data.

Justification for the theoretical perspectives

This study stands at the intersection of education, criminal justice studies and health and social care. Given the key drives to understand the participants' needs, to

promote change and learning and to develop new practice, there is a need for several theoretical strands to support the analysis. The above literature review helped to identify several theoretical perspectives informing the empirical literature, and these perspectives appear commensurate with the paradigmatic stance and selected methodological strategies. In the next section, the most relevant theoretical perspectives to the current study are discussed.

Social theories of learning

Lave and Wenger's (1991) theory of situated learning illustrates the connection between social activity and the attainment of professional and other skills. 'Situated Learning: Legitimate Peripheral Practice' discusses the authors' research on the developmental trajectories of new learners as they engage with new spheres of activity. In their theory of 'situated learning' there is an emphasis on the social character of learning as a process whereby learning occurs between individuals, via their relationships and mutual participation, within a context of meaning.

The central concept in this understanding of the process of learning is legitimate peripheral participation (LPP), which describes learning by new team members as a 'move toward full participation in the socio-cultural practices of a community' (Lave and Wenger, 1991, p32). Here, the analytic focus moves from the individual to actions and participation in the social world or from individual cognitive processes to increasingly engaged social practices. LPP is the process by which 'newcomers' and 'old timers' engage with one another, explaining how newcomers gain the knowledge and credibility needed to become part of a community.

In 'Communities of Practice: Learning, Meaning, and Identity' (1998), Wenger develops the ideas of LPP with greater emphasis on community and identity. Communities of practice (COPs) are defined by collective approaches to problem-solving and common concerns and goals – communities are sustained, and practices reproduced by ongoing interconnectivity between group members or communities. Groups develop an embodied curriculum in specific areas of interest,

which are based on mutual practices, and contribute to the development of a sense of community.

There is a shift of emphasis from the original theories of social structure to theories of situated experience that ‘give primacy to the dynamics of everyday existence, improvisation, coordination and interactional choreography’ (Wenger, 1998, p12). Consequently, the analytic focus veers towards performance and to interpersonal events, such as exchanges of communication. Subjectivity and identity are explained by the social formation of the person, cultural interpretation of actions and the ‘creation and use of markers of membership, such as rites of passage and social categories’ (Wenger, 1998, p14). The conceptualisation of power becomes more central to the theory and there is a drive to understand how individuals and groups develop meaning.

Given that the caregivers lived and worked in the same residential area, exchanged practice tips, informally supported one another and the absence of formal training, the study is based on the premise that peer caregiving is a locally emergent socio-cultural practice and an outcome of social learning within the group. Situated learning theories, specifically LPP and COPs (Lave and Wenger, 1991; Wenger, 1998), contribute towards the interpretation of the effects of social dynamics and socialisation in relation to the transmission of knowledge and skills, status and identity. Therefore, theories of ‘situated’ or ‘social learning’ provide an appropriate theoretical lens to support the analysis of existing learning processes and practices, as well as the possibility of making recommendations for future learning practices.

The concept of care

‘Care’ is an enduring and contested issue in social policy (Lloyd, 2006). Caregiving and receiving are usually understood within a context of intimate personal relationships in which one person has greater need than the other. Care is essential in the early stages of human survival, and it is likely that we will all become emotionally or physically dependent and frail as we age, and in the period approaching death. Care ethicists argue that vulnerability and dependency are

inherent in the human condition – therefore, the need for care emerges. It has a significance beyond intimate personal and dyadic relationships, to wider understandings of care in society, becoming more than an activity that takes place in the 'private' sphere that is separate from the world of politics and justice (Tronto, 1993; Sevenhuijsen, 2000; Kittay, 2002; Held, 2006).

Tronto and Fisher put forward a broad definition of care: 'On the most general level, we suggest that caring be viewed as a species activity that includes everything that we do to maintain, continue, and repair our world so that we can live in it as well as possible. That world includes our bodies, our-selves, and our environment, all of which we interweave in a complex, life sustaining web' (Tronto, 1993, p130). This broad position grounds the political dimensions of care (responsibility, power), in how care is unequally valued and distributed. Tronto (1993) conceptualises care as a process with four ethics or phases: attentiveness (caring about), responsibility (taking care of), competence (caregiving) and responsiveness (care receiving) (Lloyd, 2006). These should not be regarded as sequential, but should be integrated for the ethics of care to be realised.

Care is a way of conceptualising social and personal relationships. It permeates all aspects of our lives – the way we relate to one another, our bodies, environments and social well-being (Barnes, 2006), yet there is a taken-for-granted nature to care. For example, Bowden (1997) suggests that there is an 'aura of invisibility' that envelops care in everyday life. Care is simply so integral to the way we live and work together that we overlook its value and significance.

Ethics of care

Ethics of care originates from the work of Gilligan (1982), who 'challenged gendered assumptions on moral development by proposing a different voice in which moral deliberation might be conducted' (Barnes and Henwood, 2015, p150). Humans are seen as fundamentally interdependent, and by emphasising care as a relational process, an ethic of care acknowledges that complex practical and moral dilemmas are an unavoidable element of caring relationships. Caregiving and care receiving

should not be perceived as a simple binary, but more as a process involving a diverse group of actors with differing motives.

Much of the empirical work within social policy has focused on the experience of carers and the work involved in caregiving (Barnes, 2006). However, ethics of care provides a framework for understanding care and dependence at an individual and broader political level, and it is relevant to the development of welfare services (Lloyd, 2006).

'Choice' and 'control' are visible as key values in social policy, yet 'care' itself has become estranged from official dialogue. Ethics of care provides a framework for surfacing the negative effects of contemporary neo-liberal political and philosophical imperatives, enabling us to see the existence of the structures of power and privilege in society. Neo-liberal philosophies represent people as rational, autonomous, self-interested individuals (Rawls, 1971). This form of representation is simply not suitable for numerous vulnerable populations who require some level of support to lead ordinary lives. Neo-liberal policies translate in real terms to consumerism, fragmentation, free market economics and cuts to public services (Sevenhuijsen, 2000). The effects of such policies operate through reduced social cohesion, increased income inequality and poverty, and have been shown to affect people's health negatively, by increasing diseases due to the psycho-neuro-biological effects of reduced choice and lower self-esteem (Navarro, 2007; Coburn, 2004).

Fineman (2004) discusses the power of the 'autonomy myth', suggesting that it suits policymakers seeking to promote individualism rather than a collective responsibility for health and welfare. This is reflected in debates about the provision of social care which is framed by perspectives on the costs of caregiving, an issue further exacerbated by global demographic trends. Independence and autonomy are juxtaposed in opposition to interdependence and relationality. Care is associated with dependence, which is regarded as of less worth and, therefore, deprioritised in relation to autonomy. As 'need' is 'antithetical to the political aim of fostering independence and self-reliance as essential qualities of full citizenship, modern Western societies have devalued care and confined it to the private sphere' (Lloyd,

2010, p190). Dependency is represented as a problem that has to be overcome rather than something that is dealt with on a day-to-day basis. By choosing not to acknowledge the centrality of care to human life, ‘those who are in a position of power and privilege can continue to ignore and to degrade the activities of care and those who give care’ (Tronto, 1993, p111).

Owing to its attention to the intrinsic rather than instrumental value of caring, ethics of care provides a basis for a critical analysis of these ideals, helping to highlight the problems associated with the extension of marketisation into areas of social life (Held, 2006). By placing the person in need at the centre stage, ethics of care helps us to consider ‘the lived experiences of giving and receiving care, and how context, conflicts and power impact the difficult moral decisions as well as the practical tasks of care’ (Barnes, 2006). Furthermore, Tronto (1993) argues that care can serve as both a moral value and a basis for the political achievement of a good society. In her later work, Tronto (2010) puts forward a framework for evaluating the quality of institutional care. To provide good care in an institutional context, care has to have ‘three central foci: the purpose of care, a recognition of power relations, and the need for pluralistic, particular tailoring of care to meet individuals’ needs’ (Tronto, 2010, p158) – further suggesting that institutions require a political space to deliberate these concerns.

Kittay’s concept of nested dependencies provides a constructive model for understanding the impact of caring on the identities of both carer and cared for, as it draws attention to the influence of wider relationships, including health and social care professionals (Kittay, 2002). Care ethics provides a framework to guide and measure practice arrangements (Tronto, 2010), and it is connected to Aristotelian notions of phronesis (Gregory, 2010), which gives prominence to social thought and action, illuminating practice as a ‘practical-moral activity rather than a technical-rational one’ (Gregory, 2010).

In summary, there is an alignment between the critical principles of ethics of care and the analysis of various aspects of peer caregiving. It provides a framework for assessing care organisations, a lens to analyse the experience of both caregivers

and care receivers and asks moral and political questions about responsibilities for care, its distribution, the division of responsibilities and how it is recognised and valued.

Criminological theories of self-development

As we heard in Chapter 1, peer working in prisons serves a broad range of functions. A complex range of psychosocial theories have been used by psychologists, social workers, health researchers and criminologists in their attempts to theorise the outcomes of prison peer working. Such theories demonstrate the impact of learning, reciprocity and teamworking on the individual, helping to elicit their motivations and changes to their embodied self-narratives, towards the performance of pro-social behaviours.

In ‘Making Good: How Ex-Convicts Reform and Rebuild Their Lives’, Maruna (2001) describes the outcomes of the Liverpool Desistance Study, in which the narratives of ex-offenders are analysed, essentially to learn how offenders go straight. The connection between providing support for others and personal change is discussed in relation to several theories of personal transformation, for example, the ‘helper therapy principle’ (Riessman, 1965); ‘wounded healer’ narratives (White, 2000); ‘creative restitution’ (Eglash, 1977) and narratives of redemption and generativity (McAdams, 1985).

Based on observations of peer-led support groups at Alcoholics Anonymous, Riessman’s (1965) ‘helper therapy principle’ draws attention to the benefits individuals acquire from being in the helping role. This concept states that it is more beneficial to give help than receive help as ‘those who help are helped the most’ (Gartner and Reissman, 1984, p19). In ‘wounded healer’ narratives, White (2000) observes that the professional-ex, or those who have been traumatised, may identify with or be inspired to assist others who have been affected by similar events. Eglash (1977) argued that the process of redemption involves the individual going the extra mile, or what he refers to as ‘creative restitution’ in which the individual makes up for their wrongdoing by helping others.

From narrative psychology, narratives of ‘redemption’ and ‘generativity’ are used to explain how people come to understand their cognitive schemas and make sense of their lives (McAdams, 1985; 1993). Internal narratives are said to provide internal consistency and guide behaviour, as people create a story and act in accordance with their preferred self-narrative. The experience of intersubjective cognitive and emotional processes, such as the use of empathy or mentoring, can trigger a process of self-appraisal from which the new self can emerge. New narratives render the past as qualitatively different to the present; the new narrative identity acknowledges old wrongdoing and new futures.

From criminology, in Social Bonding Theory (Hirschi, 1969; Hirschi and Gottfredson, 1995), social processes such as marriage, educational programmes or steady employment can encourage stable relationships and changes to people’s level of responsibility, transforming offenders’ propensity to criminal behaviour. Similarly, in ‘life course theory’, Sampson and Laub (1995), suggests that a ‘life trajectory’ is a pathway or line of development over the lifespan. Life course events, such as work and marriage, can lead to altered trajectories. Lebel, Richie and Maruna (2016) examine the characteristics of ‘professional-ex’ offenders who have progressed to become community peer mentors, in doing so developing pro-social attitudes, coping strategies and overcoming stigma, thereby increasing their sense of life satisfaction.

Moreover, seminal theories relating to prison adaptation, power relations and identity management help to explain coping among prisoners (Sykes, 1958; Crewe, 2009). As the study is set within the ‘punitive-managerial’ (Cadavino et al., 1999) context of a prison, it would be counterfactual to overlook the prevailing contemporary discourses within which the research is situated.

Given that the enactment of caregiving can lead to changes in how participants perceive themselves and act in the world, it is proposed that a cluster of theories under the umbrella heading of theories of self-development drawn from the criminological literature contribute to the analysis of the data. This collection of

research and theories can help to explain the motivation of individuals to engage in new behaviours and the gains attached to sustaining change.

Chapter summary

It is apparent, in the literature reviewed in this chapter, that the needs of ODPs and interventions to support peer caregiving have taken on greater prominence in Western countries – this is likely to be driven by a shift towards more severe sentencing, an increasingly ageing population and more supportive attitudes towards victims. A high number of papers evidence the positive impact of peer caregiving, suggesting a weight of evidence in favour of peer interventions on many levels. Recent papers draw attention to the need for educational and emotional support for peer caregivers. Several papers canvas the experiences of staff and peer workers, but few papers capture the views and perspectives of care receivers. Equally, none of the retrieved papers discuss the involvement of ordinary prisoners in aspects of caregiving, leaving gaps in the literature.

It is suggested that several clusters of theory under the umbrella headings of ethics of care, theories of social learning and criminological theories of self-development can helpfully inform the analysis of the research. In Chapter 10, Intersection of the theoretical approaches, page 158, I retrospectively discuss how these theories connect and overlap, to inform the research.

Research questions

The following research questions have been formulated as a consequence of my personal and professional experience (see Appendix 1.3. Reflective notes on the motivation to undertake the study, page 231), in combination with the insights from the pilot study and literature review:

Primary research question

What can be learned from the experiences of prisoner peer caregivers and care receivers in a UK prison, and how can peer care practices be enhanced?

Sub-questions

What factors shape, enable and constrain the quality of peer care practices at the research site?

What difference does peer caregiving make to the lived experience of peer caregivers and care receivers, and what meaning do they give to it?

How can the practice of peer caregiving in prisons be developed?

In Chapter 3, I justify the use of a critical realist philosophical paradigm and suggest why I believe a qualitative methodology is the most appropriate strategy in the context of the setting, population and research question. I provide reflective commentary on the features of the data collection and the systems for organising the data.

Chapter 3. Methodology section

Chapter introduction

Given the progressive gains (and omissions) of the pilot study, the results of the literature review and the evolution of the research questions, it was necessary to develop a research design that would facilitate the investigation of existing practices and help me to develop new theories to support the development of peer care.

This chapter clarifies my motivations and decision-making in relation to focusing the research design. It justifies the use of a qualitative methodology, more specifically a self-reflexive, ethnographic methodology, featuring participant observations, interviews and researcher reflections.

Issues relating to recruitment, my position and status, and my approach to ethics in action, are set out transparently to help the reader make an assessment of the trustworthiness of the text and the credibility of the data collection and analysis.

Reflection on the choice of methods

With its emphasis on structure, practice and change, action research was well suited to the aims of the pilot study. Yet reflection on this phase of research brought an internal sense of hubris, in that I had limited the research to the caregivers and key staff, omitting the voice of the ODPs. Moreover, I had not taken the time to see for myself the nature of peer care in the environment. In relation to the next stage of research, I had a priori knowledge of the competing tensions between discourses and practices of security and care (Adshead, 2000; Walsh, 2009), leading me to suspect an alignment with the research aims and critical discourse analysis (CDA) (Fairclough, 2013) as an analytic lens. However, some elements of CDA do not fit with my experiences or beliefs that shaped my philosophical stance, namely, there is a practical and social ontology to caring and learning, in the context of the deteriorating body and physical environment.

I wanted a creative research design that enabled me to be reflexively 'in the moment' with the participants, to enable me to hear for myself the lived experiences of the ODPs and caregivers and see first-hand the state of care practices. Given the findings of the literature review, I wanted to hear the stories of the constraining and enabling factors along with the meanings and value the participants attached to their roles and relationships. I wanted to be as near to the participants as possible, to help me to understand, from their perspective, the interplay between environment, policy and mixed-age groups.

Conceptualising knowledge and reality – a justification for adopting a critical realist and ontology and epistemology

In this subsection, I situate the research in the context of critical realist conceptions of the world and knowledge creation. I then locate the methodological strategies for data collection and analytic perspectives in relation to a critical realist philosophical paradigm.

Critical realism (CR) encompasses several interlocking processes and positions. In essence, it recognises the uniqueness of the individual's subjective experience but is mindful of the presence of an external, influential, accessible world (Hammersley, 2002). CR posits that there are visible and less visible mechanisms in the natural and social world and that these mechanisms serve to shape people's lives. In this respect, CR combines human agency (in the form of reasons and motives) with unseen generative mechanisms to produce effects in a social world that is 'multilayered, complex, pockmarked, with ambiguous contours' (Houston, 2010, p74).

Bhaskar (1978) postulates that the interaction between agency, structure and enabling/constraining structures must be understood to explain social life. By striving to record what we see in the world of the empirical and identifying possible happenings in the world of the actual, Bhaskar argues that we have a basis for

arriving at an understanding of underlying causal tendencies. Specifically regarding the aims of the study, CR enables researchers to deconstruct the ‘black box’ (Houston, 2010, p89) of an intervention, to elicit the causal tendencies of how and why programmes might work, and in what circumstances.

In my view, humans are social beings who share an external reality; however, they experience reality in subjective ways, owing to their socialisation, their schematic perceptions and their experience of influential transitive and intransitive structures. CR is reflective of my personal and professional ontological and epistemological world narratives, and this is relevant in the context of maintaining rigor via the processes of reflexivity (Lincoln, 2013).

I accept that our bodies are, to an extent, constructed, but there are limits to this approach. Through the process of senescence human functionality eventually diminishes, illness and disability result in limitations, and we are likely to experience emotional and physical vulnerability as we age (Barnes, 2010). The impact of underfunding, understaffing and overcrowding is visible on the effects on mental well-being and the experience of personal precarity (National Audit Office, 2020). Equally, economic, cultural, social and political discourses all impact on the contextual reality of the participants and can affect an individual’s well-being. Ontological factors, such as the austerity of the physical environment, the embodiment of care skills, equipment and the material fragility of ageing bodies occur in the world, are real to the participants, and mediate interactions and practice. These forces exert an effect, and their influence can be observed and described.

In connection with the proposed methodological and theoretical perspectives, CR is ‘concerned with ontology, with being, and has a relatively open or permissive stance towards epistemology’ (Outwaite, 1987). CR provides an appropriate paradigm for the purpose of investigating the structures and tendencies underpinning peer caregiving, making use of deductive, inductive and retroductive processes (Houston, 2010).

While I accept the benefits of quantitative measures in terms of the measurement of independent variables, there is a limit to the data it can yield, and it risks decontextualising and objectifying people's feelings, preferences and lived experiences (Walker and Mawson, 2019). Moreover, the suitability of quantitative outcome measures, such as questionnaires and scales, are debatable in the context of participants with advanced age, and, in some cases, impaired sensory ability. Academic criminology traditionally leans towards quantitative methodologies. However, it has been criticised for its disconnection between practice and policy as well as reducing the richness and vitality of data to a 'numbers game' (Mathews, 2009; Young, 1986). CR perspectives are popular in criminology (Mathews, 2009; Manicas, 2006) and in health and social care research (Williams, 1999; Pilgrim, 2013).

Justification of methods

In seeking a close-knit set of qualitative practices, the methodological strategies of participant observations and interviews were selected as the main vehicles for data collection, for several practical and reflexive reasons. First, both methods are sensitive to the complexity of human suffering, the formation of meaning and socio-material interactions. As Corsaro and Molinari (2000) argue, ethnography is an ideal method to document participants' membership in their culture and focus on key transitions. Second, from a reflexive perspective, they provide continuity and sophistication to the methods used in the pilot phase of research. Third, ethnographic methods were a recommendation of exemplary studies in the literature review (Forsyth et al., 2019; Einat, 2015).

The attraction of using the interview technique was its 'simple design and correspondence with conversational conventions that are routine in social life' (Fielding and Thomas, 2016 p283). This reinforces Lofland et al's (2006) view that the essence of the research interview is a 'guided conversation'. The technique is suited to studies where the subject matter is sensitive and complicated and can provide greater latitude to probe for information. Indeed, Hesse-Biber and Leavy

(2005) suggest that interviews are valuable for ‘accessing subjugated voices and getting at subjugated knowledge’.

Interviews can provide the latitude to document the participants’ opinions relevant to their roles and relationships. I saw the strategy as an opportunity to interact with the participants, to ensure that I had a good understanding of their meaning, to fine-tune their explanations and to acknowledge the multiplicity of constraints, and the extreme social rules and power relations in the environment.

In relation to the underpinning critical realist position, the proposed methodological strategies generate opportunities to observe and record the *empirical*, enquire into the *actual* and to surface deeper *causal* tendencies and subsequent solutions, in essence, to reveal the tendencies to promote individual and social change.

Negotiating access to the research site and recruitment

By operating through the networks I had established in the pilot study and conducting a sequence of telephone calls and preliminary visits, I was able to gain access to HMP A (see timeline at Appendix 4, page 265). Once access to the site was achieved, I was helped to develop other working relationships. However, the landscape changed quickly, as two highly supportive gatekeepers left the organisation in quick succession, leaving the study in a rather precarious position. As the new gatekeepers were from security and managerial backgrounds, it is likely that their perceptions on the value of the research differed from my health care-orientated perspectives. Other prison researchers have highlighted the anxieties associated with losing access to prison research sites (Liebling and Stanko, 2001), illustrating the fragility of conducting research in prisons and the instability within the environment. Moreover, feelings of uncertainty and ambiguity are characteristic of the relational insecurities of researching in prisons (Schlosser, 2008).

Participants of sensitive research tend to self-isolate and work to conceal their identities, creating difficulties for researchers trying to engage with them. However,

as Waldram (2007, p963) suggests, ‘People are typically willing to share their experiences provided that trust is achieved between participants and researchers and if participants feel they are within the context of perceived safe spaces’.

Gatekeepers can help or hinder research, depending on their views on the research, and, therefore, occupy a position of power in terms of the overall viability of the research. Orlitz (2004) developed a framework ranging from ‘external’ to ‘internal’ gatekeepers, and this was useful as a means of helping me to track and reflect on relational engagements with gatekeepers. As the research process evolved, my experience could be more correctly described using the categories ‘informal’ and ‘formal’ gatekeepers (Reeves, 2010). Both perspectives fit my experience and helped me to reflect on the specific challenges associated with accessing the areas within the site and gaining trust. By reflecting on issues relating to accessing the site and population, it became evident that the quality of relationships with gatekeepers, at all levels, was fundamental to being able to perform the research and, consequently, the populations I could access.

My initial expectations of working through a single gatekeeper transpired to be unrealistic, as I found I needed to negotiate with numerous gatekeepers, occupying different levels within the staff hierarchy. These included officers, operational managers and, significantly, prominent informal figures in the research population. Early in the research process I met with a prison officer designated as a disability liaison officer (DLO), with responsibility for helping to manage the caregivers in house unit 1 (HU1). He appeared to be well known and respected by the participants. Reeves (2010, p324) suggests that such informal gatekeepers ‘are not necessarily in structural positions to exercise control, but rather influence others through the strength of their personality and character’. While it is difficult to estimate the extent of his influence, he did introduce me to several participants, and it is likely that others may have seen us walking and talking together, increasing my visibility in the environment. I was then trusted to perambulate around the ground floor of HU1, becoming accustomed to the timings and rhythms of the regime, with its hotspots of noise and social activity. I was effectively trusted to ‘hang-out’ (Geertz, 1998) with

the various staff and participants. I was free to chat, ask random questions and drift in and out of the staff office or social areas.

It was my intention to adopt a targeted sampling technique to identify 10 ODPs; however, in reality, the process became more dynamic and flexible. Lee (1993) reports that the 'snowballing' sampling strategy is commonly used in the study of difficult-to-access populations. However, my approach transpired to be nearer to a 'convenience' sample, based on who was available in the environment, and the 'word of mouth technique' described by Madriz (1995), as it is likely that my presence and work had become known within the closed community of the residential accommodation area. On several occasions I sensed staff were steering me towards ODPs who were perceived as being compliant or less discordant. In these situations, I diplomatically indicated that I felt I should be interviewing all prisoners with social needs, not just the compliant ones.

The final sample of ODPs formed a relatively heterogeneous group – their ages ranged between 41 and 93 years (I interviewed one younger disabled prisoner aged 41, but the remaining participants were all over 60 years of age) and their social backgrounds and abilities varied. Some were able to attend social and occupational activities, whereas others spent the majority of their time in their cells. The sample were characterised by their need for support with ADLs, mobility issues and difficulty ambulating due to breathlessness. I chatted to one interested ODP at length, but he declined to sign the consent sheet, stating that he did not want to speak negatively of his peers, speaking to the strength of the relationships in the community; therefore, I did not transcribe his comments or include them in the data set.

Data collection

Data was collected in four residential accommodation areas. As there was a higher concentration of ODPs in HUs 1 and 3, most of my time was spent in these locations (see Table 2 below). Regular weekly visits were undertaken over a six-month period, with the aim of becoming accepted as part of the social fabric of the environment. A

total of 22 days was spent at the research site – visits were planned from Monday to Friday, between 09.00–16.45, to acquire a full picture of the working week and all periods of the day. My intention was to adopt an impression of relative situational naiveté (Lofland et al., 2006), to encourage the participants to explain their motives and actions in detail, thus assisting with the collation of rich data. The level of rapport was developed not as a strategy to manipulate the participants, but as a means of increasing trust and equalising power relations between me and the participants.

Additional time was spent observing wheelchair ambulation between key areas in the site, for example, between the accommodation wings and the Integrated Healthcare Unit (IHU) or activities centres. Field notes were also gathered observing the peer caregivers collecting meals trolleys and chaperoning the ODPs in the remedial gym sessions. Reflections were gathered on meetings with middle-level and senior managers in various locations, including the IHU and administrational offices. Periods of downtime were spent in staff offices and the officers' mess.

Participant observations

Adopting an ethnographic strategy gave me the latitude for situated flexibility. As Hammersley and Atkinson (2007) suggest, participant observations can provide a window on people's experiences and interpretations of their social worlds. In the initial stages of the research, I collated direct observations and factual descriptions of events, quotes, processes and people in the environment, initially avoiding inference or abstraction. As my presence became more accepted, emotional reactions (including my own) were noted and theoretical inferences were recorded. Impressionistic field notes and in-the-moment reflections were written directly onto a notebook that was kept with me at all times. The practicalities of making notes 'on the hoof' presented me with the problem of having to pause to make notes while in discussion with participants, which may have formed a barrier to our communication, or having to cognitively stack key observations and statements to annotate at a later time.

The participant observations enabled me to be as close as possible to communities, their culture and practices, witnessing the caregivers' embodied skills and how they provided support. I was able to see what difference caregiving made to the participants' lives and hear about the daily tensions of caregiving in the context of custodial processes. Being reflexively *with* the participants enabled me to chart their relational dynamics and actions and develop a thickness of 'voice' that was composed of more than their words. The observations were augmented with opportunistic, informal questions, designed to clarify routine activities and performances, and to increase my understanding of the situated meaning of the caregiver's practices (see Appendix 6, page 272, for a reflection on the process of data collection).

Location	**Number of caregiver participants**	**Method**	**Time allocation (May–November 2018)**
HU 1	6	Participant observation	11 days
HU 2	2	and informal	1 days
HU 3	4	questioning.	9 days
HU 4	2		1 day

Table 2: Participant observations by time and location

Interviews with ODPs

For convenience, quietness and privacy, the interviews were conducted in the participants' cells, with only me and the ODP present – it is likely that this is where the participants felt most comfortable (Moore, 2002; Herzog, 2005). The interviews lasted between 44 minutes to one hour 40 minutes (on average 71.9 minutes, see Table 3 below). Permission was granted to use a password-protected laptop and recording equipment, on the proviso that all verbal recordings were transcribed anonymously and deleted before leaving the prison. This was found to be impractical as on many occasions, there were very few quiet, private spaces available and time was limited. To compensate for this constraint, the times of potentially interesting moments were noted separately, and these specific moments in the recordings were revisited and typed, in full, at a later point in the day. All written notes were later refined and converted into ~~a~~ digital format by myself, within a 24-hour period. The outcome of this limitation result in some of the extracts being nearer to

contemporaneous notes rather than precise verbatim transcription, consequently impacting on the quality of the data.

The level of environmental stimulation was generally low; therefore, the opportunity to be heard by someone new and independent may have appealed to some participants. Moreover, Liamputtong (2007, p196), states, 'Stigmatized individuals, like registered sex offenders and their family members, desire to be heard and have opportunities to tell their stories'. It is also possible that they may have valued the opportunity to offload personal stresses. Many of the ODPs had completed post-world war national service, and my age and previous military experience may have helped me to be accepted as someone who could be trusted.

I adopted a semi-structured approach to the interviews, with the aim of eliciting rich, detailed data. The interview questions were mostly open in orientation, in order to adapt to the flow of conversation and the linguistic capabilities of the participants (see the interview schedule at Appendix 5, page 267). My approach to each interview was relatively similar, occasionally altering the structure to probe areas of interest for further information. I felt able to draw on previously acquired professional sensitivities founded in humanistic principles, such as perspective taking, empathic listening, tolerance for ambiguity and emotional sensitivity (Skovolt and Trotter-Mathison, 2011), to listen with minimal judgment and to demonstrate genuine interest in participants' experiences. These skills further assisted the process of rapport building and gaining acceptance. Ultimately, the interviews offered thick descriptions of their lived existence, enabling me to hear in detail how the ODPs talked about their situated relationships and factors that enabled them to cope.

Participant	Age	Sentenced length	Years served	Location	Length of interview in minutes
Bobby	81	16	8	HU 1	100
Sam	67	IPP	10.5	HU 1	55
Jack	79	12	3	HU 1	63
Ralph	74	IPP	8	HU 1	85
Eric	72	8	2	HU 1	68
Harry	62	Full-life tariff	30	HU 1	85
Bernard	41	IPP	12	HU 1	87
Ted	86	20	Not recorded	HU 1	97
Stan	93	20	5	HU 1	65
Gordon	78	9	6 months	HU 1	50
Eddie	85	12	Not recorded	HU 3	26 + 38
Tom	64	16	6	HU 4	44
Average	73.5				71.9

Table 3: ODP sentence length, demographic data and interview details

Safeguarding vulnerability – ethics in action

ODPs are regarded as an extremely vulnerable population. As such, I was highly sensitised to the needs of the participants, conscious of not wanting to further stigmatise or 'other' them or incur reputational damage to the organisation. However, if services are to be developed to meet the needs of vulnerable populations, engaging them in research is clearly essential. Accordingly, Morse (2000) suggests, it is the vulnerable or disenfranchised members of our society that are in the greatest need of understanding.

Ethical considerations were approached from the perspectives of both 'procedural ethics', for example, formal authorisation for research, and an 'ethics of practice', or

dealing with conflicts and dilemmas occurring within the course of the research (Guillemin and Gillam, 2004). My aim throughout the research process was to give visibility to my decisions and actions and to increase the transparency of my reflexive processes, thereby maintaining a continuous and critical approach to ethical reflection. This process was assisted with persistent reference to the British Educational Research Association (2018) ethical guidelines.

From a procedural perspective, an internal University of Brighton ethics application was lodged at tier 2, this was endorsed by the Cross-School Research Ethics Committee on 07.11.2017. An online decision-making algorithm was used to determine that an NHS IRAS application was not required, on the basis that I was not focusing directly on NHS patients. An application was subsequently placed with the NOMS research ethics panel. Once approved by the prison governor, I was connected with a local research adviser at the research site to discuss the parameters of my study. Before commencing data collection, information was disseminated to the residential custody managers informing them of my presence and the research aims.

The data within the study is presented, to the best of my ability, maintaining privacy, confidentiality and anonymity, with minimal indication of attribution to the individual participants or the research site. My designation as a researcher was communicated at every stage during the research and participation was voluntary. Gaining consent required a skilled and sensitive approach. The participants were informed of their right to withdraw from the research at any stage, and of the data storage protocols. The participants were informed that there may be circumstances in which confidentiality could not be guaranteed, specifically where a risk to safety or exploitation might occur. Time was afforded to each participant to read the consent sheet and, where needed, to clarify key points. I explained that pseudonyms would be used and ensured that a signature was attained on each form.

The potential for psychological or emotional harm for prisoners convicted of sex offences would appear to be high, as dialogic processes may prompt participants to revisit aspects of their lives that they may have previously suppressed. Furthermore,

in-depth discussions may also give rise to new self-knowledge, with the potential for adverse psychological impacts. Researchers undertaking sensitive qualitative research must skilfully safeguard the emotions of the participants to ensure that vulnerable individuals are not further traumatised by the experience (Liamputtong, 2007). In attending to an ethics of practice, it was therefore imperative to take all necessary steps to alleviate concern before, during and after the data collection process. To assist with these issues, a 'safeguarding action plan' (Appendix 7, page 274) was devised in addition to the consent forms (Appendix 8, page 277) and participant information sheets (Appendix 9, page 279). This was designed to reassure gatekeepers and, from a more practical perspective, to signpost participants to local sources of emotional support in the event of immediate or post-involvement distress.

As described in Chapter 4, I did encounter some individuals with profound cognitive impairments. In these instances, I made judgments that the individuals lacked the mental capacity to comply with the principle of informed consent, so I did not proceed with the interviews. Furthermore, there was no need to breach confidentiality, although there was an incident in which a caregiver disclosed a breach of policy guidance in relation to the difference between personal and intimate care. The issue was acknowledged by senior clinicians and taken back to the community of caregivers to be used as a point of learning for future practice. On a separate occasion, I became concerned about the resilience levels of one of the caregivers and took steps to engage senior staff to provide support.

Despite my concerns, none of the participants became emotional while being observed or interviewed (although two interviews were postponed because of tiredness). On reflection, this is likely to be because they did not feel particularly threatened by the content of the dialogue rather than a need to suppress their emotions to preserve their status in the masculine, local community. Unsurprisingly, I heard nothing to suggest any of the participants expressed post-interview stresses; indeed, it is open to question regarding whether their concerns would have reached me.

Trustworthiness

Given that the 'specification of validity criteria in qualitative research has implications for both the research process and the research product' (Whittmore, Chase and Mandle, 2001, p534), in this short section I would like to briefly acknowledge the high value attached to achieving trustworthiness within the research.

Accepting research is a linear and non-linear process, it strikes me that it is best to discuss trustworthiness retrospectively, as part of a fuller discussion of the findings of the research. Therefore, a self-assessment of primary criteria of trustworthiness will be discussed at Chapter 9. Assessment of trustworthiness, page 149, making use of Guba and Lincoln's (1994) criteria of credibility, dependability, confirmability, authenticity and transferability.

Text box 1: Reflexive positioning and thoughts on working with MCSOs

In this section, I provide a reflexive statement in relation to the influence of my biographic trajectory and working with MCSOs, with the aim of surfacing possible biases. (See additional reflective information on the motivation to undertake the study in Appendix *1.3. Reflective notes on the motivation to undertake the study).*

Reflexivity refers to the ability to reflect upon, examine and explore the contextual details and social processes influencing the research relationships and the participants' lives (Fonoy and Cook, 1991). Whereas critical reflexivity focuses on the researchers position in relation to power, privilege or other factors that can cause tensions when critiquing the power struggles of participants (Madison, 2005). My privileged status as a white, middle-aged male, with knowledge of the prison system engendered a position of relative power, even though at times I actually felt quite vulnerable.

Uglevik (2014, p272) advises, 'In reflexively self-conscious ethnographic accounts, it is important to disclose one's auto-ethnographic roles as these are vital for the reader trying to make sense of the text'. As such, my reflexive positioning as a neophyte prison researcher is rather unusual in that I have had a good deal of biographic and professional involvement with prisons over my life course. This began during my childhood as my father was employed as a prison officer and latterly as a prison governor at several locations in England. It is likely that my socialisation at least partially determined decisions taken in later life, namely, to pursue a career within heavily structured and hierarchical environments. This is visible within my repertoire of adult professional identities, for example, military nurse, prison nurse, prison nurse manager and nurse educator.

Coffey (1999, p1) suggests, 'Ethnographers should be aware of how fieldwork, research and textual practice construct, reproduce and implicate selves, relationships and personal identities'. Moreover, Jewkes (2014, p387) acknowledges that discussion of researchers 'biography, motivations, and emotions can uniquely enrich data, analysis and writing up'. It is therefore suggested that my field worker self is mediated specifically by my embodied socialisation and by my professional experiences as a prison healthcare professional. Under such circumstances it might be anticipated that I would have transitioned back into familiar institutional conditions easily; however, my experience transpired to be more complex. Having since moved to a career in higher education it is likely that over time, I have become estranged from prison service culture and the performance of these former occupational subjectivities. Arguably my enmeshed social trajectory could be perceived to influence my researcher subjectivities, leading to a need for an ongoing, situationally reflexive approach to decision making.

Reflexive note in relation to working with MCSOs

Championing the rights of older prisoners, particularly older males convicted of sexual offences, will never be a popular cause, particularly in light of contemporary, populist notions of punishment and a shift in public support towards victims (Ismail, 2020). These are emotive issues and readers may be unsettled by emotions such as disgust, and other attitudes associated with people who carry such labels. I do not expect the general public to feel sympathy for them or expect vast resources to be allocated to improve their care. My position in relation to the participants responsibility for their offending behaviour is, the law courts are responsible for their punishment; therefore issues relating to their sentencing are between the participants and their solicitors. Although reporting on their criminal histories is in the public domain, I did not seek information on the participants' index offences (although some information was shared spontaneously). I attempted to adopt as near as possible the position of non-judgmental, professional detachment to the caregiver and receiver's offending histories.

While I do not seek to promote the coddling of chronically unwell or disabled older prisoners, I do have some sympathy in respect of their health and social vulnerabilities in the context of the environment. For example, the literature highlights increasing concern for their treatment from a range of sources and countries. My main position is one of trying to make things better with the resources at our disposal. In doing so we may achieve the aims of supporting the ODP's well-being, helping to develop the peer caregivers and achieving other social goods within the prison community.

Impression management and negotiating position

In immersive research roles, researchers actively engage in situational identity construction; this involves the self-conscious representation of the self to benefit relationships, and, ultimately, data collection. Bearing, personal appearance and language are well documented as important visible features of impression

management (Goffman, 1959). I selectively wore smart casual clothes that I thought would help to represent myself as acceptable to the prisoners and staff I was engaging with. Accordingly, Coffey (1999, p59) suggests, 'We concern ourselves with the positioning, visibility and performance of our own embodied self as we undertake participant observation'. Therefore, my posture, attire and dispositions became central to the achievement of the fieldwork.

However, as I learned, it was not always easy to maintain a constructed fieldworker disposition that was in harmony with my preferred researcher identity, and this tension became a source of emotional dissonance. In line with recognised features of prison culture and the prisoner code (Crewe, 2009), the reflections and memos attest to many challenging interpersonal encounters, as well as the emotional labour needed to manage the reactions and to assert and reassert my position.

The term 'insider' suggests one who shares the roles, experiences or characteristics of the participants, whereas the term 'outsider' describes an individual who does not share the commonalities of the participants (Corben, Dwyer and Buckle, 2009). When represented this way, the terms suggest dichotomous positions; however, my experience was more problematic than the simple binary suggests. During the fieldwork I mainly interfaced with two socially distant groups: prison officers and prison inmates, occupying a liminal position, oscillating in the vague space between the groups. My clothing, bearing and language clearly identified me as an outsider; however, as someone with professional experience of working in prisons and as a trusted keyholder, I was perhaps nearer to occupying an 'informed' outsider status. Generally, I lacked a legitimate role and membership to either group (Ugelvik, 2014).

The need to reflect on this relational dynamic became key to understanding some of the difficulties and anxieties I encountered. Reducing the distance between myself and either group brought the prospect of methodological risks. For example, appearing too much like an insider risked identifying myself with organisational ideals and the possibility of a failure to connect with or be accepted by prisoners. Alternatively, moving too far towards outsider status risked raising the suspicions or scepticism of the staff. To an extent, both positions were exploited in the process of

data collection, for example, my previous professional knowledge helped me to gain the support of gatekeepers and access to the site. I was also able to draw on my biographic knowledge to demonstrate my understanding of the culture of prisons, their language and organisational processes, and, in doing so, gaining trust and situated credibility with the staff. Becker (1967, p241) suggests 'credibility and the right to be heard are differentially distributed through the ranks of the system'. I did not intend to be overly conspicuous, but, simultaneously, I wished to avoid being seen as too passive or marginal by either group of participants.

My external, academic status gave me independence from the prison hierarchy and perceivably, something of a voice within the environment. For example, several prisoners asked, '*Not being funny Gov, but who are you with*?' or '*Are you IMB*' *(Independent Monitoring Board) or* '*psychology*' *or a* '*governor?*', which implies I was perceived as someone who could be recruited to resolve various personal or procedural problems with the local prison system. In one residential area, word about my presence and project appeared to get around. On introducing me to a fellow inmate, a peer caregiver said, '*If you want to get something done, speak to him*'. This implies a position of relative, asymmetric, power in comparison to the prisoners (and possibly some of the staff), within the hierarchical hegemony of the community.

Holding prison keys and moving between functional areas brought other intra-personal tensions. On the one hand it enabled greater independence; however, on the other the regular boundary transitions to areas where I was not known and not expected led to moments of social awkwardness and feelings of dependence on individuals for simple practical support, such as asking for directions. Molding Nielson (2010, p307) confirms that uncertainty and insecurity is prevalent in ethnographic research in prisons because the participation of the researcher 'requires shifting social engagements in relation to which the researcher constantly has to guard and disguise information and positioning'. It is felt by several authors that reflecting on the subjective strains of such experiences can lead to useful analytic insights (Liebling, 2001; Jewkes, 2011; Molding Nielson, 2010; Yuen, 2011).

Organising the data and analysis

This section provides an outline of the stages and processes involved in organising the data, code elicitation and theme generation.

As extremely large amounts of data were generated, considerable attention was given to the systematic management of the data. Dividing the data corpus into sets and journaling reflections on methodological decisions helped me to manage and prioritise the data. The data corpus was initially clustered into three main data sets:

1. Interview transcripts with 12 ODP participants.
2. Field notes from shadowing caregiver/care receiver dyads and DLOs.
3. Field notes from deep hanging out in the four residential areas, meetings and other notes.

Initially, I hand typed the notes and transcripts into Word by myself, taking care to anonymise the participants' identity.

Data analysis involves a process of transforming raw data into findings and results (Lofland et al., 2006). In this thesis, a process of thematic analysis was adopted, based on the ideas of Braun and Clarke (2006). Thematic analysis has been described by Madrill, Jordan and Shirley (2010) as a contextualist method, sitting on a continuum between the poles of realism and constructivism. This form of analysis is concerned with the meaning individuals give to their experience and ways in which social context can impact on meanings. It follows a broad process of an inductive, systematic, context sensitive sorting of sections of data into categories and broader themes.

The transcripts and field notes were iteratively read multiple times, initially without adding notes. As my familiarity with the text increased, the data was reread, moving back and forth between the research questions and aims, and then rereading alongside the journal entries and other memos, as suggested by Braun and Clarke (2006). The transcripts and notes were later reread and notes were added, emphasising inferences, reflections, decisions and key points of learning. Eventually, each transcript and field note was individually reread, questions were asked of the

data in order to add landscape (semantic) observations or abstract codes (see Appendix 10, page 289). Numbering was added to each comment or description and key texts were then transferred to word tables.

The first criteria for coding was the participants' comments based on their experiences; the second criteria originated from my initial interpretations and reflections on underlying causal mechanisms (Miles et al., 2014). Eventually, codes were developed relating to practical activities, enabling and constraining processes, relational issues, emotional responses and links to theoretical constructs (see Appendix 10, page 289).

To organise the respective data sets, codes were transferred from Word to Excel spreadsheets, based on processes recommended by Ose (2016). Exemplary quotes and observations were added into columns under the codes.
Spreadsheet 1:

Sheet 1: ODP interviews (number of codes identified – 27)
Sheet 2: Participant observations (number of codes identified – 24)
Sheet 3: Other field notes (number of codes identified – 24)

Spreadsheet 2:
Codes were grouped into two sheets or sections, these were 'interviews' (reduced to 20 meaningful codes) and 'all field notes' (reduced to 15 meaningful codes). Some codes overlapped into each data set, for example, 'effects of the environment' featured in both data sets. Next, different colours were allocated to groups of codes, to aid a more immediately visible review.

Spreadsheet 3:
A final spreadsheet was developed, clustering all meaningful codes into the themes. This helped with the process of reflecting on the relationships between the comments and codes.

The data was uploaded into NVivo within three months of data collection. The data display function presented a visual representation of the number of codes by

participants, graphically confirming what was already known from the clustering of codes into spreadsheets.

Considerable time was spent deliberating on textual differences, patterns and similarities within the text. Insights were labelled and added to the various phenomena, until saturation was achieved. Iterative reference to the research questions, reflective consideration with supervisors and the use of visual tools, such as spreadsheets and diagrammatic mapping (Braun and Wilkinson, 2003), helped to form the themes. Eventually, the codes were clustered and five themes were identified:

1. **Immediate precarity and longer-term risks.** This theme describes and discusses relational, procedural and existential factors affecting the participants at the research site.
2. **Expressions of care in prison.** In summary, this theme discusses who in the environment cares and in what ways.
3. **Caregiving and personal development.** Discusses and analyses the motivations to engage with caregiving and the impact of caregiving on personal change and development.
4. **Learning to peer care.** This theme contains data and analysis relating to social approaches to learning to peer care and identity development.
5. **Purpose and power: working relationships, official guidance, leadership.** In this theme I explore the relationship between caregiving and local and national guidance along with and the attitudes of key individuals.

Confidentiality was maintained throughout the process, in terms of storage, presenting data and in discussions with supervisors and key staff. In summary, the process was both inductive and reflexive, based on an interactive, triangular approach to relationships between theory, data collected and context (Stephens, 2009).

Chapter summary

All social research requires a skilled and sensitive approach, but the dimensions of vulnerability within the sample called for a particularly sensitive approach to the procedural and relational ethics, and a selection of research methods that were suited to the population. Spending an extended period in the environment enabled me to become known to the participants, and this helped to facilitate productive relationships.

A reflexive link is established between my professional history, and aspects of my embodied socialisation are shown to interact with my researcher self. Numerous practical, interpersonal and ethical challenges were experienced during data collection; however, these were ultimately overcome, and I was able to collate and analyse the various data. Having discussed the methodological framework and data collection process for this research, the thesis now turns to the results chapters.

Part 2: Tales from the field

Part 1 essentially set out the research context, the methodological and theoretical elements underpinning the research. In Part 2, I present a selection of findings clustered into five thematic chapters. The chapters contain quotes, narratives and researcher observations from the field of research, supported with reflective discussion and analysis.

Chapter 4. Immediate precarity and longer-term risks

Chapter introduction

In this chapter, the daily lives and personal troubles of the participants are described and illustrated. Many of the ODPs lived with the 'double burden' (Turner et al., 2018, p161) of deteriorating health status and the risk factors associated with imprisonment in later life. The extracts and analysis speak to the limitations imposed on the participants by the cultural, economic, organisational and material influences within the environment. The extracts allude to the subjective costs of life within a regime that is undifferentiated by age and environmental quality. The data reveals that day-to-day life is characterised by a blend of predictability, concerns for personal safety, uncertainty about their longer-term futures in the community and the possibility of dying in prison.

Precarity is considered to be a 'condition of living with insecurity, uncertainty and possible exploitation as well as social suffering that affects most of the (prison) population' (Casalini, 2020, p134). Based on the principles of risk, insecurity and vulnerability, precarity provides the foundation from which to explore the experience of living with frailty and disability in prison and, subsequently, the priorities of care. Disability will be defined in accordance with the UN Convention on the Rights of Persons with Disability (2006) (see page 224 for a hyperlink to this document).

Risk and vulnerability based on medical needs and disability

The chapter opens with a personal reflection on the health status of some of the ODPs I encountered in the environment.

(Researcher reflection, recorded in HU1, during time spent with caregiver, Gary). 'I was quite alarmed to see 'Do Not Attempt Resuscitation' (DNAR) cards outside three ground-floor cells, meaning the occupants must have advanced directives in place not to resuscitate them in the event of an acute health crisis. In the same area I met a further three ODPs who I deemed ineligible for interview on the basis that I felt they could not consent in a fully informed way owing to either reduced mental capacity or cognitive impairments. One of the elderly gentlemen appeared to be living with dementia and a severe hearing impairment, a second displayed discernible levels of impulsivity and aggression; another appeared to have learning disability or a mental impairment. This all adds to my sense that the level of vulnerability in the older adult population was much higher than I anticipated and remember from my previous experience'.

This reflection was recorded early in the data collection process and captures some indicators of the concentration and level of dependency among the local ODP population. There is an emotive edge to the reflection, and, as Yuen (2011) and Liebling (2014) suggest of prison research, emotion can serve as an important prompt for analysis. The high level of vulnerability is contrasted with my assumption that most ODPs would be well enough to be interviewed. It is possible that the population were more needy at this specific moment in time or, as I thought, it could be a sign that the general health status of the local population had deteriorated.

An increasing level of dependence was typified by the views of an 85-year-old ODP, who enjoyed relatively good physical health but lived with a diagnosis of dementia. It is an emotionally charged statement, in which multiple vulnerabilities become apparent.

(Interview in HU3, ODP Eddie). Researcher: 'So generally speaking, what sort of relationship do you have with the buddies?' Eddie: 'Life would be very different without them. I wake up and I don't know where I am, it takes me a while to get going. I don't feel like I'm getting older, but I opened a packet of biscuits the other day and they ended up going all over the floor, I suppose that's a sign (of ageing). I'm 85, I've outlived my closest family, I won't see my sentence out. It's not their (the buddies) job but they come in every day and every night, it's valuable to me.'

The example of undertaking an ordinarily simple activity is used to highlight a growing awareness of physical and mental decline, and this evokes a sense of loss associated with the universal processes of ageing. There is a mixed view on the caregiver's skills and competence, but also an appreciation of the contribution their visits make to his quality of life – this is coupled with a hint of reluctant dependence and feelings of being burdensome. This self-perception can add to the pressure on older adults, who wish to avoid being seen as losing their capacity for self-reliance (Lloyd et al., 2014). Eddie has learned that the buddies' visits help to instate an affective sense of belonging, and the sense of connection appears to carry added importance given the absence of other supportive relationships brought on by the loss of significant others. Lloyd et al. (2014) suggest that frayed or unredeemable family relationships can exacerbate older adult's sense of vulnerability and precariousness. Eddie's experience can be related to the increasing severity of sentencing (Liebling, 2017), which in this case amounts to a de facto life sentence, and there is an unhappy reference to the prospect of dying behind bars.

The following quote represents an example of complex physical health needs. The full accuracy of the medical details are perhaps contestable, but, if taken at face value, a connection can be made to the intimate relational knowledge within some of the caregiver/care receiver dyads and the potential for an advocacy function for the caregivers.

(Example of complex physical health issues, discussion with buddy Brian, HU3). 'We had a gentleman who was seriously ill; he was hallucinating, he had gangrene in his leg and he had to have it amputated. The doctor was seeing him, but he kept saying,

'I don't know why I'm here doctor, I feel fine'. Eventually, I went over with him, I sat with him in the doctor's room. The doctor asked him 'How are you?', he came back with 'I'm fine thank you'. I can't believe it! I say, 'Well, could you explain to the doctor what you were doing at 0200 this morning?'. 'Oh', he says, 'There was people coming through the walls'. Well that was that, off he went (to hospital)'.

This extract indicates that the ODP's condition had deteriorated significantly before being recognised and referred to a local hospital, raising concerns about the process of assessment and the proximity of trained health professionals to the prisoner population. The extract highlights the attentiveness of the peer caregiver, implying an intimate level of knowledge of the health issues, almost like a family member. If left to individual choice, the ODP would have avoided the prison general practitioner (GP) and his condition would have continued to deteriorate. The situation speaks to the liminal position of the caregivers, whose work is mostly hidden and overlooked. However, on this occasion officers are prepared to trust Brian to accompany the ODP to fulfil an advocacy role, and this appears to have helped to facilitate a medical referral.

Stoicism is consistent with both masculine norms in older adulthood and within hegemonic prisoner expressions of masculinity. Older adults frequently downplay their symptoms and this can culminate in an avoidance of medical services until the condition progresses to the point of crisis (Clarke and Bennett, 2012). Few ODPs talked directly about themselves as older males or discussed their health concerns, preferring to maintain a proverbial stiff upper lip. For example, when asked about his health status, Stan (HU1) commented: *'I'm leaving here in a box, that's the end of it!'*. This position is consistent with the view that that 'men perform a repertoire of continuous masculinities that are central to their identity management' (Thompson and Langdorfer, 2016, p123), and implies that health workers could recognise the dynamic, taking issues of age identity into consideration in their practice.

(Discussion with an officer in HU4 describing an ODP with dementia, taken from my observation with buddy Marv). 'There were times when he just didn't seem to have any kind of clue. He was refusing to return to cell one afternoon. One of the officers

said to him 'Mr. X, you are here as a sentenced prisoner, you have been sentenced to 10 years. You need to return to your cell!'; he just burst into tears as if it was the first time he'd ever heard anything about it. He just didn't know how to react and became tearful and confused. He went out to hospital and all sorts, but in the end, he got his 'C Cat' and got transferred to another prison. There was nothing we could do for him, we just got Marv to write out a list of all his preferences and the things he could and couldn't do. God knows if it actually got to the right person'.

In this extract, the older prisoner lives with a cognitive impairment. Consistent with Aday and Krabill's (2013) notion of prison-specific ADLs (or PADLs), he simply is not able to process the officer's order to return to his cell. Memory issues inhibit the ODP's awareness, leading to interpersonal conflict, before a moment of realisation and then emotional distress. The situation speaks to the effects of living with a cognitive disability in the context of the busy, functional workspace, with a strong suggestion that environmental and procedural factors add to the ODP's ongoing experience of distress. The officer's comments betray a sense of dissonance with the inappropriateness of the regime, which is not designed or resourced for the additional needs of cognitively impaired older adults. Accepting the often-pernicious nature of the symptoms of dementia, and taking into consideration the distress experienced by the perpetrator's victims, it could be questioned, from a moral perspective, that if someone is not mentally well enough to understand that they are in prison and serving a sentence, is there value in punishing or detaining them, particularly given the hazardous nature of the environment?

In these events, the older prisoner's situation embodies the well-rehearsed 'retribution or rehabilitation' debate (McLaughlin and Muncie, 1996). The incarceration of people with advanced states of frailty and illness is clearly not about managing risks or providing rehabilitation – it relates to retributive justice for victims. However, an environment that cannot support an older person's health represents a breach of human and equality rights and constitutes a social justice and moral issue. The situation is reflective of a justice system that privileges imprisonment over diversion or rehabilitation (Turner et al., 2018; House of Commons Justice Select Committee, 2020).

The intersection between poor health, age, infirmity and environmental factors

Having shed light on the intersection of physical, cognitive and social vulnerability, I now turn our attention to situated socio-material needs. As described in Chapter 1, much of the research site was designed and built in the pre-Victorian era with the purpose of accommodating younger, able-bodied individuals in line with assumptions based on the age-crime curve (Mann, 2012).

The next extract outlines the difficulties associated with the limitations of the physical environment, in the context of functional ability and needs.

(From interview with ODP Bobby, in HU1). 'I had a heart attack at 08.30 in the morning they (paramedics) eventually came. They got me on their stretcher, but then they realised they couldn't get it through the door, so they had to get me off the stretcher again. Next, they tried with their wheelchair but couldn't get it through the cell door either, it was too narrow. So, they had to man-handle me out of the door, then into a wheelchair. This is just after a heart attack! If that had been outside in civvy street there would be uproar'.

This extract is illustrative of the limited nature of the physical environment. It creates an image of awkwardness, depicting a general lack of suitability in the design of the cells and corridors in relation to basic mobility and the use of medical equipment. In HU1, the cells contained a bed, shower, sink and toilet, there was very little room to manoeuvre a wheelchair, leading one of the senior managers I interfaced with to describe them as '*glorified toilets'*. Impracticalities aside, the configuration of the spur did lend itself to social contact between the residents, contributing towards relational gains and community building.

(Researcher observation recorded while observing buddy Brian, in HU3).

'A handrail was fitted on the wall near to his toilet, as far as I can discern this is the only additional material adjustment to his cell. The ODP appears to have significant mobility problems and can only just about stand; a wheelchair is available for out of cell activity, but I am told this is rare. Unlike HU1 there are no showers in the cells, meaning this chap has a separate chair to wash at his cell sink, and this is where he spends his day when he is not on his bed (I note that the chair is not an orthopaedic high-back chair, although I doubt if there is enough room for one). The showers are in a recess located near the centre of the ground-floor landing, there is a flimsy nylon curtain but any personnel going to or from the wing office must pass this area, therefore reducing the privacy to passing visitors. There are also two steps to traverse. I am unsure as to why he has not been moved to the social care area'.

There is a myriad of interconnecting issues within this passage of text, but the image is one of isolation, neglect and indignity. The ODP's mobility status dictates he has very little choice regarding how and where he spends his day. The use of the shower is virtually off limits to this older adult. If taken at face value, the lack of adjustments represents a contravention of his civil liberties (Equality Act 2010; Human Rights Act 1998; Prison Rules 1999; United Nations Standard Minimum Rules for the Treatment of Prisoners, 2015), not to mention the risks attached to an emergency, such as a fire or a fall. He is reliant on the caregivers who go out of their way to visit him daily, and this helps to boost his mental well-being and, for a limited period, his quality of life.

The following quote pulls together a range of issues, including a connection between materiality, ageism and disablism.

*(From HU1, interview with ODP Sam). 'I used to get on well with this young Brazilian chap, he used to pop down and have a chat occasionally. I asked him to push me (wheelchair) once, but he just didn't have a clue. He thought it would be funny to go a bit faster… it wasn't! I don't think he realised; it wasn't a good experience for me**…** it frightened the life out of me; coming out of my wheelchair would be really dangerous for me. There was another chap, he pushed my chair through a pile of pigeon poo, it's not nice stuff. It sounds so petty, but it attached to the wheel, and*

then it got all over my cell floor, I can't get to it to get it off. And then I go to push my wheel and it gets on my hands, he didn't care about that. Another time I had been taken out to hospital. An officer was pushing me in my chair, he pushed me into a door and stubbed my toe, it was excruciating. Far from an apology he says, 'Well, you are in the right place!'

There are several elements to this extract, each suggesting that the ODP's needs, and by extension his rights, were overlooked. There is a narrative of disempowerment towards both his general personhood and health status. His younger friend thought it would be a thrill to ambulate his wheelchair erratically, but he is unaware of the ODP's fear, and of the consequences of him falling from his chair. There is a taken-for-granted view that anyone could or should be able to ambulate the wheelchair without any kind of care or training.

There is unconscious carelessness in relation to the experience of his chair being pushed through pigeon waste. Spatial and environmental factors come into play, as issues of being ambulated outside of the house unit switch to his cell, which is cramped. The ODP has difficulty manoeuvring himself into a position to be able to uphold his personal and environmental hygiene needs. The event places him in a dependent position, as he will have to rely on someone to assist him with these unpleasant tasks. Finally, there is a sense of flippancy or inattentiveness to the indignity and pain experienced by the ODP; his feelings do not seem to be a feature of any of the interactions and he experiences this as demeaning. These paternalistic, undignifying and unconsciously ageist/disablist behaviours are an indication of an 'I know best' approach to older others, which combine to amount to 'institutional thoughtlessness' (Crawley, 2006) and result in a sense of disempowerment.

(Interview with ODP Harry, HU1). 'I can take my bedding off and leave it out to be taken away, I keep things tidy as I can. I can't get my own meal though, I'm not allowed up there, health and safety wise, when everyone is about. I'd get in the way, if you know what I mean…'

In contemporary Western cultures a high value is placed on individual autonomy and independence, and such ideologies can influence practices (Lloyd, 2006). The lively

and populous nature of the environment, coupled with a requirement for the smooth and efficient operation of the institution, leads to concerns about the risk of accidents. This results in meals being delivered to the OPDs' cells by hand, and a sense that ODPs are construed as an inconvenience. In this approach, the needs of the majority (younger, able-bodied) population effectively override the needs of the minority, less abled and frail individuals. Drives for a smooth-running prison regime override what is best for the marginal group, hinting at the dominance of instrumental, inflexible practices along with discourses of not only efficiency and control, but also ableism and ageism. The situation resonates with Carney and Gray's (2015, p124) definition of ageism: 'institutionalised and endemic use of social norms and conventions which systematically disadvantage people on the basis of chronological age'.

One can see how the potential for institutional discourses of older adulthood and burdensome could be internalised. Moves towards increasingly regulated, risk-averse practices link to changes in care practices under neo-liberal policies (Baines, 2004). This issue is mirrored in community care and provides an indication of how older people may be 'cared for' (Cunningham, Baines and Shields, 2017).

Personal safety concerns

Jewkes (2005, p46) suggests, 'Of all the 'pains' associated with imprisonment, the fear for personal safety, which is engendered in every direction between inmates and staff is arguably the overriding feature of life in most institutions.' The following extracts outline the experience of ODPs in the context of a regime undifferentiated by age and immediate feelings of personal insecurity.

(From HU1, interview with ODP Ralph). 'The young ones aren't necessarily bullying the older guys (directly), but you know, they might be throwing a tennis ball around or just being boisterous, there's not the space for it, and just it causes friction. A while ago this older chap was just minding his own business making a phone call;

two younger ones were play-fighting and clattered into him. He wasn't expecting it, I heard it really damaged his hip'.

This quote further exemplifies the problems associated with a regime that is undifferentiated by age and living within limited proximity. The younger prisoners are engaged in horseplay, without cognisance or concern for the frail or less able prisoners, which is perhaps understandable given the lack of stimulation within the environment. There is not necessarily an intention to cause harm, yet, on this occasion, their thoughtlessness for older adults, in combination with environmental limitations and proximity, has led to an accident.

(Recorded in HU1, interview with Eric). We discuss the impact of coping with the younger, more demanding inmates, he says, with an air of resignation, 'Let them get on with it; I can shut the door', he says smiling, implying a limited amount of agency. 'But some of them… ugh; there is a guy across the way, in his thirties, he shouldn't be down here, people are frightened of him. He's a bully, he's got a big frame and he is always shouting his mouth off. It should be just old people in this whole area and then things would be alright. There are some others, smoking their cannabis, and doing God knows what else… (I intuit sexual behaviour). I don't know, it's one of those things that doesn't make you feel that great…'

Most of the ODPs grew up in the 1940s/1950s and are likely to be socialised into strong conventional heteronormative masculine roles, such as successful careers, marital and family roles (Townsend, 2002). In these eras, 'Men's identities were negotiated and defined based on their ability to uphold the expectations associated with manhood, earn other men's respect, and distinguish himself from all women' (Thompson and Langdorfer, 2016, p121). These values were visible within their narratives and through the artefacts and pictures in their cells.

All of the prisoners at the research site were sentenced for sexual offences, yet there were culturally defined differences in how the generational groups were perceived. Younger MCSOs are culturally associated with the offence of rape, whereas older MCSOs are associated with child-related, historic offences, leading to othering in the

population (Riccardelli, 2014). This meant that the ODPs were on the wrong side of both an age and offence binary. Within the small community of ODPs, hierarchical relations and, to an extent, the prevailing prisoner culture was less overt, yet the issues are brought into focus when a younger prisoner is located on the spur for reasons other than social care. The social care area cells were not ring fenced, meaning the residential governors had the authority to locate prisoners in the area for disciplinary reasons, such as disputes between prisoners. However, when young prisoners were moved into the area it could result in tangible effects on the ambience and how the older residents experienced life. Research by Turner et al. (2018) found that 72% of older prisoners expressed a preference to be accommodated in separate residential housing.

Friction between groups resulted in occasional intergenerational expressions of frustration, for example (*HU1, interview with ODP Jack), 'They kept bringing me the wrong meal, I couldn't put up with it. I went down there and threw my lunch back at them. But, let's be honest, I can hardly breathe, never mind have a go (fight) with them'.* Here, we see an attempt to manage a delicate sense of self in the context of diminishing physicality and autonomy. This could reflect a need for a managed front and to express agency in the context of the wider/prisoner culture and risks of exploitation. Jack projects a masculine image of toughness, independence and risk-taking, alongside internal concerns about frailty and safety, resulting in him feeling one way but having to behave in another. As Biggs (2004, p51) observes, 'the mask of masculinity is a trick of identity management'.

There were numerous other quotes with similar themes…

(Recorded in HU3, while observing peer caregiver, Steve). 'There are a lot of problems with younger prisoners here. Since we've gone to high security, the wing's become a dumping ground from the Seg (segregation unit), we are all mixed up with the younger generation. Some of these boys have been running into their cells, stealing stuff or throwing things out… our boys are very isolated. We are looking out for them, but we can only go so far. If we are in the room, it puts them off … but we cannot get ourselves into trouble'.

In HU3, 29 ODPs are located on the ground floor, to assist with their mobility needs, but this is a busy space used by all wing residents, staff and visitors, making it an impersonal functional space. Sometimes cells are left unattended, doors can be left open or the ODPs may be isolated in their cells. Ageing and declining health status in combination with an absence of officer regulation can result in an increased risk of victimisation. To an extent, the caregivers are able to maintain a presence in the area, adding a safeguarding dimension to their role. Despite this, there is a limit to what they can do, as there is an implication that they could risk a disciplinary infringement, which may reflect badly on their parole reports.

The next extract makes the connection between health-related vulnerability and the risk of exploitation.

(Researcher observation with buddy Gary, in HU1). 'I am observing Gary during the course of his duties. We are near to an open cell, it's the middle of the afternoon but I notice an ODP laying on his bed. He sits around to engage with us although I struggle to decipher what he says. He appears able-bodied but his hair is unkempt, his nails are overgrown, and his cell is in a poor state, for example, there are no sheets on his bed, just a single, unmade blanket. I mention my concerns to Gary, he says he will put in a 'healthcare app' to trigger a nursing intervention. Gary mentions this man needs an extra cell clean per week as he puts food in his loo and forgets to flush it, and consequently it becomes blocked frequently. He suggests the ODP is very quiet and never asks for help. In Gary's words he is 'mentally vulnerable', he suggests he is 'easy prey', anyone could take his property and he wouldn't try to resist (there doesn't appear to be any property to take)'.

This ODP is vulnerable on many levels and needs support with his ADLs – his level of ability leaves him vulnerable to the risk of neglect and exploitation. His personal limitations and dependence mean he does not align with neo-liberal assumptions of individuals as autonomous, conscious and self-determining (Rawls, 1971). However, within the ethics of care, it is argued that such ideals do not allow for the condition of human dependency. It is argued that because of the cultural rejection of

dependency, caregiving and receiving has been confined to the private realm, in which the norms of citizenship cease to apply. A key point within the ethics of care is that dependency is integral to phases within the life course and should not be regarded as an aberration (Lloyd, 2006).

From a reflexive perspective, I was personally troubled by this man and his situation, which I believe triggered a sense of transference and injustice. My impression is that he is unfit to cope in the environment and should have been diverted to a more appropriate setting during the sentencing process. Neo-liberal influences in sentencing and populist punitive public sentiments have influenced policy to make sentencing tougher (Garland, 2001; Wacquant, 2010). My assumption is that he would need some level support in the community, yet, paradoxically, he does not qualify for formal social care in the structured environment of the prison, apart from the support he receives from his peer caregivers, which serves to maintain a minimal level of care. His situation raises questions about the threshold or criteria for formal social care and, again, the social value of sentencing extremely vulnerable individuals.

Fears for the future, release to the community

Some ODPs were more up for the challenges presented by release from prison than others, for example, excerpts from interviews with ODPs Ted and Tom:

(Ted, HU1). 'Well, I hope to have at least a couple of years out there before I die. At this stage in the game, I would like to see how the land lies and how I would get on out there. It will be strange not having people around so much, not to have anyone point me in the right direction, I'm so used to it in here'.

(Recorded in HU4, interview with Tom). 'In the community I'd be worse off, I know things in here. I don't know how it's going to work, being a sex offender, I won't have a community. It's going to be an interesting time; in here I have a buddy. I will need

accommodation on the ground floor, I will need a full-time package of care, wheelchair access, I will need access to a pharmacy, so yeah, I'm really worried…'

These extracts demonstrate the level of ambivalence and concern in relation to release from prison. The quotes speak to the value of their localised community attachments and the importance placed on their relationships with their caregivers. Interestingly, seven out of 12 ODPs expressed a view that support in prison is more robust, in comparison, than the support found in the community. There is a hint that some of the participants have grown highly accustomed to prison life. Indeed, it is possible that they have become institutionalised or made 'docile' by influences in the environment (Foucault, 1977). Declining health and fears of greater precarity in combination with the prospect of change is shown to induce anxiety.

The candid expression of emotion in the following extract testifies to the strength of Bernard's concerns about the prospect of release:

(From interview with Bernard, younger disabled prisoner, HU1): 'I'm really angry. I'm in a wheelchair, I'm blind … my probation officer wants me to go to a hostel for 12 weeks. If I was fully fit, I would be a target, you could imagine? But being disabled, I can't see who is there, and I can't get away. I am literally shitting myself. I've tried to explain to my probation officer, it seemed to go in one ear and out of the other. Say someone comes to my door, I can't see who it is, I'm literally a sitting target. With this latest bullshit allegation, he (the complainant) lives 14 miles away…. not 40, 14! I'm bound to run into him'.

Bernard's explosive emotional expression implies fear rather than anger. He has benefited by being able to serve the majority of his sentence within a small community of MCSOs, but here the participant articulates the reasons why he will be vulnerable if released to a probation hostel near to his previous community. His status as a MCSO with sensory and physical disabilities place him in a vulnerable position and at risk of assault. Yet the one-size-fits-all approach to people management extends beyond the prison walls to the community-supervised premises.

Chapter summary

In this chapter, advancing age and disability is explored through the perspectives and narratives of various participants. The extracts confirm the findings of the literature review, with regard to the high level of vulnerability in the older prisoner population, and provide a front-row perspective on the sources of precarity. In HMPPS policies, older prisoners are represented as a heterogeneous group in terms of age and ability. However, high numbers of ODPs were found to be dependent and struggled to cope with the rigors of the environment. Despite initial expressions of stoicism, when probed, all 12 ODPs alluded to their need for support with basic ADLs. Furthermore, there were numerous expressions of concern for their ongoing need for care, discharge from prison and the possibility of dying behind bars.

As a consequence of the stigma associated with their offending, discourses of ageing and hegemonic masculinity, the ODPs were at the bottom of the prisoner hierarchy. It was also observed that the ODPs sought to maintain a sense of age-appropriate, masculine identity. The transcripts show that although the ODPs privately expressed vulnerability, they wanted to be perceived as independent and competent within their community.

The extracts show that there were both risks and protective factors within the environment. The risk factors can be summarised as: increasing frailty and disability consistent with older adulthood, operational bias in favour of the majority (younger) population, problems caused by the design/fabric of the environment, offence-related stigma and exposure to younger prisoners, bringing increased risks of accidents and exploitation. For the most dependent, the combination of these factors resulted in reduced choice and marginalisation within the closed community. These factors can be juxtaposed with some protective factors (in some areas): slightly reduced exposure to the mainstream prisoner population, the security associated with living near to a small community of older people with similar offending histories and some organised social activities. It seems that dividing prisoners into groups of younger

and older prisoners is too simplistic and represents a false binary. However, without a specific policy to address the needs of ODPs the populations remain undifferentiated by age and environment, and this is shown to be a source of stress. These findings will be considered and discussed further in Chapter 10, page 157.

In Chapter 5, I present and discuss issues relating to locally emergent expressions of peer caregiving, examples of personalised care, horizontal care and the bidirectional nature of caregiving among the local population.

Chapter 5. Expressions of care in prisons

Chapter introduction

The previous chapter confirmed the austerity of the conditions, threats to personal safety and the uncertainty attached to the ODPs' futures – and this is in the context of deteriorating functional health. On many levels, life is difficult for the ODPs, the caregivers and given the decrease in resources, conditions appear to have worsened for the officers. However, in comparison with other prisons the regime is quite liberal, and, in many cases, the micro-communities of caregivers and care receivers is perceived as supportive.

This chapter deals with the issues of who cares, and in what way. I delimit caregiving as restricted to formal services, showing the expression of care in prisons to be diffuse, multi-dimensional and often spontaneous. I situate peer caregiving within a continuum of socially emergent helping practices, by providing examples from the data with discussion and analysis. Practices associated with peer caregiving are shown to occur within the interconnecting fabric of peripheral social activities that serve to shape prison life and help the prison to function.

A topographic review of the data depicts a mixture of perspectives on the quality of care receiver/caregiver interactions, showing that even within a single institution, approaches to performing care were variable. In summary, there were generally higher levels of antipathy and complaints in HU1 in comparison with the other three residential areas (see Table 4, page 103). Examining the differences in the processes and attitudes to caregiving between the residential areas proved helpful in terms of investigating care activity and responding to questions of what can be done to promote learning and to enhance the overall standards of care.

Who cares and in what ways? Horizontal care

An assumption based on my professional experiences was that care in prisons is delivered in vertical relationships, that is either by formal health and social care services or peer caregivers. However, the data reveals ample evidence to suggest that caregiving was not solely confined to these structures. Prison culture and hegemonic masculinity are influential forces in the prisoner population (Jewkes, 2005; Crewe, 2009) and mitigate against expressions of emotion and care among the male population. However, the following examples buck stereotypical notions of hierarchical relations and demonstrate a willingness to 'do right' in response to human vulnerability.

(Researcher observation, during the interview with ODP Harry, HU1). 'I observe that one of the ODPs doesn't seem to require as much support from the buddies, I have seen him actively assisting some of the other care-receivers. We pause to talk and he tells me he suffers with COPD (Chronic Obstructive Pulmonary Disease), PTSD (Post-Traumatic Stress Disorder) and various other long-term conditions, meaning any form of exertion leaves him breathless. He says he likes to help his pals, for example, by fetching items, washing and ironing odd bits of clothing and he brings Harry and Bernard a coffee every hour or so. He does all of these things on a voluntary basis as he says it gives him some structure to his day and makes him feel useful'.

This extract sheds light on the reciprocal relations and transactions between the ODPs and activities that help to shape a sense of community in the residential area. Owing to the research site's rehabilitative function, the prisoner churn is slow, meaning that relationships have an opportunity to develop in comparison to other types of prisons. The situation depicts the supportive nature of some ODP relationships or horizontal support, from which both parties appear to extract benefits. The ODP suggests that the activity adds structure to his day and assists him to manage his time. The actions connote with notions of phronesis, or doing good for self and others, an issue explored further in Chapter 6.

The following quote is taken from the perspective of a buddy in relation to the care of an ODP with dementia.

(From an interview with buddy Dennis in HU3). 'Thankfully some of the other guys (ordinary prisoners) on the wing get involved with helping. If I'm in the middle of doing something, they will do their bit to keep an eye on him (referring to the vulnerable ODP) and keep him right, you see. I think they see what we do, and thank goodness, some of them pitch in and help, otherwise it (peer care) would become impossible'.

Here, a triadic situation emerges whereby ordinary prisoners in the vicinity become cognisant of the ODP's needs and the caregiver's shortage of capacity. This prompts them to respond by offering assistance, on a purely voluntary, goodwill basis. The situation is suggestive of a need for greater resources to deal with the levels of dependence, and develops notions of a more general level of interdependence or collective altruism. Even within the hypermasculine culture, some ordinary prisoners do not stand by and let the ODP (and caregiver) struggle. Processes of ordinary prisoners providing support for other dependent prisoners may not always be visible; however, this instance shows the practice of care is seen to be diffuse and to occur outside of formal structures. This connotes with the concept of 'natural helping', a process found in Navajo Indian communities, in which care is simply provided whenever it is needed, by whoever is in proximity to the person in need (Waller and Patterson, 2002).

The following field note further epitomised a spirit of camaraderie that existed between some prisoners.

(Researcher note recorded in HU1, while interviewing ODP Ralph). 'In the course of my interview with Ralph we are spontaneously interrupted by a former buddy who has casually called in to check on his well-being. He seems like a competent sort of chap and my impression is that his attitude to supporting others was in the right place. I use the opportunity to keep him talking about his experiences; in relation to peer care he suggests… 'The main thing is having a bit of mutual trust and having a

bit of chat… a cup of tea and biscuits. You get to know things like how they like their beds made … it could be something silly, something simple. I used to leave a clean cloth with a dob of disinfectant on it by the sink, then he can have a go at cleaning something himself if he needs to…'

There are several striking elements within this extract. The visitor no longer works as a caregiver, yet he retains a sense of responsibility towards the ODP and continues to visit him, even though there are no financial incentives or gains in terms of his sentence. He acknowledges the importance of trust, attention to detail, and, consistent with the findings of research by Clarke, Dyer and Horwood (1998), of not waiting to be asked how to help. He appears to understand that helping the ODP to help himself is more important than doing things for him. By leaving a cloth and cleaning product in an accessible position, he enables the older adult to uphold his level of self-care and sense of personal autonomy, and this is important in terms of maintaining or actualising the ODP's age identity.

The above situations appear interesting in terms of individual motivations to support others and how they have learned to provide support. They demonstrate that the process of providing help and care is not neutral, as some individuals appear to be more motivated to provide support than others. This is significant in terms of planning peer caregiving and the potential of matching caregivers and care receivers. There were other similar examples within the data corpus:

(Field note added to interview with ODP Ted, HU 1). 'During the interview two younger prisoners appear at the cell door. They have brought the older prisoner a pear, one of the chaps says, 'I bring it to my father'. There is a bit of sheepishness between them, perhaps my presence is enough to put them off a full conversation, but the ODP is pleased to see them and his reciprocity is tangible. I ask Ted why they brought him the pear and if they share the same religion. He says, 'I don't think so, they are just good Muslim boys. We met in the induction wing'.

All of the participants in this scenario are from minority backgrounds, the two younger prisoners appear to be from the Indian subcontinent and the older

participant is from Afro-Caribbean descent. Their ethnicity status may be significant in the context of the under-representedness of minority groups at the research site, in terms of connection and culturally appropriate matching. The young men bring the older participant an item of food as a gift. They may have assumed he was from a similar religious background, or this may be an aspect of their religious code in which the older generation is venerated. The implication is they were in some way attached to Ted, and they go out of their way to see that he is well. As with the situation above, there would appear to be little external gain; however, reciprocity transpired to be an important element in many of the participants' accounts of support. Although potentially sensitive, similar phenotypes, such as race and culture, may be principles by which to plan successful matching between caregivers and ODPs. This is congruent with the concepts of homosociality and homophily, whereby people with similar phenotypes are attracted to one another and form mutually supportive groups (Flood, 2008).

There were numerous examples of well-received socially emergent care practices.

(Researcher note from observation of buddy Brian with an ODP with dementia in HU3). 'I observe Brian as he enters the cell to give the ODP his breakfast pack, he says, 'Morning! Room service', and then, 'What would you like this morning Sir? Will it be cornflakes, or cornflakes?' There is good eye contact and the ODPs face lights up in reaction; Brian's cheery dynamic is appreciated by the ODP and a good deal more social chit-chat ensues, I'm impressed with Brian's perseverance'.

The rewards and recognition for peer caregiving are low, but, in the face of the adversity, here is a good-humoured and open-hearted dynamic. The caregiver has interactionally gained an appreciation of what works to facilitate their engagement and is able to extend a bright, warm greeting. In this moment the buddy seems to acknowledge the challenges associated with their limited existence, but rather than striving to promote growth or recovery, he simply seeks to make the situation more tolerable, demonstrating 'care as a form of attitude and action' (Sevenhuijsen, 1998, p4).

(ODP Gordon, discussing his experiences of peer care in HU2 in comparison to HU1). 'I go to the gym now, you see this is the difference here (between HU2 and HU1), one of the buddies in HU2 came to see me and said, 'We'll go to the gym, come on. It's nice and light, it's things like carpet bowls, come on', he says. 'It's three times a week it is…'. And I'm, 'What on Earth am I going to do in a gym?' But he kept persuading me. My buddy looked for this bowling thing and almost dragged me along to it. So, we go now, and it encourages you to make friends and do some things. It's the one thing I do. They (previous buddy) were sympathetic, they were empathetic, they have everything'.

Gordon had moved from the induction wing (HU2) to the social care area (HU1), providing an opportunity to compare his experience of peer care between the residential areas. In HU2, the buddy uses his greater experience and knowledge of the system to coax Gordon to the social activity. He has the foresight to persist in the face of Gordon's resistance, as he experientially learned that the social element of carpet bowls helps new ODPs to integrate, thus assisting with adaptational issues. Although limited, there were other social activities specifically for ODPs, such as organised religious activities and the occasional veterans' groups. Several participants suggested that these were not the sorts of things they would involve themselves with outside of prison, but they provided a valued source of social activity within prison.

In the following extract, an older participant serves a supportive function to the younger buddies.

(ODP to buddy care, recorded in HU1, with buddy Lee). 'It's not what I'd have expected but I sometimes like hearing what the older guys have to say, and it does help me when they listen to me and give advice. The young help the old; we have a talk and that, and the old help the young'.

The above extract describes the responsiveness of the older participant towards his caregiver, and provides evidence of completely informal, supportive relationships. The relational exchange implies a sense of intergenerational 'generativity', which

McAdams et al. (1997, p678), describe as ‘the concern for and commitment to promoting the next generation, manifested through mentoring’. The ODP provides a supportive ear for the younger caregiver, and their discussions appear to positively influence his mental well-being, reduce his anxiety and enable Lee to progress through his sentence constructively. In their discussion of peer working in prison, Perrin and Blagden (2014) suggest listening to others’ problems creates a feeling of togetherness and helps to counteract loneliness. There are several implications within this short extract: caregiver/care receiver dyads have the potential to foster positive affective outcomes, there are intersubjective benefits for both parties, and significantly, care can be bidirectional.

Peer care, the light and the shade

Thus far, the extracts shed a mostly positive complexion on the state of informal care and peer care at the research site. In the following extract, ODP Gordon provides an example of inattentive practice, and this too is contrasted with better treatment in a previous residential area. This appears to reinforce the notion of differences in the quality of care and relationships between the residential areas.

(Interview with Gordon, an ODP with a visual disability, in HU1). ‘The buddy doesn’t knock, he comes in without me picking up on it, he is suddenly on my shoulder. I’ve asked him two or three times, ‘Please can you announce yourself’? The buddies on (HU2) were so much more aware of these things. This lot would pass you in the corridor and not say ‘Hello’; yet it was so natural to them on (HU2). They haven’t got the faintest clue what’s going on with me’.
Researcher: Was it something about the familiarity between yourself and the buddies on (HU2)? Gordon: ‘It was something more; they were human beings they made you less aware of the stark reality’… (Participant’s voice fades into silence; I interpret, ‘of being in a prison’).

A picture begins to emerge in which we see that peer caregiving is experienced as more effective in some communities than others. As the extract suggests, the

caregivers in his previous wing were more intuitive to his needs. Gordon uses the example of unexpected intrusions into his personal space to illustrate his experience of impersonal and insensitive practice, whereas engagement with his previous caregiver is characterised as interested and personalised, and this was clearly appreciated. The new caregiver has been asked to be more aware of the proximity issues in the context of the older participant's visual problems. However, we know little about the caregiver's background or his motivation for undertaking the role, other than to note that he is completely untrained and, given the rapid turnover of caregivers in HU1, likely to be relatively new to the role.

Ethics of care views the needs of both the care receivers and caregivers as part of the same continuum (Tronto, 1993). Although the situation is not ideal for either party, it would seem churlish to blame the untrained buddy for his lack of attentiveness. In her discussion of such issues, Brown Coverdale (2017) uses an analogy of using a physical education teacher to cover teaching for a mathematics class. No matter how much goodwill is displayed, the teacher is simply not trained or competent for the role, so it would be inappropriate to blame them for doing a poor job. Indeed, the analogy could be extended to include the wider institution and HMPPS more generally, which is currently configured towards discourses and practices of security and managerialism rather than care. Lessons can be drawn from these comments to shape future practice, the most obvious is the absence of training and competence development in relation to interpersonal skills or simple attention to personal preferences.

In the following extract, the caregiver is able to carry out a range of practical tasks; however, extra time for social engagement would appear to be the most valued process.

(Recorded in HU1, interview with ODP Sam).
Researcher: 'What sorts of things does your buddy help you with?'
Sam: 'Cleaning the shower, sink, toilet and floor, he gets me hot water for tea, fetches the bedding, then he's gone again. I wish I could do it myself … I just can't wash the floor. If I get down, that's it, I can't get back up again'.

Researcher: Would you like more time to chat?
Sam: 'I would but he has got a cleaning job to get on with. They are too quick, they draft them away, that takes them away from the job he is doing….'

There is a suggestion of interpersonal detachment while the buddy performs a range of practical tasks, with a hint of regret that there is not more time for social engagement. The buddy has other labour-intensive tasks to attend to in order to help the wing function, such as collecting meals trolleys. At the research site, caregiving and generic wing-based work appear to have become conflated, which detracts from the ability to form more meaningful and productive working relationships. It is not clear why this is the case, as the official guidance does not indicate a need for this. Despite the pitiful remuneration for undertaking the tasks, it could be speculated that the situation has emerged from local drives for efficiency and a culture of 'wanting more for less'.

This situation is evocative of similar issues in community social care which have seen a greater emphasis on making resources meet demand (Baines, 2004), and this can lead to 'a focus on tasks and preclude a focus on people' (Clarke et al., 1998, p12). The issue reflects the 'time and task' approach, in which caregiving is commodified into 15-minute scheduled care calls, which inhibit time for the relational aspects of care (Baines, 2004). Increasingly, 'standardised' care tasks are divided into units of time that can be measured on a for-profit basis. This model of working epitomises a shift from welfarist to neo-liberal imperatives in care, and has become a feature of new public management (NPM) ideals in care. Often, more obtuse complaints were expressed about the buddies in HU1. For example, from Gordon in HU1: *'On your way out take a look into the canteen area, you will see them sitting around with their feet up'*, or Eric in HU1, *'They just aren't as good as they used to be, the turn-over is too quick, they are changing all of the time'*; these sentiments are confirmed in the reflection below.

(Researcher reflection based in HU1). 'There appears to be a higher level of antipathy between the buddies and ODPs in HU1 than I remembered from the pilot study, whereas the feedback from the other wings is mostly appreciative in

orientation. There were numerous suggestions that the buddies weren't around long enough to get to know the role. Expressions like an effective buddy 'goes the extra mile', or 'does the little extra things' appeared so many times they began to take on the feel of a linguistic trope. I believe the complaints could relate to a number of factors, including the difficult nature of the work, the culture within the teams, a lack of experience and maturity, and lower motivation'.

The ambience between the buddies and ODPs in HU1 had changed since the pilot study – as a generalisation, their practice was characterised as task orientated, less thoughtful and less personal. A comparison is made to the past, which is remembered as a time when the buddies in HU1 performed more consistently. The high workload, low numbers of caregivers and high rate of turnover is highlighted as an explanation for less well appreciated practice, and this is consistent with other factors in the environment, such as reduced staffing. These points are further illustrated by comparison with the other three residential areas, where the caregiver teams are better established and relationships appear to be more cohesive (see Table 4: Summary of differences in caregiving between the residential areas, page 103).

An emotive expression of frustration is presented in the following extract from this visually and physically disabled ODP.

(From HU1, interview with Bernard). The buddies know I am blind; it's fucking obvious right? Say like tomorrow, I'm going to health care, they just wheel me up and leave me, I haven't got any kind of clue where I am. I'm just left, bang in the middle of a corridor or something, I don't know if it's on purpose or not, but it makes me feel stupid. A couple of people in here get short tempered, 'cos I can't see them, I bump into them, and I get, 'Hey, watch where you are going!' I'm like, 'I'm blind!'… 'That's no excuse!' It really fucking pissed me off a couple of months ago… one of the buddies said, 'You'll have to do more for yourself', I say, 'hold on a minute, what are you actually doing for me? I do it all myself!'

There is a tangible sense of frustration in this emotive burst of dialogue. The uninformed, careless approach is experienced as frightening, embarrassing and possibly a risk to the safety of the disabled prisoner. The situation chimes with neo-liberal ideas of responsibilisation, in which people with support needs do not fit into the image of individual autonomy and independence (Lloyd et al., 2015). The extract shows that practical and relational help are not necessarily separate processes but are often performed together, and the outcomes matter to individuals and can lead to negative consequences. Yet, with a little more awareness and communication training, the situation could quickly be transformed into a positive scenario.

The above complaints can be contrasted with the perspectives and experiences of the caregivers.

(Recorded in discussion with buddy Kevin, HU1). 'It might be the smallest of things, but I get a sense I've helped him with something, getting him something, it might just be a piece of clothing or a tooth-brush. Or sorting out his laundry, or sorting out a mess, but it's their cell, and it's important to them. There are times when I'll sit with them for 10 minutes and that 10 minutes can turn into 45 minutes, once it was the best part of two hours! Sometimes he'll go off on a long old story, I wait, thinking about the other things I need to do'.

Kevin has approximately four months' experience as a peer caregiver. The quote illustrates that he is sensitised to the needs of his ODP, as he empathetically elicits that his needs are relational in nature. According to Walby and Cole (2019), peer workers can use their listening skills to relieve the anxiety of fellow prisoners. There is a sense that he too extracts enjoyment from their time together, but he has cognitively stacked a mental list of other tasks, and this presents a source of conflict between attending to the immediate intrinsic needs of the older adult and his other tasks. The extract is suggestive of tensions implicit within the role, namely, listening attentively at the cost of other practical tasks.

The above extracts depict variable levels of satisfaction with peer caregiver practices between the residential areas, which appears to be based on a number of

organisational and individual factors, including competence levels, resources and an absence of leadership and training.

Vertical care

This section reports on the ODPs' experiences of internal and external formal health care services. Mirroring issues in the community, the ODPs complained that hospital appointments were cancelled at short notice, without explanation, and items such as medication and specimen samples were sometimes lost. These issues were frequently cited as a source of concern and had a tangible effect on the participants' affective status.

(From HU1, interview with ODP Eric). 'If I go down to the nurses (at the IHU), they are generally good to me, you know, supportive. If I ask for something, I generally get it. The time I was in the local hospital before my heart attack, the officer watching me was also my personal officer, he said 'I can't believe how bad you were, never again will I let this happen to you. I will see to it that you get a compassionate discharge.' One of the specialist registrars came in and said to me, 'I'll give you three months to live', and she just walked off, just like that, she was horrible. My officer says, 'You can't say that! He's still a human…'

Here, Eric appears to express a general level of satisfaction with prison health and security services. The narrative can be read in a number of ways: it could represent an as near to true account as the participant remembers it, or it could be a constructed image that he wished to create. The ODP's health status is low, and he was being treated poorly, so if taken at face value, the ODP/officer interaction helped to humanise a difficult moment. The participant's vulnerability appears to invoke a sense of protectiveness in the officer, who responds with relational warmth. The situation speaks to the pains of exposure to offence-related stigma and othering. However, this is contrasted with a more respectful relationship, in which, surprisingly, the external health care services are constructed as undignifying and the officer is constructed as more caring. The interaction trumps the usually distant

officer/prisoner hierarchical relationships that would normally be unthinkable in relation to the prisoner code (Sykes, 1958).

In the following extract, the officer's attitudes are juxtaposed with more caring buddies.

(From HU1, interview with ODP Gordon). 'He took the job very seriously and he was a constant source of support and encouragement. For instance, my canteen sheet arrived on Saturday morning, I managed to lose it under my bed somewhere. I later found it, but the officers said to me, 'It's too late to put it in now', but you know, I need the extra food, you know, crackers and things to supplement my diet, I've got dietary requirements. I asked, 'Can't you fax it, email it or something?' I found out later they could have done but didn't, they just couldn't be bothered with me. He (his caregiver) went out of his way to bring me food that was acceptable to me'.

The above two extracts demonstrate a mixture of experiences and opinions on the quality of formal services. As is consistent with many other historic offenders, this older participant was a first-sentence prisoner and, from all outward appearances, from a well-educated, middle-class background. He was new to the environment, and it is possible that he had not fully assimilated or adjusted, which may have been why his anxiety levels were discernibly higher than many of the other ODPs. Here, the staff are constructed as cognitively rigid, exercising instrumental power by enforcing institutional procedures, whereas the caregiver is depicted as going above and beyond what would normally be expected of someone in his position, helping to resolve the issue and resourcefully acquiring some extra items of food.

(Officer statement recorded in HU4, while with shadowing Marv). 'The officer says, 'We are not going to say no to helping someone' but he went on to say that he felt inadequately prepared to look after vulnerable prisoners. 'Even if there was training, there are two staff on the wing, and 72 prisoners. We see them briefly when we unlock them in the morning, we might see them briefly at bang-up, but not in between, we don't really engage with them. We haven't got time to spend with them to find out what is really going on'.

Prison officers are generally preoccupied with matters of security, good order and the functional implementation of the regime. They are clearly not trained carers, yet many demonstrated a genial approach to engagement and, as we have seen, their own brand of compassion. The officers were not blindsided to the needs of the older adults and have been shown to care, albeit in culturally and institutionally defined ways. On this relatively small wing, the prisoner/officer ratio leaves little opportunity to listen to problems, let alone make supportive interventions, as the need to implement the regime overrides the needs of individuals, leading to a one-size-fits-all approach. The excerpt is suggestive that officers are generally aware of individual prisoner needs but are neither trained to care nor in a position to respond to their needs.

Chapter summary

Chapter four established high levels of vulnerability, dependency and precarity within the local ODP population, surfacing a need for greater levels of responsiveness and care. In this chapter, a range of peripheral individuals and groups involved in helping and supporting were described, providing examples of socially emergent care and carelessness.

The extracts detail how care is mediated by institutional processes, a lack of training, attitudes and the allocation of resources. As the caregivers were permanently based on the wings, they were well placed to develop an understanding of the ODPs' needs and be the main source of personal care. Within the all-male, hypermasculine environment, the visibility of dependence appears to trigger a willingness to respond with humanised, altruistic interactions. Some ordinary prisoners and officers are shown to be attuned and responsive to suffering, and examples of horizontal and bidirectional caregiving were cited. Differences based on roles or binary opposites (that of caregiver or care receiver) can be too rigid and, subsequently, unhelpful when instrumentally applied. As Barnes (2012, p179) suggests, horizontal care has

the potential ‘to destabilise distinct categories that lead to competitive constructions of political objectives based on separate identities’.

When data was collated from all four residential areas, differences in practice were noted between the residential wings, showing that practices were not standardised. Individual actions had the potential to impact the ODPs’ sense of independence and self-esteem, either positively or negatively. Where engagement was lacking or task orientated, it was experienced as less satisfactory by both the care receivers and caregivers; whereas, when care was more relationally orientated the data shows intrinsic rewards for both parties. Where there were greater levels of experience, maturity and stability within the communities of caregivers, there were less complaints and higher levels of ODP satisfaction.

The quality of engagement can be expressed on a continuum from productive to demeaning interactions, or summarised by HU in the table below:

HU1 (6 buddies; 28 ODPs) • buddies – low job satisfaction • dependence – high, medium • ODPs – mixed, mostly lower satisfaction • high turnover and lower age of caregivers • instrumental, task-orientated approach to care	**HU2 (2 buddies; 6–8 ODPs)** • buddies – high job satisfaction • assistance from the ordinary prisoners noted • ODPs – non-interviewed • greater continuity and maturity among caregivers • relational approach to care
HU3 (4 buddies; 6–8+ ODPs) • buddies – high job satisfaction • level of dependence mixed, medium to low • ODPs – high satisfaction • greater continuity and maturity among caregivers • relational approach to care	**HU4 (2 buddies; 6 ODPs)** • buddies – high job satisfaction • level of dependence lower • ODPs – high satisfaction • greater continuity and maturity among caregivers • task and person-orientated approach to care

Table 4: Summary of differences in caregiving between the residential areas

The following chapter discusses the factors that motivate, and sustain motivation, in relation to involvement with peer caregiving, as well as the effects that caregiving may have on an individual's identity and altered life trajectory.

Chapter 6. Caregiving and personal development

Chapter introduction

In the previous chapters a mixed picture of vulnerability, care and carelessness was presented and discussed. In this chapter, we see that even the most committed of caregivers complained about the lack of recognition and rewards that accompanied their roles. Caregiving in prisons can be physically and emotionally demanding. It can be fraught with conflict, and often the ODPs and officers are critical. Yet I heard the expression 'I just want to care' on numerous occasions. Taken at face value, this seems like evidence of good citizenship or altruism, but what other intrinsic processes does this aspiration serve? Developing an understanding of the costs and benefits that the caregivers extract from the role, as well as factors that sustain their motivation, would appear central to developing knowledge of what factors might promote or demote the role.

This chapter presents a discussion of the pains and gains associated with peer caregiving at the research site. It provides an outline of the practical, relational and emotional constraints, and this is in the context of resourcing, prison culture and hegemonic masculinity. Narratives of personal sacrifice, increased self-awareness, personal growth and identity reconstruction become visible within the data.

The costs of peer caregiving

The following extract depicts some of the deficits attached to performing the role.

(Recorded with buddy Kevin, in HU1. Quite charged). 'No one wants to be a buddy; why would they? There are just not enough perks. You get £14.50 a week… on £14 we are being penalised! …I don't have enough for the canteen I want. If I went up to the workshops I'd get paid more, I'd have my lunch time free, and get the odd cancellation, meaning I'd get to go to the gym. If I left, there would be no one to do the job. They need to train more wheelchair pushers… you are never off'.

Prisoners have an opportunity to purchase items from a weekly canteen list – this is a focal point of the week and it can make a tangible difference to their morale. Here, Kevin refers to a lack of financial incentive, highlighting there is better-paid employment elsewhere in the prison. The issues relating to low pay and difficult working parameters are suggestive of how peer care is valued in the organisation. Low pay and low status issues also characterise social caregiving among community caregivers (Baines, 2004), and in the context of the universal human need for help, this issue is defined by Barnes (2006) as a social injustice. As we heard in the previous chapter, the low number of suitably trained caregivers clearly impacts on the availability of recreational time, meaning Kevin misses out on gym. This is significant to his health and identity, particularly in the context of prisoner culture, where there is a relationship between the maintenance of body shape and a sense of masculinity (Jewkes, 2005).

The data reveals numerous other disadvantages experienced by the caregivers. In HU2, Dennis was, ordinarily, positive about his role, but taken in isolation, the next quote presents a negative picture:

'I've had no formal training for any of this; I learned the job from him (refers to his co-worker Mark). We don't get any extra pay, and its seven days a week, 365 days a year, with no break… even on Christmas day! You can't just not take someone their meal; there are stores to be collected, a whole list of things that can't wait'.

Echoing the issues highlighted above, Dennis flags a lack of downtime, meaning an almost absolute obligation to the role. Although I found no direct evidence of abusive behaviours, these issues flag the potential risks of caregiver burnout (Depner et al., 2018), paternalistic or parochial practices (Tronto, 2010) or, taken to the extreme, abusive practices (DH, 2012). Without sufficient reward, training or investment, there is a risk of losing caregivers or a 'you don't invest in me, I won't invest in the role' perspective.

In the following extract, Steve from HU3 implies that undertaking the role can negatively affect the caregivers' progress through their sentences.

(Buddy Steve). 'I've done almost every job in the prison. It was much easier when I worked in the education department, I got a good entry (meaning a positive comment in his personal record) every week. I don't think I've had a single good entry here. I'm working my bits off and it's not doing me any good. I'm not asking for a pat on the back but we are just forgotten about, it's as if the work we do just floats off into the ether.

In the education department it is likely that Steve worked in closer proximity to educational professionals, who are more likely to operate in alignment with rehabilitative paradigms (Bhatti, 2009). Steve suggests his work was noticed and rewarded, and there is an indication that this represents a favourable complexion in parole reports. Yet, in comparison, peer caregiving is more demanding, and the wing officers are less likely to acknowledge his good work with positive statements. This seems like a missed opportunity in the context of his personal development. As Maruna et al. (2004) and, more recently, Nixon (2019) suggest, individuals are not merely passive recipients of feedback, positive appraisals and recognition can affect self-understanding and help to shape a sense of self.

Yet aside from the ODPs, who else notices the outcomes of his endeavours? The extent to which Steve and his colleagues' work is unseen and unacknowledged relates to an absence of professional oversight, the officers' training and their professional discourses, which revolve around security. Attending to matters of personal care is not their first priority, and they simply do not have the knowledge to oversee care work. The issue was echoed in ODP Eddie's experience, *'Even though an officer is on the corridor checking the locks, bolts and bars, I point out an issue, and he says, 'Yes, I will come along and check', but they never come and see how I am'.* This oversight speaks to a double cost of a lack of agency to resolve their problems and a lack of visibility, which is again an issue mirrored in the community, owing to the private nature of domestic social care. Eddie's situation is reflected in

the title of the 2007 DH paper ‘No problems – old and quiet’, or to complete the adage in full, ‘No problems - old and quiet, *nothing to see’*.

Emotional costs, attachment and resilience

Becoming a peer worker involves learning to manage one’s own emotions as well as the emotions of others (Walby and Cole, 2019). As noted in Chapter 2, page 29, there was a dearth of research into the emotional labour of prisoner peer workers (Depner et al., 2018).

(Steve in HU3). ‘We have to be quite selective about who gets to be a buddy, and we have to try not get too close or connected with our older prisoners, we’ve had three (ODPs) die here. Mr. X has just been transferred out to hospital; he could be dead for all we know. I try not to get too emotional, but it can be wearing, you know.’

Each of the caregivers described their own subjective threshold to the stresses associated with work pressures, attachment and loss. Walby and Cole (2019) suggest that emotional support is crucial in dealing with negative emotions in peer work. However, aside from ad hoc meetings with the DLO, there was no formal resource to deal with role-related anxiety – this may be another reason to account for the high turnover of caregivers. In view of the need to safeguard both the caregivers and care receivers, it would seem sensible to create a space to offload accrued emotions and to share learning, but who within the institution is skilled or motivated to support this facility? The on-site health care staff would seem the obvious choice, but the service has been contracted to private services and social care is outside of their remit. Moreover, in the current financial climate, it seems unrealistic that local social services departments have the personnel to provide such a facility. This issue again reflects a lack of understanding and recognition of the skills and investment needed to provide care well. Without such a resource, the caregivers are left to hold an emotional load, meaning that an opportunity for reflective learning and sharing good practice is bypassed.

In the following extract, the caregiver goes the extra mile to reconnect with his ex-care receivers.

(Recorded during a discussion with buddy Mark, in HU2). 'I guess you build up a rapport, and I think they would like to see us. I'd like to go on follow-up visits to the people we've supported but we are not allowed. We get attached too you know… I make a point of going to Chapel, no disrespect (laughs), just to see a few old faces'.

As Fletcher and Batty (2012) suggest, peer working practices may contribute to a sense of community and solidarity. Mark's comment implies that a bond has developed, attesting to a two-way sense of attachment. There is a sense that the ODP and the buddy would benefit from meeting again when the ODP has moved on from the induction wing. The request sounds reasonable and beneficial, yet unorthodox in the context of prevailing security practices. Maycock (2018, p2) suggests that criminological literature has overlooked 'some of the more subtle, nurturing and emotionally engaged performances of masculinity in prison'. Such emotional and intimate exchanges are more typical of 'inclusive' forms of masculinity, which allows for greater emotional and physical openness (Anderson, 2008).

In the following extract, the benefits and risks of empathic relationships and attachments are foregrounded:

(From HU3, buddy Nick). 'I think … I think I've become a better person. When I started the role my empathy level was at 0% but I've learned to try and see things from the older guy's perspectives, so I feel it's given me a sense of empathy. I'm helping them but it's kind of helped me… to think differently. I'm in my cell thinking, I wonder if such and such is doing okay?'

By taking the perspective of his ODPs, Nick suggests that he has learned to cognitively enact an empathic position, and this has helped him to understand the care receivers' needs differently. Indeed, there is a sense that the use of empathy helps him to think about his own situation differently. However, the development of

this insight brings an emotional cost, as he appears to use mental energy to think about his care receivers during his limited downtime. The extract is suggestive that the development of empathic relationships through caregiving can be the catalyst for personal change, and is possibly critical to understanding behavioural transitions (Collica-Cox, 2016; Depner, 2018); although this should be viewed in the context of other factors, such as progression through his sentence and life-course.

The next extract provides a flavour of how the buddies were perceived by other prisoners.

(Caregiver Dennis in HU2). Researcher: 'Tell me about the downsides of the role?' (Dennis): 'Well, we get called 'screw boy' that sort of thing, we've had it all. Some idiots have made some comments, 'Oh yes, off to give such and such a bed bath', or something about wiping ass, or getting in the shower with older chaps. It's like a schoolyard.
Researcher: 'So, some of these comments must get through to you, at a personal level?'
(Dennis): 'Well, yes and no. I have broad shoulders; they've made suggestions that I (perform other lewd acts) with older males. At the end of the day, you have to have thick skin.'

Various theories explain the connection between personal identity and the motivations to support others. Ugelvik (2014, p10), suggests that when a person is sentenced to imprisonment they are automatically positioned as a 'prisoner'. Individuals then resist this imposed identity by trying to reposition themselves to become something else, in Dennis's case, he has assumed the identity of a helper or peer caregiver. However, some identities are more acceptable than others and can bestow more status and agency. It appears that Dennis's work was associated with care, and discourses of care occupy low status among other prisoners.

In Brannon's (1976) seminal paper on masculinity, the mantra 'No Sissy Stuff' proposes that men must avoid anything that is remotely feminine – they must avoid displaying weakness and keep intimate details 'backstage'. Furthermore, Lloyd et al.

(2014) suggest that men who reveal emotional vulnerability are labelled as 'feminine' and therefore stigmatised. Any kind of perception of weakness is subordinated in the context of competitive, hierarchical social ordering by males seeking to boost their neutralised sense of agency (Riccardelli, Maier and Hannah-Moffat, 2015). Barracking forms part of the prison culture and inmate code (Sykes, 1958), yet Dennis's narrative makes it clear that the peer caregivers were also concerned with upholding an acceptable identity as competent males within the wider community and culture.

Within the hypermasculine culture, discourses of ableism and individualism are privileged over dependence. Care is associated with dependency, femininity and by implication, weakness, and this attitude is consistent within wider neo-liberal ideologies (Barnes, 2012). The prevailing social climate is dominated by discipline and control, whereas the caregiver's role is to provide care. This mature buddy appears sanguine in relation to the abuse, rationalising the comments and assuming a position of superiority over the childish dynamics. Despite the verbal abuse, this repositioning is possibly significant in terms of his sense of self. However, with only his co-worker to offload to, it is possible that such dynamics could be internalised over the longer term. Not only is there little reward or recognition, the role is othered and subordinated within the prisoner hierarchy, which adds to their experience of injustice.

The gains associated with caregiving

The above extracts shed light on the deficits incurred by the caregivers. Despite this, many stuck with the role and were able to extract intrinsic and extrinsic gains in support of personal development. In the following subsection, the data extracts represent a broad-brush impression of some of the more beneficial outcomes attached to the role.

(Recorded in HU1, with buddy Robbie). 'If I have a low day, the job does keep me occupied. It kind of reminds me that at least I can go and do things, I can play tennis

on the yard if I want to; the old boys can't do that. Helping the old boys is satisfying. Coming into prison can be hard, I've been there; more than once. But I really believe I have something to offer, and you know what? It's a two-way thing; I want to prove to people I can cope, that I can change.'

In this extract, Robbie describes several intrapersonal processes, significantly, a desire to project a positive external self-image, and this could be viewed as part of a strategy of reconstructing the self. Robbie juxtaposes the advantages of his youthful, embodied good health with the frail physical state of the older adults. There is an indication that he identifies with the problems associated with entry into prison and adaptation into prison life. Occupation brings benefits to his mental health, and although supporting others can be difficult, he discloses feelings of satisfaction or what Skovholt and Trotter-Mathison (2011) describe as 'psychic income reward' from the role.

In the final sentence, Robbie earnestly describes a drive to help others, this is connected with a desire to show he can cope and change, thus redeeming himself in the eyes of others. Liebling and Arnold (2004) suggest that prisons need to organise activities to enable prisoners to develop their potential to prepare them for community re-entry. Caregiving can provide the benefits of growth and development, and this is crucial for behavioural reform. Although providing evidence of long-term desistance is beyond the scope of this thesis, there are signs that peer caregiving can lead to changes in behaviour, self-esteem and self-perception.

The potential for self-transformation was visible in numerous other extracts:

(From interview with Lee, buddy in HU1). 'I haven't always coped well with change; my anxiety and PTSD are much worse when there is a lot of change. The role has given me the structure and stability that I need… I feel calmer. I'd like to do all of my time here, but I know I will need to progress. I used to suffer with anger problems, I used to self-harm, but I've learned about myself. I've learned it's not all about me; I was very self-centred growing up out there, I thought it was all about me'.

Lee takes the lead for one of the two ground-floor corridors within the designated social care areas. He appears heavily invested in the role and the ODPs perceive

him as hard working, a quality much valued by this generation. He is the most experienced caregiver in HU1 and in a position to influence the others in the small community of caregivers. Lee outlines the benefits of being free to circumambulate within the enclosed space, and this is identified as helping him to structure his time and adapt to the realities of his sentence. Accordingly, Dhami, Ayton and Loewenstein (2007) suggest prisoners need to have control over their lives to constructively adjust to imprisonment and counter negative emotions, such as hopelessness.

Towards the end of the extract Lee reaches back to his pre-prison self, and there is a sense of comparison between his current settled, caregiver identity and a time of psychological turmoil and inwardly focused behaviour. The expression '*I thought it was all about me*' contains a confessional tone, and there is a sense that he attributes his offending to this self-orientated internal process. The statement is suggestive of a change of outlook, from that of 'self-orientation' to 'other orientation'. The implication is that the role has helped him to think of others' needs before his own, and this constitutes a turning point for personal change. The unprompted, indirect reference to his past is suggestive that thoughts of his offences are never far from his mind, but if the change is maintained, these insights may have some utility for life after prison in terms of crime desistance. The sentiment could equally hail from the rehabilitative coursework Lee has undertaken; either way, the experience is being described in the context of his caregiving.

(From HU2, interviewing buddy Dennis). 'I've done factory work pressing rivets, it's just … ugh! (Accompanied by an exasperated facial expression). This work (caregiving) gives me something to get up for. It's challenging, and yes, that's helpful to me in here. The old guys appreciate what you do; you get more out of it. And yes, there's a selfish element to it; it gives me a purpose'.

The level of stimulation in the environment is generally low, and this appears to extend to the quality of employment within prison industries, which is branded as repetitive and unsatisfying. Alternatively, caregiving is characterised as more relationally involved and, ultimately, more stimulating. The challenges associated

with attending to people in need can involve complex ethical tensions and messy social interactions, and Dennis appears responsive to these challenges. Caregiving offers opportunities to express agency, for example, through practical, social and emotional problem-solving. Increased agency contributes towards the mitigation of institutionalisation, providing opportunities to maintain status in the context of prisoner culture and hegemonic masculinity. This is significant, as an increased sense of agency is an important feature of one's personal identity (Liem and Richardson, 2014).

The use of the term '*purpose*' is significant as it connotes to a sense of duty, of wanting to help vulnerable others as a moral imperative. The '*selfish element*' is indicative that his work brings intrinsic gains, as in helping others he is helping himself. This accords with Reissman's (1965) 'helper therapy principle', which draws attention to the benefits helpers acquire from acting in the role of helper. This concept states that it is more beneficial to give help than to receive help, as 'those who help are helped the most' (Gartner and Riessman, 1984, p19). This perspective aligns with evidence from general population surveys, which found that 'helping others is strongly related to one's psychological health and that one does well by doing good' (Piliavin, 2003, p227).

(Recorded in HU2, buddy Mark). 'I have always cared for people, in one way or another. I want to help… to smooth a difficult time for people... I've always done a teaching or mentoring role of some sort. It helps to be seen as a volunteer and it doesn't hurt in terms of my parole (uses mimicry to typify an officer's voice): 'There's such and such… he shows a bit of willingness and gives help'.

Mark appears to connect the learning and supporting elements of caregiving to his pre-prison subjectivities. Like Robbie, above, he identifies the process of incarceration as a difficult disjuncture and feels he can mentor newcomers through this transition. This suggests the possibility of experienced caregivers fulfilling the additional role of helping new entrants to adapt to the environment and culture. Mark is hopeful that his pro-social projections will lead to the possibility of positive parole reports. However, this more overt allusion to self-gain could be interpreted as an

attempt to manipulate how others perceive him, or as pseudo-altruistic motivation for performing the role. Sex offenders are known to demonstrate interpersonal versatility, for example by attempting to condition staff (Nixon, 2020). Equally, Klein, Bailey and Sample (2018) discuss sex offenders arousing suspicions in researchers by attempting to subvert perceptions. Yet it is understandable that prisoners might want to create favourable impressions in parole hearings.

The theme of altered self-perception is extended in the next excerpt *(from interview with Mark, HU2):*

'I like to see myself as a bit of a Mr. Fix-it, for old people, like with Mr. X a few weeks ago. When he got here, he'd lost his glasses; it might sound like a little thing, but he was in a right state over it. This sort of thing means everything to someone with dementia. I helped him do an 'app' to go over and see the optician. He'd lost his dentures, I helped him get an app in to see the dentist. He might want to pick something from the menu, something tough or chewy, but I make sure he gets a soft diet… otherwise he won't be able to manage it… and he wouldn't be able to eat. I like to be recognised as a 'go to' guy for this or that, it makes me feel useful. I know the system; I like having a purpose and I'm being helpful'.

Here, a blend of intrinsic and extrinsic gains become discernible in Mark's representation of his preferred self. The older participant is not knowledgeable enough or sufficiently able to negotiate the applications process and needs someone to intervene and support him. Mark has reached a stage in his sentence where he can make use of his experientially accrued knowledge to 'work the system' (Goffman, 1961, p189), and, in doing so, be of practical support to the newly sentenced ODP. He demonstrates an empathic awareness of the anxiety induced by life without the identified items, particularly for someone living with a diagnosis of dementia. The interventions are relatively small, but, taken as a whole, they have the potential to make a tangible difference to the older prisoner's well-being.

Within the literature, peer workers are said to be motivated towards generative goals with a drive to 'give-back', and this serves to strengthen the desistance process (Nixon, 2019). In his study of the factors that contribute towards crime desistance,

Maruna (2001) found that many offenders expressed a strong desire to provide assistance and support others as a way of 'giving back' to society and as a method of earning redemption. The 'wounded healer' narrative (White, 2000; Maruna, 2001) refers to the 'professional ex', for example, offenders who have recovered from addiction or in this case, an offender who has made the adjustment to prison culture. Their identities are repositioned or transformed in relation to helping others who have yet to realise change. This is accomplished through sharing one's experience, strength, hope and acting as a role model, or 'helping others who are not as far along in the recovery or reintegration process' (Lebel, Ritchie and Maruna, 2016, p110). Collica (2013, p23) further extends this process, saying in order to 'make good', offenders need to be able to find 'a higher purpose while subsequently making sense out of their life histories'.

(Researcher note recorded in HU3, buddy Brian). 'I am told Brian is in his cell resting and although it feels unnatural to leave the ground floor, I go upstairs to 'the two's' (level two), to see if I can locate him. The environment is typically austere for a gallery-style wing from this era. Rather atypically, Brian has made a small sign and placed it on his door frame, near his cell identity card. It says, 'I used to drive trucks, I drive wheelchairs now'.

The sign is emblematic of how much Brian identifies with the caregiver role and the meaning the work brings to his life. It is an expression of his need to be seen as authentic and changed. Similar to Lee's comments above, there is a sense of reflexive nostalgia, a representation of a previous self in a more functional role as a truck driver, and this is juxtaposed in comparison to his current inhibited lifestyle. Research on successful crime desistance suggests that ex-offenders develop and internalise self-narratives that help them to appreciate their experience of personal change and why offending has become incompatible with their previous life story (Vaughan, 2007). This aligns with notions of a transformation from the 'old me' to the 'new me' (Blagden and Perrin, 2014). Research from Blagden et al. (2011) and McAdams (2006) shows that the enactment of 'moral' or 'good' scripts can lead offenders to actively perform these narratives. The sign infers that the role as caregiver acts as a cue for Brian to reflect over his life-course and that intra-personal

changes brought about by caregiving have supported a process of personal transformation.

The theme of personal change is continued in the next extract.

(From HU1, buddy Gary). 'If you had of seen me two years ago you wouldn't have believed I could be capable of doing this job. Things had really gone wrong for me out there; I needed to come in (to prison). I was in a really bad way; honestly, I can't say how bad things had got. I always took whatever I fucking wanted; now I'm helping not hurting'.

There is a retrospective, emotional edge to Gary's extract which looks back to an undisclosed but darker side of community life. Prison has provided an opportunity for the complete change of lifestyle he needed to recover his health and sense of self. This is reflective of a view that, under certain circumstances, prison can work for some (Crewe and Ievins, 2019). Caregiving provides an opportunity to telegraph to others that I am not who I once was (Toch, 2010). There is a sense that he could not have foreseen himself working in a caring capacity, yet in doing so he has discovered unexpected personal gains. The final sentence seems emotive, even poignant, describing movement from shade to light, or 'making good'. The emerging narrative has a redemptive subtext, typifying ideas of personal transformation, towards pro-social behaviour and an ideal future self. However, is Gary alluding to helping others or himself, or, dualistically, both? Interestingly, Maruna (1991, p287) notes that helper narratives serve 'to make acceptable, explicable and even meritorious the guilt laden, 'wasted' portions of an actor's life'.

Maturity and personal transformation

In the final extract, Tony provides a connection between the process of maturity, self-awareness and personal change. Note the repetition of the linguistic trope 'giving back', which aligns with the wounded healer narratives outlined above.

(Recorded in HU3, buddy Tony). 'Just a few years ago I wouldn't have been sitting talking to you like this. I was pretty fucking horrible back then to tell you the truth, I really wasn't your model prisoner. But you get an age where you are more conscious of what's going on around you, more worried about your health and other things. We are not like the unruly one's, we are giving back to our society… and yes, we'd like to think some-one will be around to help us when we are older'.

Farrall et al. (2011) suggest that successful change is also supported by other processes, such as personal maturity and the development of social bonds. There is an inference that Tony's disrupted health trajectory coupled with the process of maturity may have led to a change in his self-perception and increased his self-awareness. In life course theory, Sampson and Laub (1995) state a 'life trajectory' is a pathway or line of development over the lifespan, including work, marriage, parenthood or criminal behaviour. They suggest, 'Trajectories are long-term patterns of behaviour, while transitions are marked by specific events that are embedded in trajectories and evolve over shorter spans' (Sampson and Laub, 1995, p66). Pro-social experiences, such as caregiving, can constitute such a transition, providing a turning point or the hook for change needed to 'redirect or modify one's life path' (Giordino, Cernkovich and Rudolf, 2002, p992).

Flanagan (1981) further identifies the contribution of maturity in changing patterns of behaviour. The role played by the maturation process connects to other landscape features of the data, that is, peer caregiving worked more efficiently in the three residential areas where the average age and length of experience of the caregivers was greater. This feature of the data also fits with the views of Cloyes et al. (2014), whereby mature peer caregivers with over two years' experience took on a more generative approach to the role.

Chapter summary

The extracts give rise to an intertextual richness in which the nuanced and overlapping sub-themes of costs/benefits, motivation, self-awareness and identity change come together in the context of personal change.

Through their association with caregiving, the buddies were subordinated in the prisoner hierarchy, but in some cases the role enabled them to perceive themselves differently, and this helped them to cope with negative interactions and slander.

Factors which sustained their motivation appear to extend from a mixture of practical benefits clustered under the sub-grouping of a connection between occupation, the management of time and gains associated with sentence management. Intrinsic motivations include: the satisfaction associated with providing support for vulnerable others, the adherence to a sense of duty, the effects of empathy, the repositioning of the self in the context of their moral careers and the enactment of new personal narratives. These processes are shown to enhance reflection and self-awareness, leading to the prospect of longer-term change, adding to the literature on the pains and gains of caregiving among prisoners.

These findings are supported by Toch (2000, p276), who suggests, ‘By helping others they are able to reform their past, recreate their self-identity, and finally accomplish a certain level of success’. Therefore, peer caregiving appears to provide an opportunity for a transition or the turning point the participants crave to renegotiate a spoiled identity (Goffman, 1963).

In Chapter 7, social theories of learning help to illustrate how teamworking, social bonding, increased responsibility and changes to status can support the process of learning to peer care and the possibility of identity change.

Chapter 7. Learning to peer care

Chapter introduction

In the previous chapters we heard how a combination of reduced resources, material conditions and uninformed practice conspired to produce a variable standard of interactions, that were not always perceived as helpful to the ODPs. We also heard that care extends beyond formal boundaries, that caregiving brings benefits to both caregivers and care receivers and about the processes that sustain and maintain the caregiver's motivation.

Aside from occasional guidance from untrained staff and other artefacts, formal opportunities for learning about care values and practices were rare. Under ordinary circumstances education occurred in specific locations, led by professional educators, in clearly defined courses, which are likely to be aligned to resettlement aims. For a range of reasons, some of the formal training interventions identified in the literature review seem to have enjoyed only limited success, in some cases this was attributed to staff shortages (Forsyth, 2019; Tracey et al., 2019).

In this chapter, I foreground processes aligned to socially situated learning, specifically experiential learning, processes aligned to LPP (Lave and Wenger, 1991) and COPs (Wenger, 1998). In particular, the analysis attends to the effects of group interaction on caregiver development, the social transmission of learning and the potential for changes to self-perception, status and identity in the context of co-participation. The research establishes a link between social participation, morality and learning.

Socially emergent practice, experiential learning

In the following section I am observing caregiver Gary in one of the ground-floor corridors in HU1:

Gary is in a cell with an older participant who appears to have a cognitive impairment which I deduce to be a form of dementia; he appears quite dependent. I notice Gary slowing the pace of his words, intermittently raising the volume and intonation. There is a good level of eye contact, they are smiling at one another and there is some laughter between them. I'm impressed and tell him he seems to have quite naturally picked up some great communication skills.
Gary: 'Umm, yeah'. (A pause implies thinking space). 'He can be quite awkward; I try to get him onside with a joke. Sometimes he drifts off down the wrong path and gets confused. I have to try and get him back on track or we won't get anywhere, and then he gets upset'.
Researcher: Okay, can you think of some examples for me?
Gary: 'Well, yeah, we were just doing his menu card (he shows me the meal preference list – the ODP would not be able to complete it without support). 'If I just say 'do you prefer gravy' in a normal way he might not understand, but if I say 'mash potatoes' then 'gravy' he will know what I mean and can answer'.
Researcher: 'That sounds good, although it could be quite time-consuming?'
Gary: 'I don't mind, it's like cracking a puzzle, I really like that side of the work'.
At this point a prisoner in an adjacent cell over-hears and mimics, 'You really like that side of the work', then, 'You are so full of shit!', and some banter kicks off between the two. When it subsides Gary says, referring to the ODP, 'Mr. X was moved from (x wing) and it put him out for a bit; he was really confused for a while. He wouldn't get out of bed and he stopped eating for a bit, but I've got him back into a routine again. I just look him in the eye and say (changes facial expression comedically and his intonation, trying to sound authoritative). 'Get your butt out of bed or I will kick it out of bed!' Gary goes on, 'I raised my voice… but it's done with giggles and smiles. And seriously, he does actually respond, he gives the shit right back to me, 100%'.

This micro-drama provides a window on the complex interactional work invoked by the ODP's degenerating health status and his need for skilled support. Gary has experientially gained an understanding of the ODP's needs and developed the strategies and skills needed to overcome the barriers to communication in the course of their interactions. He has learned to adapt his approach by changing the pace and

intonation of his comments, and by grouping specific words to maximise the ODP's responsiveness. Gary could have completed the menu card on behalf of the vulnerable ODP and walked away, and no one would be any the wiser. However, he has learned what it takes to engage with and motivate this dependent older male prisoner.

By professional standards, the interaction between caregiver and care receiver is far from perfect; however, the dynamics are mutually shaped with humour, and this helps the participants to maintain a productive connection. The interactions are situated within the context of the prisoner culture, generational differences and their unique working relationship. A neighbouring ODP feels that it is acceptable to intrude on our conversation, this is reflective of the culture and proximity in which the care work is conducted, speaking to an absence of confidentiality, and the role of banter in maintaining status and competence within masculine community relations. There is a suggestion that the stakes are high in terms of the older adult's delicate health status, but also that, when successful, there are emotional gains for both participants.

Gary has learned these processes, not through training or guidance, but through attention to intimate behavioural cues in the context of his internal responses, which help to reinforce successful elements of his practice. The situation illustrates the cognitive labour required for learning to care and attachment formation. It is suggestive that positive practices can emerge and, by extension, be developed. I am concerned about the consequence of Gary being moved to a different location or prison – this will be inevitable at some stage of his sentence. If a focused learning space became available, the situation could be used as an exemplar for reflection, and the main messages shared with the others in his community of caregivers.

The following breezy account also illustrates an example whereby problem-solving and experiential learning are used to progress immediate care and longer-term relationships. Responding to individual needs with care appears to drive learning, and ongoing learning perpetuates better care.

(Recorded in HU3, while shadowing Brian). 'I have a chap, he's 85 years old, he has the beginnings of Alzheimer's disease. I have the same conversation every day, every single morning without fail; it's brilliant! But that's what it takes to keep him right. I could sit in my cell and read a book, but it's like, if I didn't go in and say, 'Hello', and make sure he is alright then no one else would. One of the things we did to help him was to put a memory board in his cell with a few basic details, and a list of who has done what. We do what we can to promote their level of independence. We do what we can to encourage them to get up and use their muscles, and that's good for their longer-term health'.

In this instance, Brian has assumed a level of responsibility to support the older adult, and he is confronted by the nuanced communication needs associated with living with memory loss. He identifies the subjective challenge of maintaining interpersonal optimism, and, by maintaining a positive approach, he is more likely to achieve a successful outcome (as consistent with the ideas of Kitwood,1993). Brian brings his own variety of practical wisdom to the situation, developing the memory board for the benefit for the older participant and as an artefact for the community of caregivers.

He recognises the benefits of promoting independence, thereby preventing downstream health problems, by encouraging movement and exercise. The situation demonstrates interactionally shaped, sensitive practice, with particular respect to empathy and patience. Indeed, Brian appears to draw satisfaction from what appears to be relatively insignificant interactions. Both of the above examples demonstrate a level of patience which can be difficult to achieve in contemporary society, with its emphasis on competition and the achievement of goals (Tronto, 1993).

Legitimate peripheral participation

The following researcher reflection features aspects of group dynamics and an example of group morality.

(Researcher reflection from HU1). 'I joined the buddies in the canteen area after the lunchtime meals had been served. Lee gave me a run-down on the formation of the group, the main players, how long each group member had worked in the role, which seemed surprisingly brief by comparison to the caregivers in the pilot study. Lee and the others described a previous buddy, suggesting he was racist and had aggressive traits and this was identified as incommensurate with the role, saying, 'He had to go'. They went on to describe an ex-buddy who had recently relinquished the role. He seemed to be universally vilified by the others in the community of caregivers, but the reasons why were less clear. He was viewed as being uncompromising, unhelpful and not fitting in as a team player.

I actually met the chap at a later time and had a conversation with him; at face value he struck me as being quite reasonable. He was unforthcoming about the reasons why he quit the role, but I gleaned an element of anger towards one of the team members who I assumed to be Lee, and I intuited there was a difference of opinion between them. I thought about what might have made him unpopular; from the tiny pieces of information, I formulated a view that he was probably being assertive about what he was prepared to do, or not do, but this had set him in opposition with the others. The composition and attitude of the group was different to the pilot group, they appeared less reflective, and less thoughtful. There seemed to be an almost begrudging attitude towards some of the ODPs, that some of them were 'swinging the lead', but this was genuinely not my impression.'

The collective narrative of the group appears to serve a binding and regulatory function. The comments reflect socially evolved ideas and values within the culture-sharing group. Some points seem well intentioned and appear to describe a safeguarding process in support of the ODPs, but there was a discernible edge to some of the other sentiments. The comments seem to be less about sharing learning

and more about prevailing attitudes, group conformity and ‘toeing the line’, which, in combination, contribute to the establishment of a wider regime of competence.

Such localised attitudes can translate into practical actions, as seen in the extract below.

(Researcher note from HU1, observing buddy Chris). ‘I ask Chris what he feels he gains from the role, and whether he draws satisfaction from the interactional element of his work. The response was not quite what I was anticipating. He suggested that, ultimately, he needs to clean the cell and too much time chatting can impede the process, which would result in back biting from the other buddies, if not complaints. He says it is actually more practical when the ODP leaves the cell, to create the space and give him time to complete the tasks’.

Chris is a relatively inexperienced group member, he reiterates a view that cell cleaning should be afforded greater primacy than the possibility of social interaction. Indeed, if the cell is not cleaned then he faces the possibility of verbal rebukes from his teammates. This situation echoes the tensions between task-centred or person-centred approaches to caregiving, discussed in Chapter 5, and is reflective of his colleagues’ attitudes. Reviewing the experiences of this new group member helps us to explore the influence of group dynamics on the processes of knowledge sharing and skills acquisition. There is a mildly punitive feel to the dynamic, a sentiment that I did not observe in the other residential areas, and this may be another reason why the turnover of buddies in HU1 was more rapid than in other areas.

As can be seen in the above extracts, group socialisation is not always a straightforward or comfortable processes. Deviation or non-compliance with the community ethic can be connoted in principled terms, generating overtones of wrongdoing and, possibly, guilt in the new learner. New recruits acquire the knowledge to perform an activity, but in doing so absorb a morality that is a ‘model of excellence specific to that practice that determines at once an ethic, a set of values, and the sense of virtues associated with the achievement’ (Nicolini, 2012, p84). There is a sense that an internal group morality is expressed through negative

dynamics, and this serves to influence learning, subsequently shaping practice. The community becomes closed to those who do not embrace the practice of this morality, perhaps accounting for the exclusion of the group member described above.

(Recorded in HU1 while observing Gary). 'Gary is issuing instructions to a new buddy. He tells him that he has forgotten to collect two of his ODPs' canteen requests, this could result in the ODPs missing their weekly batch of canteen items. The oversight is identified as an issue for the ODPs, and for the standing of the team with the officers. However, Gary has spoken with the officers and has been able to resolve the issue. The ODPs will get their canteen items, but they will get them later than usual. The new buddy is apologetic, and he expresses relief and gratitude for Gary's intervention'.

The newcomer overlooks the importance of the canteen requests, which could have negative consequences for the ODPs and incur a degree of reputational damage to the community of caregivers. Again, a deviation from a standard group practice is replayed in moralistic terms. The situation shows how community participation can temporarily alter the individual's self-perception, illustrating the intricacies of internal group regulatory processes. Gary is on standby to provide guidance, spanning the boundaries between the peripheral communities of caregivers, officers and ODPs, helping to manage the issue. As a more experienced group member with responsibilities for new learners, the officers are more likely to listen to him. This difference in status separates him from his peers, who do not enjoy the same level of credibility or trust, demonstrating the influence of greater experience and competence on his status and identity.

In Chapter 6, we read that interactions were not always positively acknowledged by the officers; however, in this situation Gary has successfully renegotiated his position to suit all audiences. Gary and the new recruit occupy different positions, and this becomes prominent through the discernible expression of deference and a hint of regret in relation to the omission. Through his ability to negotiate with the officers, there is a sense that his status is further enhanced with the officers and within the

community of caregivers. This is significant, as in line with the prisoner code, being seen to communicate with officers could result in ostracism from the wider prisoner population, or worse (Jewkes, 2005). However, he has the legitimacy to influence events and address the conflicting interests. According to Wenger, where differing COPs interconnect with each other, they constitute a 'complex social landscape and shared practices' (1998, p114). Such brokering is complex, involving coordination, translation and an alignment of perspectives (Wenger, 1998).

The above extracts describe situations in which, through the fulfilment of knowledge and status, the more experienced caregivers undergo a change in their external and internal perceptions. The difference in status enables them to manipulate the regime of competence and the development of peripheral group members by subtly controlling their centripetal movement towards competence and full participation.

In general, the ODPs were not really concerned with caregiver training, but when probed, they expressed some good ideas for their training. The following comment from ODP Stan in HU1 is interesting in the context of team dynamics and learning from practice, specifically in relation to 'being around vulnerable people', 'learning from others' and learning by 'starting at the bottom and working up'.

(ODP Stan in HU1). 'They just grab someone and say, 'You are a buddy', and then go and introduce them to an older chap. The thing is, they haven't got a clue how to be around people. They should send them off with another buddy to learn what to do; he's got to learn the job from somebody. Like, learn from the learned. They need to start at the bottom and work up, so they know all aspects of the job.'

Stan is a former merchant seaman; therefore, it is likely that he was socialised towards team models of learning and working. This theme continues in the following two statements, which are connected by a sense of dissatisfaction within the communities of caregivers.

(Recorded in HU3, shadowing Brian). 'You don't get a say about who gets appointed as a buddy. We haven't had a DLO, since (DLO2) went off with an illness. We have people who are interested but an application goes to security, and we don't hear anymore. A while ago the DLO recruited a buddy for us; he lasted a day!' The comments are supported by an officer in HU1*: 'We don't necessarily have the buddies we want'.*

Senior staff have the power to bypass the usual employment processes and place prisoners directly into the caregiver teams. This is probably done with the best of intentions, but, as we hear, the imposition of an unsuited or unliked newcomer can unsettle the team. Such impositions can help to explain disharmony and account for some caregivers occupying more marginal roles than others within the teams. The situation epitomises a level of discordance between organisational objectives and what is viewed to be right within a community where participation, connectedness and practice has already been established.

Lave and Wenger's (1991) concept of LPP develops the notion of learning as a socially structured process by which new members are centripetally absorbed into a community of practice. Such processes are relevant in the context of the participants' ability to construct a legitimate trajectory towards full participation and an identity of 'caregiver'. A breakdown in this process could also account for the higher turnover of caregivers. For example, in HU1, where the turnover was rapid, there was little continuity and learning could not be shared, increasing discontinuity over time. Accepting that good peer caregivers do not grow on trees, the issue implies that a more thoughtful approach needs to be taken regarding the recruitment and nurturing of new members to the caregiver teams. This process also contributes to our understanding of the reasons for it being more acceptable for caregivers to avoid attending to the more sensitive, nuanced aspects of interpersonal care, instead resorting to practical activities such as cleaning.

Social systems, learning and practice

In this subsection, I foreground theory aligned to social learning, specifically COPs (Lave and Wenger, 1991; Wenger, 1998), in relation to social influences on learning.

(Brian in HU3). *Brian says a little melodramatically: 'We work as a team and play to each other's strengths. I make a point of listening to the lads… but it doesn't always mean I'm going to act on it!' (With a grin). He says that he sometimes has information or a healthcare issue to pass on. Brian says they try and get together as a team once per day, although I observe them together at several points in the day, sometimes for long periods of time.*

There is a discernible pecking order within the small community of peer carers in HU3. Status is based on personality, competence levels and length of experience (a similar structure is visible in HU1, with Lee and Gary each assuming responsibility for a corridor). Brian seems to fulfil a foreman-style role, helping to coordinate the other group members and occasionally liaising with the wing staff. He has performed the role for two years, and it is my observation that he is liked and respected by the other members. I later recorded Steve from the same team saying, '*When he (Brian) isn't available, Nick steps into the role to act up as number one. Brian does need a bit of looking after; we can usually see when Brian or someone else is going through a tough time and when that happens, we know how to step in and cover, it's like teamwork'.* There is a consensus that they support one another quite well, their personalities are complimentary and they are mutually engaged in jointly negotiated working practices. There is a shared repertoire of skills and shared histories of learning; accordingly, their 'practice resides in a community of people' (Wenger, 1998, p78).

Here, social learning theory identifies learning not as a cognitive process but as social processes, stressing the importance of 'belonging, engagement, inclusiveness, and identity development' (Nicolini, 2012, p80). As mentioned in

Chapter 6, criminological research has examined the role of desistance variables, finding that social relationships, being believed in and a sense of purpose are meaningful in terms of reducing offending (Gobbels, Ward and Willis, 2012; Maruna et al., 2004). Similarly, in his seminal work, Hirschi (1969) classically identified the four elements of 'attachment, commitment, involvement and belief' as important control factors in supporting changes towards pro-social behaviour in offenders. The analysis of learning to be a peer caregiver shows how, through social developmental processes, theories of social learning and criminological theories of self-development overlap. For differing but related reasons, learning to care appears to offer the opportunity for self-development and longer-term personal change through internal and social processes associated with bonding and identity change.

Suggestions for multi-disciplinary training

Suggestions for the development of various forms of 'awareness' and 'care' training featured strongly within the data corpus.

(Recorded in HU3, while shadowing Tony). 'We've seen DLO2, two or three times over the past few months, we are struggling; everything has been left to us to work out. One of the chaps had trouble swallowing, so we had a group discussion amongst ourselves. But he has had skin cancer for years, now he has Alzheimer's, someone with medical training should be guiding us.'

It seems morally inconceivable that the caregivers are not provided with any kind of training, yet we know that this can be the case for other informal carer groups in the external community (Kavanaugh, Cho and Haward, 2019). The above extract speaks to the caregiver's sense of responsibility towards the ODP, but also to a lack of confidence, an absence of knowledge and informed guidance. Tony's anxieties may have been reduced by a clarification of peer caregiver and formal health and social care professional roles, and possibly a plan of care. Numerous suggestions for training and educational content were made (see Chapter 11, page 177).

Interestingly, the perceived need for training was extended to not only the caregivers but other groups in the environment; some comments were delivered with greater subtly than others:

(From HU4, while shadowing Marv). On meeting Marv, I introduce myself and provide an outline for my reasons for being on the wing. Before I get an opportunity to try and recruit him to the research, he says, 'Forget about the buddies, it's the officers who need training. They are bloody useless'.

Perfunctory statements such as this were typical of the participants' responses. The following extract adds slightly more detail to the picture.

(Recorded in HU3, buddy Tony). 'The staff aren't taught what a buddy is and why we need to be out of our cells; they don't all know. They should be taught more about how to respect older people and what sort of things to look out for health wise. Sometimes we are looking for support and guidance, but the staff don't seem to know what to do either'.

The caregivers described situations in which officers did not understand the caregiver's role and, consequently, they were not unlocked to perform their duties. The extract reinforces earlier comments relating to the lack of expertise in the environment and the competence required to support people with various disabilities and long-term conditions. Given the trajectory of increasing numbers of ODPs being incarcerated for longer periods, one might assume that there will be an increase in the number of clinical incidents. Arguably, changes to the demography of the population in prisons means their role and function has reached a turning point. The function of prisons has expanded to include the safeguarding of medically and socially vulnerable adults. Consequently, officers need time to check on vulnerable individuals, to know when to recognise issues, to know how to intervene and when to refer matters on to the appropriate formal services.

In Chapter 5, we heard that some ordinary prisoners were quite forthcoming with ad hoc support, but this does not appear to have been universally the case. The following statement develops a case for supporting ordinary prisoners to be more aware of ODP needs.

(From HU2, buddy Mark). 'They (ordinary, able-bodied prisoners) need more awareness… Some won't even move if an (ODP) with mobility problems is struggling along a corridor, they won't even get out of the way. There should be some sort of safety brief included in the induction talk. The staff get it wrong too (ODP X) was being guided to the ordinary showers, not the disabled showers… (pause), just not thinking straight I suppose'.

Newly admitted prisoners spend a considerable amount of time in the induction wing before being transferred to the residential areas, and during this time there are induction presentations. In the context of a need to create change, adding age and disability awareness training to the induction programme does seem like a sensible suggestion. This objective could be extended by providing training to all operational staff and managers.

Chapter summary

In Chapter 6, intrinsic drives to demonstrate change and be seen to atone were shown to motivate some prisoners to engage with caregiving and this served to satisfy internal aspirations. In this chapter, social elements of learning were rendered visible and analysed in the context of peripheral relationships between individuals and communities in the environment. Responding to human need, aspects of group morality and being in a position of responsibility for others, appears to motivate some caregivers to learn in order to improve their performance.

Peer working has the potential to generate new social relationships which can afford solidarity and the sharing of knowledge, but breaches of group norms brought the risk of marginalisation and exclusion, showing a connection between learning and

morality. Increased levels of competence are shown to instate intrinsic and extrinsic benefits. For example, social processes associated with experience and responsibility helped caregivers to show key others that they could be trusted, and this contributed to changes to self-perception and status. Social bonding and identity change were established as common links between theories of social learning and criminological theories of self-development.

Ultimately, none of the current caregivers had access to training, they were simply asked to do the job and learned experientially, from each other and through occasional guidance, largely getting on by goodwill. This is potentially troubling, as panic or overconfidence can lead to accidents, or vulnerable individuals could be left unattended (Johnstone et al., 2019). The staff appeared to understand a need for training but did not have the resources or expertise to support it. In synthesising the issues in the literature review and in this chapter, it appears the solution to the success of training is not found in standardised didactic training, but by making more of what works well in the environment, namely social learning processes – for example, shadowing, mentoring, providing opportunities for reflective discussions and sharpening practice with focused workshops. Learning needs to be redefined as socially produced or falling outside of formal, vertical boundaries.

In Chapter 8, the relationship between national guidance, decision-making and the attitudes of key individuals are explored in relation to caring and learning.

Chapter 8. Purpose and power: working relationships, official guidance, leadership

Chapter introduction

By their very nature, prisons are institutions in which power and control are complex issues (Walsh, 2009). As we have seen in the previous chapters, they contain heavily stratified groups of individuals immersed in interconnecting webs of social activity and practice. Prisons are low-trust environments (Crewe, 2009), in which 'secrecy, distress, anger and also conflict characterise everyday life' (Molding Nielson, 2010, p310). The overlapping roles and trajectories brought the caregivers and officers into conflict, and this becomes a visible feature within the data.

As mentioned above, peer care is guided by an HMPPS policy (PSI 17/2015). The language and structure of the document evokes an impression of authority that can lead to 'an automatic acceptance that it must be the truth' (Walsh, 2009, p9). I saw evidence of locally adapted artefacts and boundary documents, listing the tasks the caregivers could and could not perform, giving the impression that the parameters of the PSI were known. However, the PSI is limited and could not possibly detail the full range of interactions generated by caring for people with often complex combinations of needs.

In this chapter, I bring together the intersecting concepts of *purpose* and *power* to progress the analysis of peer caregiving and receiving at the research site, and to review how the practices of caregiving are situated and maintained. Power will be defined as 'the capacity to achieve outcomes' (Giddens, 1982, p39). Giddens also suggests that social subordinates can resist power by turning 'their weakness back against the powerful' (p39). The extracts and analysis surface complex expressions of asymmetric relationships, highlighting shifts from traditional, clearly bounded, 'hard' power, towards notions of more contemporary, diffuse and anonymous 'soft' power. The analysis of power is a common link between ethics of care and theories

of social learning, as both theories encourage a critical discussion of power. Conflict is shown to be a feature of both learning and caring.

Expressions of power

The opening extract helps to illustrate the nature of some ODP/officer interactions, and says much about the relatively relaxed, community orientation in the designated social care area of HU1.

(From interview with ODP Bobby in his cell in HU1). An officer looks into the cell, his facial expression is slightly ominous and imposing, he then says, 'Have you got any Spice? Have you got a mobile phone? Do I have to spin (search) your cell?' It's all very tongue in cheek, he walks away while we sit together chuckling. Bobby says, 'What would I want with a mobile phone? They drive me mad they do. The only thing I miss around here is a cigarette, but my lungs are at 24% capacity'. An ODP passes in the corridor in his wheelchair, looks in and the joke continues, 'Have you got any illicit items in your cell?'

The penny drops, we realise the officer is joshing with us and we play along with his ironic script; it is an unexpected distraction which lifts the social climate momentarily. If taken at face value, the dynamic appears to mock stereotypical prisoner/officer roles and relationships – I believe that the officer would be unlikely to behave this informally in front of his colleagues or younger prisoners. The interaction speaks to the backstage/frontstage social rules for acceptable interactions between the ODPs and staff in this insular community. The element of parody runs counter to the accepted prison culture, in doing so serving a bridging function and helping to build the community on the spur. Yet we are left in no doubt regarding who is in charge, as the dynamic reproduces the asymmetric power differences between the socially distant groups. There is no need to take a strong disciplinary line with older prisoners, as in Bobby's words, '*Risk? How can I present a risk? They could leave me anywhere, I'm not likely to run away',* and the possibility of any kind of disciplinary infraction is low.

The officer's subtle use of relational 'jail craft' (Tait, 2012; Peacock, Turner and Varey, 2017) is underpinned with an element of humanity, and this differs to the application of harder, more authoritarian forms of power required to influence younger prisoners (Crewe, 2011). The dynamic connects hierarchical relations and the localised culture, and reifies the status of the officer and older participants.

This situation can be contrasted with the following extract taken within the same residential area.

(Researcher note and officer statement, from HU1): 'The desk officer asks me about my vision for the peer social care training, I suggest that it could include many topics and list a few examples. When I mentioned issues relating to safeguarding and interpersonal boundaries, he became rather charged and responded… 'You talk about boundaries; these are people who exploit personal boundaries. This con from HU2 (former buddy) wants to come over and 'help'; he's an ex-heroin addict, he wants to come over and grab whatever drugs he can get his hands on. Such and such is forgetful, he won't notice if his meds go missing, he won't know the difference. And do you know what else? He has £500 in his account, he's vulnerable'.

This animated monologue speaks to the respective positions of the ODP, caregiver and officer, and the relationship between them within the context of the wider, rules-based organisation. The officer is clearly suspicious of the request; he constructs the ODP as vulnerable and blocks the request to protect him from the previously drug-addicted, predatory other. The prisoner churn is slow; therefore, it is likely that he has access to their records and has a good working knowledge of the backgrounds of the individuals involved. Inter-wing interactions are configured as a security risk, and this trumps any potential benefits of a meeting. This view is perhaps understandable in the context of the officer's professional socialisation and discourses of security. The officer uses his procedural knowledge and professional experience to make a discretionary judgement which he believes will uphold the

safety of the ODP. However, it is also possible that the request could have been made in good faith and an opportunity to boost the ODP's quality of life has passed.

The extract shows how the physical environment, policy, occupational culture and tacit rules shape attitudes, actions, relationships and affect decision-making. The flow of power becomes overt within the organisation and the status of the actors is maintained. In his discussion of the use of power in prisons, Crewe (2011) suggests that power has become more proceduralised, moving away from officers. However, in this instance, the officer could make a difference to the lives of the participants, but his decision aligns with discourses of security rather than the promotion of relational benefits. The situation could represent an example of officer resistance or operational cynicism (Nixon, 2019), or simply a point of friction between the role of the officer and the commitment shown by the peer worker. The PSI is devoid of any type of guidance for situations such as this, and the officer resorts to established custom and practice.

Policy and purpose

(Recorded in HU3, observation with buddy Steve). 'Mr. X is in a terrible way, everything is saturated in urine, I gag every time I go into his cell. We are not allowed to undress or clean him. We are allowed to take away a bio-bag with soiled clothes, but only the BICs-trained (British Institute of Cleaning) prisoners can deep clean the cell. We supervise his showering, well really, we just stand outside and wait for him to sort himself out'

A number of issues are implicit within this scenario. There is an indication that this ODP is in an advanced stage of ageing and lives with persistent urinary incontinence, which creates an ongoing functional hygiene need. Assistance with this sensitive, personal matter is devolved to the buddies, who appear to be the only people in the environment available to deal with the issue. The caregiver is able to provide preventative care in line with the criteria set out in the PSI, and this appears

to offset the need for formal social care or a nursing intervention. The comment rehearses the difficult and personal nature of the role, which requires practical skills as well as relational and procedural knowledge. Significantly, in respect to the boundary between personal and intimate care, Steve adheres to the PSI and does not appear to overstep his position. The description of events in the extract leads to questions relating to the interpretation of the threshold for formal social care in the context of the PSI. Whereas, in the following extract, the combination of individual need and circumstances mean that compliance with the PSI is more complicated.

(Example of policy/practice gap. Observation from HU3, buddy Tony). Tony and I walk and talk along the ground floor of HU3. I am introduced to an ODP in his cell, he has varicose veins, and these are prone to bursting, causing quite severe bleeds. When this happens, Tony says he normally holds a dressing to the wound and raises his leg until the bleeding desists. My understanding is, this would be regarded as 'intimate' rather than 'personal' care on account of a need to manage body fluid spillage. I question whether this is in keeping with the parameters of the PSI as it would appear to be a medical issue rather than a matter of social support. Tony says, 'What else are we going to do? We are not about to leave him'. We later discuss the matter within the community of caregivers, the feeling is, under similar circumstances in the community, a neighbour would come to the assistance of an in-need neighbour. Until recently a nurse would have been present during the working day leading to a discussion on the absence of wing-based nursing staff'.

A conflation of factors influences the outcomes for the ODP's health in this extract. First, the effects of macroeconomic policies, in the form of cutbacks to officers and the privatisation of health care staff, mean there is no one on hand to deal with the bleed. In the wake of austerity, government benchmarking led to a 30% drop in officer numbers (Ismail, 2020). Among others Turner et al., (2018) and Peacock, Turner and Varey, (2017), note that the shortage of staff leaves nurses and officers with little time to spend with individual prisoners, which causes other deleterious consequences, in the form of longer waiting times for appointments with health care staff.

Second, the extract demonstrates the ambiguity between complex individual needs and the limited guidance set out in the PSI. Dealing with a wound and body fluid spillage would appear to be defined as intimate care or health care, and should therefore be off limits to the peer carers – indeed, there may be risks attached to contamination from blood-borne viruses. The situation highlights that 'there is always a margin of ambiguity and incompleteness in rules which is contingently specified' (Gherardi, 2012). It implies that the caregiver responded in a way that was felt to be right, but this involved overriding the guidance. Real-life events are manifest and unpredictable, and the caregiver's intervention seems to have become an accepted practice. Grosjean and Lacoste (1999, p144) point out that situated experience cannot be completely proceduralised, 'By contrast, it is the shared experience, the habitus of the occupation or profession, which confers a practical meaning on written protocols'.

One might assume that a national instruction would represent an opportunity to standardise caregiver practice, particularly in an enclosed and limited environment. However, the instruction is at best perfunctory, at worst incomplete (Stewart and Lovely, 2017), and this is problematic, as it needs to be translated into situated practices by people without expertise in social care, often within messy social situations. The guidance in the PSI is insufficient, and the small amount of information can lead to an instrumental interpretation of how to act. Given the range and complexity of human needs, the PSI needs to offer something more detailed and qualitative. This contributes to mixed approaches to caregiver practice, in which the PSI was at times complied with, and other times, partially through necessity, ignored and overlooked.

The following extract describes an example of caregiver resistance in HU3, when one of the buddies reached the limit of resilience and quit his role.

(Researcher note, from HU3). 'Tony tells me Brian got into a verbal altercation with a member of staff and quite publicly quit the role, by symbolically removing his 'buddy' T-shirt and returning to his cell. It appears he was publicly criticised for not helping the meal servers when he was delivering a meal to an ODP. My guess is he might

climb down from his position in time, but I sense the situation is not good for Brian, the community of caregivers, or more importantly the ODPs.

Naturally, there are limits of people's capacity to perform care under difficult circumstances (Sevenhiujsen, 1998). The situation represents yet another complexion on the role of power, in this situation Foucauldian notions of diffuse power moving in more than one direction (Foucault, 1977; Giddens, 1984). Although relatively powerless in the face of near monolithic institutional power, the caregivers have some agency – they have the power to say no or to do nothing. Is the behaviour representative of resistance or, alternatively, as Rubin (2015) suggests, is it simply an expression of interpersonal friction between conflicting roles?

Cowman and Walsh (2012) and South, Bagnall and Woodall (2016) suggest that developing peer-training interventions can result in a change in power differentials that can create challenges to authorities. This suggests that social learning has the potential to challenge the prevailing discourses, particularly where control is influential. Indeed, processes connected with learning are documented as having the potential to transform the social textures of specific practice situations. Accordingly, Foucault (1966, p34) asserts 'To learn is both to join and to subvert the existing fabric of power/knowledge. By modifying the knowledge distribution, this subverts the established knowledge/power relations within the social context or subverts the established relations that determine the power of actors involved'. In the context of peer caregiving being a relatively new discourse within the environment, Nicolini (2012, p82) argues that, although uncomfortable, conflict can serve a progressive function of 'putting changes in practice in motion'.

Power and regimes of competence

There were numerous descriptions of medical crises bringing the buddies and officers into conflict from all four residential areas. This often resulted in the flexing of authoritarian power and subsequent demoralisation of the caregivers, many of whom already had a tenuous connection to the role.

(Recorded in HU3, while shadowing buddy Steve). '*I do get frustrated when the officers are shouting at me, telling me what I should do. I feel myself getting angry inside. There isn't usually any need to shout, I can see what needs doing, I'm used to doing the job! It makes you want to wrap it all in'.*

The following is from the same residential area:

(Observation from HU3, buddy Tony). 'We get a mixed bunch (referring to officers). We have a great day with some of them; some of them have a lot of trust in what we do. Others say, 'It is health and safety' and resort to the union guidelines. There was this time when (using ODP's name) fitted twice in one morning, I went in to help, and this officer shouted, 'Take a step back; stop what you are doing! I want this doing my way. You are not a carer. We need to go and get health care'. I work with them 7/7; I know I'm not a nurse, but I can't sit there and let things happen. At times like that, how can anyone tell me not to care; that I am too involved? I'm only trying to make his situation better for him at that time'.

Complex health incidents can invoke feelings of uncertainty, but in specific situations the peer caregivers appear to have more confidence and experience with care issues, and this brings them into tension with the officers. The buddies know the ODPs and have experientially gained in competence. However, this appears to challenge the officers, and power is exercised as a means of superordinating their authority, a point reinforced by Nixon (2019, p52), who suggests liminal moments 'will always be overruled by the dominant prison culture'. Ordinarily, the officers are happy to defer the responsibility for providing day-to-day care, but only when this is less visible. The public nature of the incident exposes the officers' ineptitude and a lack of specific guidance.

Prisoners assuming greater leadership over situations would be unacceptable in the context of normative staff/prisoner relationships; however, despite their lack of knowledge, the officers retain the power to set the agenda (Lukes, 2005), deciding who is and is not competent. I later recorded the following comment from a desk

officer in HU3, *'They (the buddies) get unlocked when we need them and then locked back up when we don't, they don't get much association time'.* This implies a taken-for-granted awareness of the scope of their role. The sequence plays out to the cost of the buddies' morale and mitigates against good care.

The following extract further illustrates the potential for tensions to arise between individuals and COPs within peripheral webs of practice, operating to differing working discourses. Again, status comes into play where officers risk losing face publicly if they are not seen to be in a position of authority.

(From HU3, while shadowing buddy Steve). 'We were there one day, he (ODP) fell and fitted, and we were all worried for a second because it looked like he'd stopped breathing. The officer wanted us to pick him up straight away, but it would have made things worse for him. We know that when he fits his limbs cramp and it's painful for him to stand. We spoke to him, you know, got him round slowly. We said to the officer to leave him five minutes, let him come around in his own time, please don't just pick him up'.

Ordinarily, communities of caregivers and officers operate peripherally to one another; both communities form close relationships and specific ways of working that are closed to outsiders. There is ambiguity between the extent of their respective roles in relation to the incident, and the officer impulsively issues an order, based on a common-sense view of what he feels to be the most appropriate response. However, in this moment the caregivers are more experienced and have a better working knowledge of the ODP's needs. Despite the power asymmetry, the caregivers are able to impress their opinion that it is better to allow the ODP to recover for slightly longer, further aided by a display of deference, and a decision is negotiated.

Leadership and cost cutting

The data extracts in this subsection reflect the prevailing attitudes of key members of staff and how their influence shapes the caregiver's performance. The extracts rehearse the narrative of organisational needs overriding processes of individual care.

(Researcher note from initial meeting with DLO1 in HU1). 'We are walking and talking on the ground-floor corridors allocated as the main social care wing. DLO1 tells me he should be allocated to HU1 so that he can oversee the work of the buddies, but more often he is hived-off to other wings that are short staffed by 'central detailing', who he describes as non-operational administrators who don't have a clue about the job. He experiences this as a source of frustration, as it prevents him from undertaking his role. He appears to say more than one thing; he is committed to helping the buddies, but he complains that his hands are tied, for example, by limited power to make decisions. His main complaint is that he doesn't have enough time to spend with the buddies'.

In 2013, the Secretary of State for Justice proposed that the public sector 'could duplicate commercial models which have addressed the challenge of increased cost pressures and demand for lower prices' (Para 61, House of Commons, 2015). Some of the DLO's frustrations can be partially explained by government drives to reduce manpower costs and drives to 'embed the neo-liberal principles of market forces and competition' within HMPPS (Turner et al., 2018, p163). However, the redundancies associated with the 'benchmarking' exercise reduced the numbers of experienced officers and produced a crisis that led to increases in substance use, assaults, prisoner deaths and self-harm incidents (Ismail, 2020). The ratio of prison officers to prisoners fell from 1–2.9 in 2000 to 1–4.8 in 2013 (PRT, 2014). The effects of these changes show that safety for both prisoners and staff has rapidly deteriorated over the last six years (PRT, 2017; National Audit Office, 2019).

Although untrained in matters relating to social care, DLO1 is an experienced officer who appears to have a good understanding of the everyday needs of the ODPs and

how to support the caregivers. However, organisational drives to improve efficiency mean he cannot perform this element of his role effectively, and this induces feelings of dissonance between conflicting personal and organisational values. His concerns are reflected in the complaints of the caregivers who suggested that they were sorely lacking leadership and formal support (a feeling expressed above in chapters 4 and 5). In keeping with the theory on 'street level bureaucrats' or 'petty sovereigns' (Zacka, 2017), DLO1's potential to advocate for the buddies and ODPs and to influence practice is crucial. However, his 'hands tied' narrative appears to signify a lack in agency to effect change within the context of an organisation set on reducing cost.

Power has been centralised to administrators, and this is in keeping with ideas around a shift to softer, or more diffuse, forms of power. Prison officers have become less powerful figures on the landings and decisions are made by faceless, unreachable others (Crewe, 2011). Ambiguity within the PSI does little to balance, let alone prioritise, the needs of marginal, dependent populations against the needs of the majority (younger) population, and the need for care is deprioritised against the functional needs of the organisation. It is not that DLO1 lacks leadership potential, but it is more a case of competing needs and tensions between organisational priorities, whereby discourses of security and efficiency, once again, are privileged over discourses of care.

These issues are further illustrated in the exchange of dialogue below. It is taken from a rare moment when the buddies and DLO2 (the DLO responsible for HU3) are together as a group, discussing operational problems.

Showing non-verbal signs of frustration, buddy Brian appeals to the DLO… 'When we take someone over to see the GP (to advocate on behalf of an ODP), we need cover to collect and serve meals, we can't do both'.
DLO2: 'When you are taking people over to health care, you are no good to the wing, we need you to be here!'
Brian: (Place's head in hands), 'Aargh!'
The moment is a little fraught, I interject…

Researcher to DLO2: 'When the buddies are with the ODPs in the doctor's surgery, they are providing a valuable service, to the ODP and, ultimately, to the wing community…
DLO2: (looks away, unresponsive).

The frustrations reduce to a choice between resourcing wing-based tasks or deploying the caregiver in a supportive activity. The buddy wants to be able to take his ODP to the surgery, as he feels he can make use of his intimate knowledge to advocate for his ODP, thus supporting greater continuity of care. However, DLO2 takes a utilitarian approach to supporting the needs of the wing, which is in keeping with his professional socialisation and discourses of efficiency. Until this bias is recognised and there is clear guidance and leadership in relation to greater flexibility, the needs of the majority (younger) population will override the needs of individuals. Most of the staff I met were well intentioned, but creating change in one prison activity has the potential to have knock-on affects on other processes.

The data reveals other interpersonal friction and frustrations, this time between me and a manager (Gov2), who had become my main point of contact. Towards the end of data collection, Gov2 asked me to attend a meeting to discuss the future of caregiver training. The aforementioned DLO2 and a LA social worker were also invited.

(Researcher reflection): 'I found the meeting particularly emotive. From a practical perspective, there didn't appear to be an agenda, no one took notes and subsequently there were no minutes or action points. Gov2 seemed very detached from the content of the discussion, spending the first 30 minutes either looking at her computer screen or putting stickers on box files. During the meeting it became clear she hadn't read some of our correspondence as she was asking for information that I had already supplied. We began to disagree over the minimum standards for the training. For example, she could not seem to differentiate between 'people handling' and 'inanimate object' handling. The social worker and I explained that there are legal parameters to 'people handling' training, we explained that a caregiver or care receiver could sustain long-term injuries from improper techniques which could result

in liability, but she persisted in sticking to her view that an untrained gym officer could 'easily' deliver the session. Moreover, she wanted the buddy training to be delivered in two days. I argued that we had previously developed an evidenced based, five-day package of learning, if we cut it to two days then she will effectively end up with cleaners, not caregivers. She ended the meeting saying she felt anything was better than nothing, to which I could not agree in the context of the safeguarding for the caregivers and care receivers and other legal directives. In my experience, two days' training could amount to as little as six hours of teaching sessions; that's if there were no problems with staffing or the operation of the prison. I felt this was unsafe and setting the prospective buddies up to fail'.

My assumption is that she was speaking from a position of what she felt was realistic, in the context of trying to keep costs to a minimum. My sense is that she would have a more realistic idea of what is needed if she spent some time with the ODPs and caregivers in the course of their daily work. The social worker and I have several years of experience delivering care and care training in prisons, yet she did not appear interested in our most basic recommendations. DLO2 later suggested that Gov2 was '*Under pressure to be seen to be making things work*', which implies that she had been drawn into an achievement-orientated culture, effectively attempting to tick a box. It is difficult to resist such forces if one wishes to be seen to be competent or worthy of promotion. However, human safety and need are at stake, and there is a difference between being seen to make things work and providing a more substantive, meaningful level of care. Within the target-driven culture, perhaps the staff at the institution have become accustomed to the 'quick-fix' satisfaction of performance targets, even if this means not providing a fully adequate response to the problem.

I experienced numerous other incidents which align with points mentioned above. As mentioned in the background section, Gov1 and the original health care manager (HCM) were instrumental in helping to arrange the research, but both left the organisation in quick succession. The HCM was replaced with a business manager, heralding a shift from a health-orientated paradigm (a humanistic, person-centred approach) to a business paradigm. I later recorded a statement in which the

business manager could not understand the reasons for supporting the caregivers or what the prison was getting out of the arrangements. She appeared to have no comprehension that by supporting higher standards of more accessible care she was helping to prevent longer-term physical, emotional and psychological health problems, and thereby reducing the costs to her own service.

The issues reflect discursive fault lines between practices of care, security and managerialism and the separation of health and social care budgets. On reflection, I believe I observed a general decline in the level of recognition and support for peer care, typified by neither Gov2 nor the new health care business manager being able to appreciate its value.

Chapter summary

This chapter explored the issues relating to power within individual relationships and between peripheral groups, along with its effects on peer caregiving. In specific situations, the caregivers were shown to have acquired greater knowledge and competence than the officers, and this was perceived as a threat to their status and authority, leading to interpersonal conflict and the exercise of instrumental power. When in a position of making choices, staff resorted to their professional socialisation, making decisions in line with discourses of security and managerialism rather than in support of relational processes. Purpose and power are shown to interact and to account for tensions, leading to reduced caregiver morale, but there was evidence of pushing back and occasional resistance.

A connection is made between the interplay between staff discourses and practices, official guidance, under-resourcing and leadership. PSI 17/2015 was introduced to encourage and guide peer care activity, and although its instructions appear to be understood, staff were not available to provide advice or check the outcomes of the activity, contributing to variability in practice. Axiomatic issues relating to a lack of knowledge and leadership are visible at several levels of the hierarchy.

Reduced staffing is linked to cost-cutting macroeconomic drivers, and this is reflected in a general drift from a welfarist to NPM/business orientation and practices. Consequently, discourses and practices of security and managerialism are privileged over discourses and practices of care.

Part 3: Discussion, conclusions and recommendations

In Part 2, the extracts and analysis combine to provide an overarching narrative of the research findings. The following section of the thesis will be presented in three broad subsections. The first section discusses the application of primary and secondary criteria for assessing the trustworthiness of the research, which is followed by a discussion and analysis of the research findings. The concluding element presents the recommendations and final reflections.

Chapter 9. Assessment of trustworthiness

The discussion of trustworthiness helps to demonstrate a commitment to accuracy, credibility and plausibility in the research process. As foreshadowed in Chapter 3, in this section I discuss multiple, self-critical approaches by which trustworthiness was established and evaluated within the research. Many authors have raised concerns with the congruence of traditional perspectives on the evaluation of reliability and validity in qualitative research (Lincoln and Guba, 1985; Ely et al., 1991). Accordingly, Cresswell (2013) suggests that qualitative researchers make use of more naturalistic approaches to the assessment of rigor, Verstehen and thoroughness. Based on the ideas of Guba and Lincoln (1994), the primary criteria to document and assess trustworthiness are the categories of credibility, authenticity, dependability, confirmability and transferability.

Credibility

Bryman (2016) suggests credibility can be confirmed via two main methods, respondent validation (or member checking) and triangulation. As objective reality can never be fully captured, triangulation is an effort to attain as near to an in-depth appreciation of a phenomenon as possible. Several strategies for triangulation were

adopted within the research, for example, data triangulation was achieved via a mixed approach to the generation of qualitative data sources, inclusive of observations, interviews, fieldnotes and written artefacts. These were cross-referenced against one another, enabling methodological triangulation. Analytic or theoretical triangulation was achieved by approaching the data with multiple theoretical perspectives in mind. Finally, Janesick (1998) suggests that interdisciplinary triangulation helps researchers to view data from other than dominant perspectives, which was achieved through my ongoing involvement with staff from several disciplines at several grades.

Sandelowski (1993) suggested that stakeholders do not normally have the credentials to endorse research findings; however, their advice and guidance provided an extremely valued steer. Member checking was regarded as valued and integral to the research, and it was achieved through several processes. First, there were several multi-disciplinary team meetings (inclusive of prison officers, nurse managers, a social worker and governors) at key points throughout the study. These supported me to deal with practical problems and to ensure the work was relevant and applicable to the needs of the population. Second, I met frequently with the HCM to discuss and verify the state of the work, checking for confluence in our understandings and to ensure the accuracy of various details in my reporting. The meetings also served as a debriefing function. High staff churn and the COVID-19 pandemic impacted on the member checking of the results; however, the HCM agreed to check my findings and final recommendations via email. Finally, the senior governor asked for project reports, returning written feedback and comments via email.

Authenticity

Questions of authenticity ask if the differing perspectives and voices were fairly, accurately and authentically represented. To this end, reflective consideration has been given to the balance between the representation of my opinions and experiences and enabling the voices and perspectives of the participants to be

heard. As discussed on page 60, constraints were imposed on process of recording and transcription affecting the quality of the data. However, the findings chapters present a substantial number of unedited verbatim quotes, paraphrases and narratives. In sum the extracts help to construct an overarching narrative, and make linkages between the data, interpretations and conclusions (Corden and Sainsbury, 2006).

In recognition of my role as the primary research instrument, I have demonstrated an ongoing commitment to self-awareness by maintaining a reflexive stance towards all aspects of the research, inclusive of relational ethics. This includes an active examination of biographic orientations, professionally influenced subjectivities and the potential for biases and prejudices, by reflexively exposing and surfacing emotional reactions and subjectivity (see Text box 1 and Text box 2). Peer-reviewed articles were published on the challenges of researching in prisons and my experiences of working with vulnerable groups of prisoners, which also support my claims to an ongoing commitment to reflexivity.

Research reports and training were delivered in each phase of research, providing evidence of reciprocity.

Text box 2: Samples of self-reflexive analysis on the process of data collection (later adapted for publication in Stewart, 2020).

Dealing with unsolicited disclosure and researcher resilience.

Initially, I felt that a helpful method of gaining trust was to express a position of not wanting to encroach on sensitive historical social matters by asking questions in relation to the participants' offences. I reasoned the participants might be highly sensitised to such matters and that this could pose a threat or engender resistance to the research process. I began each interview with words to the effect of, 'Issues related to your index offence and sentence are of no relevance to the research'. However, as discussed by Henslin (2001), researchers undertaking sensitive research can expect to encounter unanticipated self-disclosures of intimate information. In my experience these related to details of their index offence, aspects of their lifestyle, or generalistic reflections on their previous identities. For example, some of the more innocuous statements were, … (participant discloses his offence), followed by… 'I thought we'd better get that out of the way', or more indirectly… 'It was all about me, I thought I could get away with anything'. On other occasions my shock was more a reflection of the casual manner of which their crimes were discussed as well as than the offence itself.

The motivation for such disclosures may be subjective and vary from person to person; one assumes that such disclosures must have somehow met an intrinsic need. It is possible that some of the participants felt compelled to discuss these matters because of ongoing situational anxieties. Or the confidential nature of research may have enabled the participants to reveal their concerns; other participants may find it empowering or therapeutic (Hall and Kulig, 2005; Rossetto, 2014). Some participants may have felt it helped them better understand their situations (MacKinnon, Michels, Buckley, 2009). Alternatively, the disclosures may have been driven by a desire to shock or to destabilise the dynamic, perhaps due to narcissistic personality traits or through some other form of intra-psychic gain found in eliciting reactions in others. Daly (1992) suggests that the inherent power imbalance between researchers and research participants may result in unplanned disclosures, as some participants may feel obligated to answer questions that they would not usually respond to.

I heard the linguistic trope, 'I know you've heard this before, but I shouldn't be here', sometimes more than once per interview. Two of the participants claimed their charges were the result of jealous family members whose agenda was financially motivated. These could have been 'neutralisations' (Sykes and Matza, 1956), 'cognitive distortion' (Maruna and Mann, 2006), part of a narrative of denial or an attempt to construct and project a more acceptable, trustworthy identity. This narrative was also visible within the family photographs and artefacts that I observed in their cells. The participants were clearly concerned about their moral status and attempted to manage how their peers and visitors to the community would perceive them.

There were occasions when aspects of my own biographic history overlapped with those of the participants. For example, one of the participants came from a geographic area where I had once lived; it is an area where I continue to enjoy social connections, some of whom have families with young children. The participant described cycling around the area as a leisure activity which in the moment occurred to me as potentially predatory behaviour; I wondered if he was visiting family areas, essentially hunting for new victims? On one hand I wanted him to like and trust me; I went along with his generally jolly demeanour as a way of developing rapport and extracting data. However, simultaneously there was something about the situation that left me with discordant emotions. It was as if by laughing along, I was validating him as a person and thus condoning his deviant activity. Informal or friendly behaviours from sex offenders can be perceived as attempts to manipulative or groom researchers, resulting in diminished inclinations to trust offenders' stories' (Payne and De Michele, 2008; Klein, Bailey and Sample, 2018). Exposure to this kind of interpersonal versatility unsettled my preferred disposition of trying to remain objective. Farrenkopf states, 'Beyond disgust, researchers also experience anger at subjects for a variety of reasons' (1992, p213). I was not so much angered or nauseated, experiencing something nearer to incredulity. I was conscious of the need to 'surface act' (Hochschild, 1983), in order to control internal emotions and my reactive, give away, body language.

Researchers undertaking sensitive research may be affected by the social stigma of the population or research area. This process was referred to as courtesy stigma (Goffman, 1963), or more recently as 'stigma contagion' (Kirby and Corzine 1981, p3). I often experienced a surprised reaction when discussing the population and research with professionals outside of the research site. On some occasions I have felt the need to

distance myself by explaining that at least initially, I did not know that all of the participants would be convicted sex offenders. I feared that people might make assumptions that researchers who associate with those types of people, are 'those types'. In such situations researchers can become vulnerable to social stigmatisation based on the notion of 'guilt by association' (Miller and Tewksbury, 2001: 206).

Researchers have discussed how the process of conducting research on sensitive issues has affected them personally (Riessman, 1990; Cowburn, 2007). As the narratives that researchers obtain maybe of 'intense suffering, social injustices, or other things that will shock the researcher' (Morse and Field, 1995, p78), researchers undertaking sensitive research must make judgments on the impact of their research, on not only the participants but also on themselves (Liamputtong, 2007). 'Compathy phenomenon' is described by Morse and Mitcham (1997, p650) as the 'acquisition of distress and/or psychological symptoms by an apparently healthy individual following contact with the physical distress of another'.

Based on Goffman's methods of institutional adaptation, Cowburn (2007) learned to adopt a combination of processes to mediate the intra-personal effects of researching in prisons with men convicted of sexual offences, concluding that 'playing it cool' is often the best option. As a lone researcher with professional experience in the field, I did not anticipate any kind of reaction or trauma from the interactions, yet some interactions troubled me, and feelings of emotional discomfort remained available in my mind over the longer term. I was able to adopt an in-the-moment strategy of suspending judgment, then later reflect on the reasons for my emotional labour in particular situations at a later opportunity. Thinking and writing about the issues helped to expose the intra-psychic causes of my discomfort and eventually process the issues.

Dependability and confirmability

Cresswell (2013) posits that, in qualitative research, dependability is preferred to reliability and confirmability is preferred to objectivity. Evaluators of this research need to be able to establish whether the planning, process of data collection and analysis is coherent and transparent.

A research plan was developed and largely followed, give or take temporal drift (as outlined in Chapter 11, Strengths, weaknesses and practical limitations, page 177). A total of 25 days were spent at the research site during the pilot phase, then pre-visits and communication precipitated a further 22 days of observations and data gathering in the thesis phase of the research (Appendix 4, page 265). During this time, I was able to immerse myself in the staff and inmate cultures, get to know the layout of the research site and establish constructive working relationships with staff

at all grades, crucially prominent gatekeepers such as the HCM and DLOs. My professional involvement with offender health services and knowledge of the prison system helped me to gain interpersonal credibility with the stakeholders and participants.

Timelines, audit trails and reflections were diarised, including discussions of plans and processes with supervisors, methodological decisions and constraints. Email trails helped to explain and confirm some aspects of problem-solving and decision-making, and these were also used as a source of reflection.

A semi-structured interview schedule was prepared and used as a guide to questioning (this can be found at Appendix 5, page 267). Notes were gathered before and after interviews, reflecting on the content and process, and to elicit an accurate and deeper understanding of the participants' meanings. My familiarity in the environment coupled with the length of the interviews established trust and rapport with the interviewees, which helped to elicit enhanced responses. Gentle probing techniques were used to facilitate further elaboration or clarification of responses. The process of coding was based on movement between data, the research aims and questions (this process has been made explicit in Chapter 3, Organising the data and analysis, page 69). Dialogic reflective processes were used in research supervision to discuss and challenge the process of coding and theme formulation.

Several authors recommend the use of journaling to prompt memory, to record processes and to reflect on collated data (Lofland and Lofland, 1995). Numerous reflective accounts were documented, chronicling important, and sometimes emotive, moments in the research journey and evidencing reflexive processes (see Text box 1, Text box 2 and Appendix 6, page 272). Moreover, I made use of opportunities to share the work at a Royal College of Nursing's (RCN) International Research Conference (2017), and shared the research methods with colleagues and postgraduate students. The process of taking questions and gathering feedback helped me to make links between philosophical positions, theoretical perspectives and choice of methods, proving useful to the study.

Transferability and dissemination

Geertz (1973) describes ‘thick descriptions’ as rich details of a culture-sharing group. Bryman (2016, p386) suggests that thick descriptions provide others ‘with a database for making judgements about the possible transferability to other milieux’. Support for transferability has been evidenced through a robust research protocol, through multiple presentations of raw data, thick textual descriptions, through a transparent application of methods, as well as organising data and data analysis. The case for transferability has been enhanced by rich accounts of material factors, the participants lived experiences and localised cultural processes within the environment. Moreover, I have sought confluence with extant literature and research, citing key authors, government audits and policies.

Sharing knowledge has the potential to prompt social action and promote justice. To this end, new insights and knowledge have been developed, information has been shared and practical recommendations suggested. The findings and recommendations will continue to be disseminated via university forums, blogs, podcasts and professional networks, for example, the RCN’s ‘Nurses in Justice and Forensic Health Care’ professional forum. Discussions have occurred with practice educators from NHS-commissioned prison health care services, and findings will be presented in further peer-reviewed journal articles and conference proceedings.

There are four other prisons in England with a similar function and population, and it is likely that some of the points of learning from the study will be beneficial to these institutions. However, practitioners will need to establish their own relationships with the findings, and critically interpret the recommendations in light of their own experiences and circumstances.

The processes related to rigor and trustworthiness are summarised below:

Criteria	Strategies
Credibility	Data, methodological, theoretical and interdisciplinary triangulation. Respondent validation/member checking.
Dependability	Internal coherence of the study. Long-term engagement at the research site. Research diary/audit trail. Individual reflection. Interdisciplinary triangulation. Regular dialogic reflection in research supervision.
Confirmability	Planning meetings, research plans, audit trail. Reflective diary and reflexive accounts.
Authenticity	Reflective diary and reflexive accounts. Reciprocity. Reflective consideration of position.
Transferability	Thick/rich description. Knowledge sharing.

Table 5: Summary of the processes used to support the evaluation of rigor and trustworthiness

In 1950, Isaac Asimov wrote: ‘Science is just a mass of collected data plastered together with makeshift theory… it is fiction, with its interplay of human motives and emotion that interests me’ (p103). Fetterman puts forward a more balanced perspective: ‘The ethnographer is both the storyteller and the scientist’ (2020, p2). Both comments resonated with my approach to the representation of the research, as I aimed to strike a balance between rigor and creativity, avoiding what Janesick (1994, p215) described as ‘slavish attachment and devotion to method’ or ‘methodolatry’. I believe the extracts and analysis go some way towards meeting Whittmore, Chase and Mandle’s (2001) secondary criteria of validity of thoroughness, congruence, vividness, explicitness and sensitivity. I believe the work is a fair representation of how I have seen and experienced things; however, the reader will have to decide how they see things for themselves.

The following chapter presents a discussion of the research findings, before moving on to the recommendations and final reflections in Chapter 11, page 177.

Chapter 10. Discussion: ‘Helping not hurting’: horizontal care and learning

This chapter is divided into several subsections. It opens with a summary of the research process and a discussion of how the theoretical perspectives intersect to shape the analysis. The chapter discusses the realities of life for the ODPs and caregivers, the meaning and value they give to peer care, their roles and relationships. It provides an outline of the benefits of learning and caring for individuals, peripheral groups and the wider community. The latter sections of the chapter discuss the underlying mechanisms influencing the experiences of the participants, highlighting some of the moral, legal and ethical questions relating to the sentencing and treatment of ODPs.

Research summary

In response to the question, *‘What can be learned from the experiences of prisoner peer caregivers and care receivers in a UK prison, and how can peer care practices be enhanced?’* a critical realist philosophical position was adopted, enabling a flexible approach to data collection methods. A qualitative, self-reflexive ethnographic methodology was felt to be the best way of bringing me closer to the culture-sharing groups and obtaining an informal perspective on the participants’ lives and activities. Meanwhile, the interviews facilitated backstage opportunities to explore the participants’ personal views and opinions, away from their colleagues and staff. Caring and learning were identified as key social practices and the thematic lines for analysis. The presentation of data and the analysis gives voice to individual perspectives, presenting continuities, discontinuities and thematic patterns, without necessarily harmonising what can sometimes appear to be contradictory accounts.

Intersection of the theoretical approaches

As advocated by Van Maanen (2011, p52), 'the use of theory allows the humble fieldworker to stand on the shoulders of giants (and see further) by using well-received constructs as receptacles for field data'. To this end, the selected theoretical perspectives helped to develop my interpretation of the participants' 'sayings, doings and relatings' (Kemmis, 2009, p463).

The theoretical perspective of ethics of care brought several benefits, including a dualistic view of the caregivers'/care receivers' needs and the evaluation of care within an institutional context. It enabled movement between micro and macro levels of analysis and an axiological interpretation of values. Theories of self-development from a criminological framework shed light on transformative learning processes, such as self-awareness, maturation, motivation and the possibility of changed-life narratives. Theories of social learning (LPP, COPs) brought critical attention to the role of practice, the transmission of social learning and issues relating to identity and power.

The respective theories provided different perspectives, functions and analytic devices, and could be used to examine landscape, latent and overlapping elements of the data. For example, matters relating to identity maintenance and change were common to theories of social learning and theories of self-development. The importance of attachment and social bonding was identified as a productive mechanism in both theories of social learning and theories of self-development. For differing reasons, ethics of care and situated social learning theories helped to identify issues relating to conflict and power at individual and social levels. The tenets of CR and ethics of care overlap in their aspiration to uphold social justice by exposing the circumstances and causes of inadequate practice and developing the structures to challenge poor practice.

In summary, ethics of care, criminological theories of self-development and theories of social learning helped to situate and deconstruct caregiving, and learning to care, at the research site. The combination of theories and methods informed different

aspects of the study, combining to shed light on the phenomena of peer caregiving and learning to care in the environment. The examination of the interactions of care dyads, team roles and peripheral communities surfaced issues relating to morality, generating alternative strategies and practices for caring and sharing learning, as well as the relationship between care and social justice.

The lived experience of ODPs

The study reports on the issues that were important to the ODPs. All of the ODPs interviewed required variable levels of assistance with their ADLs; moreover, nine out of 12 of the ODPs interviewed were serving their first sentence in later life. Their narratives revealed their concerns, which were caused by both intrinsic and extrinsic factors. Intrinsic factors included physical and cognitive processes relating to age and disability, the effects of long sentences, separation, a lack of control over their situations and fears for the future. Extrinsic factors included aspects of the institution's regime, ageist and disablist practices, marginalisation, othering and the stigma associated with their status as older MCSOs.

Consistent with the literature relating to ageing in males, stoicism was a feature of their responses to questions and descriptions of their lives, health status and futures. The ODPs did not want to discuss matters of 'health', 'dependence' or 'well-being' directly; moreover, they expressed that they did not want to be seen to be 'cared for'. They wanted to be supported to look after themselves, even though the biopsychosocial processes of ageing worked to undermine this.

Mostly, the ODPs did not ask for help, preferring to struggle independently, sometimes preferring horizontal assistance from neighbours or friends when available. In some cases, asking for help was perceived as difficult, a waste of time or just something they would not do. For others, peer support was appreciated and coalesced between practical support for ADLs, such as cleaning, wheelchair ambulation, meeting hygiene needs, assistance with medication and emotional/social support, inclusive of problem-solving. Help with these issues

supported them to exercise varying degrees of autonomy and was central to their perceptions of independence.

The combination of increasing frailty and disability, as well as poor environmental design, literally limited the ODPs' lives. Even where adaptations and adjustments had been made, the data describes problems, such as the distance between facilities, poor-quality furniture, cramped cells and accessibility issues. Furthermore, these issues served to impact on the way that others were able to support and care for them. The prison regime was undifferentiated by age and loaded in favour of the majority (younger) population, which resulted in concerns for their personal safety, increased ambient noise levels, led to issues relating to the expression of masculinity and the consequence of operational decisions being loaded in favour of the majority population. There were numerous accounts of disempowering interactions, such as paternalistic 'I know best' approaches to decision-making, which effectively amount to unconscious institutional ageism and disablism.

Yet, conversely, there were examples of supportive relations and social activities that brought a level of satisfaction to the individuals and the micro-communities of ODPs. The institution provided for basic needs and an element of social protection that may be lacking in some areas of the community. In some spaces the ODPs had collectively built a sense of community, they enjoyed good relations with their colleagues and some staff, and these intersubjective features were important to their well-being. Some ODPs described the value of feeling cared for via peer support. The demonstration of empathy, awareness, interest, trust and consistency were identified as important qualities in their caregivers. Living with a sense of autonomy within their cells and communities was also identified as being important to the ODPs.

Analysis of peer care in prisons

Prisons are usually thought of as places where care is not always immediately visible; indeed, expressions of emotion and care are antithetical to the prevailing values of punishment, hegemonic hypermasculinity and prison culture (Jewkes, 2005). In respect of care for older adults in prisons, Crawley (2005) accused HMPPS of institutional thoughtlessness. Girling and Seal (2016) extend this criticism, describing prisons as death-intensifying institutions. Formal health care had been pared back in the wake of privatisation and austerity measures (Ismail, 2020), and formal social care is still relatively new to prisons (Williams, 2014; Lee et al., 2018). Six years after the implementation of the Care Act (2014), social care in prisons still attracts criticism (Forsyth et al., 2019; Shaw et al., 2020). HMPPS has been slow to make changes, but it lacks the expertise, funding and political leadership needed to create change.

However, it is established within the literature and the research that, when carefully managed, peer caregiving in prisons can provide benefits to the peer carers, care recipients and the wider prison community (Edgar, 2011; Bagnall et al., 2015). Peer care is shown to be a socially emergent practice, shaped by a combination of institutional aims, local interpretations of guidance instructions and the drives of individual champions.

As an emerging practice, peer caregiving was found to be both undervalued and difficult to achieve. From an intrapersonal and interpersonal perspective there were emotional, relational, procedural and ethical tensions; from an organisational perspective there were resourcing and retainment issues, problems associated with role drift, as well as poor reward and recognition. In some residential areas, engaging in the practice of caregiving was not seen to be productive in terms of the caregivers' sentence plans or parole reports. The absence of training, the lack of professional guidance and the lack of facilities to offload emotional tensions served to limit the experience of the caregivers, affecting the style and quality of care they

were able to deliver, and, consequently, these factors did little to enhance the quality of life for the ODPs.

Where care was able to flourish, there was ample evidence of reciprocity and meaningful human relationships. Caregiving was described by some as an intrinsically rich, satisfying and purposeful activity. Some caregivers were cognisant of helping ODPs, to ensure they did not feel dependent, and discretely supported self-care. The ODPs expressed a preference for caregivers who ‘knew what to do’ or who ‘went the extra mile’ without needing to be asked. In some dyads, the ODPs found ways to engage with and motivate their caregivers or seek support in such a way that they did not feel as if they were being a burden. The study shows that factors which positively influence the experiences of the ODPs also positively influenced the satisfaction levels of the caregivers. For example, relational and person-centred approaches, as opposed to socially distant, task-orientated approaches, brought intrinsic satisfaction to both groups. This implies a good level of mutual understanding, involvement and collaborative engagement within the dyads.

Interestingly, displays of vulnerability expose the need for greater levels of formal care, but also revealed horizontal, inmate-to-inmate care. Some ODPs were observed to support each other and their younger counterparts; therefore, care appears to be transmitted bidirectionally. The discussion of care outside of formal roles represents an original contribution to the literature on care in prisons, and the descriptions of exchanges of emotion and intimacy challenge notions of hegemonic prison masculinity.

As reported in the research, despite the many constraints, the caregivers were well placed to assist the ODPs with their ADLs, uphold their level of independence and, through social connection, promote well-being. Despite the increasing levels of vulnerability and institutional impediments, the research confirms that peer care can be successful, legitimating the role. Moreover, the study shows that there is scope to develop the role. Peer care represents an opportunity to respond to health and social needs, it is a collectivist gesture which has the potential to offset individualistic discourses and practices.

Peer caregiving is cognitively, physically and emotionally demanding work (Walby and Cole, 2019). The literature review revealed ethical concerns about the use of prisoners as caregivers, and although numerous authors recommended greater attention to supporting caregiver resilience levels, promoting carer resilience did not appear to be a feature of many peer programmes. This research shows that many of the caregivers had their own vulnerabilities and were, additionally, subject to generic 'pains of imprisonment', which are affiliated with low mood, reduced self-esteem, diminished self-worth and, at worst, non-suicidal self-injury (Sykes, 1956; Liebling, 1999). Given that psychological safety and support is essential when dealing with the negative emotions associated with personal distress and suffering, peer caregivers faced the challenge of learning to look after themselves and others.

Although there were no outward signs of abusive practices, such factors have been associated with the potential for caregiver burnout, paternalistic or parochial care, poor practice, exploitation or abuse (Barnes, 2012; Depner et al., 2018; Walby and Cole, 2019). Effectively, the caregivers had only their informal networks to learn from and offload their accumulated stresses. In the areas where the caregivers were more cohesive and mature, the communities of carers were better able to support each other, and there is a corresponding association with better outcomes for the ODPs.

Peer care and national guidance

The extracts and observations in Chapter 5 show a variation in the actualisation and quality of care in the different residential areas. Analysing the differences in practices provided a point of comparison and helped to visibilise the tendencies that might inform learning to support better care. In HU1, managerial impositions led to a standardised, task-orientated, time-limited approach to peer care, and this appears to have affected the satisfaction levels of the caregivers and care receivers. In line with drives for efficiency, the role had become conflated with other wing-based work, which diminished the resources that could be directed towards caregiving. In HU1 there was a higher turnover of caregivers and greater instability and discord within

their community – notably, similar processes have been described by community social carers (Bains, 2004). This was due to many factors, including high numbers of ageing and dependent prisoners, reduced capacity, inadequate written instructions, as well as officer discourses aligned to managerialism and security, culminating in well-meaning but, ultimately, inadequate guidance and leadership.

These differences are in spite a standardised national instruction to prison governors (PSI 17/2015). Chapter 8 shows the instruction to be a source of ambiguity, and vital elements appear to be missing. For example, there is no discussion of its main purpose: supporting preventative, home help-style assistance, and details about the allocation of resources and training are, at best, sketchy. Without expert guidance or strong local champions, officers resorted to a fall-back position of traditional security-focused custom and practice, and opportunities to support peer caregiving were lost. Numerous interactions were shown to expose institutional power flows that typically prioritised the needs of the majority (younger) population, often at the expense of the ODPs.

Not to diminish the best efforts of those involved, but it seems incredible that there was no written guidance for peer practice before 2015. Furthermore, as low-level care falls outside of the remit of formal health and social care audit, there does not appear to be any mechanisms to regulate or judge the quality of peer caregiving other than visibly patching local oversight. Moreover, the situation invokes broader questions, for example, what would happen if the caregivers decided to either comply fully with the PSI, that is, they refused to deal with intimate care issues? Moreover, how would personal care be delivered if no one volunteered for the role? These are legitimate questions considering the research findings and the results of the literature review, which suggest the level of need for preventative care is shown to be both acute and increasing – the MOJ and NHS can simply not afford to ignore these issues.

The role of other participants

Officers

Time was spent with the DLOs and wing managers in HU1 and HU3, I also enjoyed opportunistic chats with officers on the landings, the wing offices and staff canteen. The interactions were characterised by a corresponding occupational stoicism and humour. Our discussions mostly related to matters of organisational change, resourcing, shifting professional autonomy, training issues and the tension between a one-size-fits-all approach and a perceived need for flexible man management. The officers consistently identified that ODPs' needs were different to those of younger prisoners, requiring different skills, institutional processes and greater levels of support. Some disclosed sensitivity to the needs of dependent prisoners, expressing a sense of cognitive dissonance between their personal values and organisational practices. Life at the research site was characterised by increased instability, a higher turnover of staff and the privatisation of some departments – fatalistic expressions were recorded in relation to these changes and their roles.

Ordinary prisoners

I did not interview any ordinary prisoners directly; however, as mentioned above, there was a good deal of interaction during the participant observations. Although I heard narratives of indirect intimidation, I also observed spontaneous acts kindness and support. It appears that exposure to human vulnerability stimulated a minority of ordinary prisoners to make spontaneous caring gestures. This may be through a personal sense of duty or responsibility, altruism or for other intrinsic reasons connected with socialisation and biography. Therefore, the data surfaced a shortfall of formal health and social care services, simultaneously exposing examples of goodwill and horizontal care among the inmate population. The research locates the performance of care on a continuum between vertical (formal) health and social care (inclusive of peer support) and horizontal (completely informal) dimensions of care.

Learning and training

In Chapter 5, we heard that care was not only confined to formal mechanisms, and Chapters 6 and 7 show that this was equally the case with regard to learning processes, which were, ordinarily attached to specific courses with specific outcomes. Criminological theories aligned to self-development and social theories of learning helped to expose several features within the data, including the motivation to engage with caregiving, socially transmitted learning and impediments to learning. These factors helped to develop ideas for new strategies to support sustainable forms of learning. The following section begins with a discussion on individual change, before moving on to discuss social learning and the role of conflict in relation to organisational change.

Performing care and identity transformation

The data shows that prison life and ordinary prison employment was experienced as predictable and unsatisfying. This has been linked to intrinsic processes, such as a reduced sense of agency, self-esteem and emasculation (Jewkes, 2005). However, caregiving was perceived to be unlike other forms of occupational activity in the environment. For example, the intersubjective effects of responding to human need and distress brought uncertainty and the need for cognitive and emotional labour, but it also brought subjective rewards. Caregiving is a visible, embodied, social, emotional and moral activity, and the fulfilment of these elements can serve developmental functions (Einat, 2017). Sevenhuijsen (1998) suggests that the experience of providing care to dependent individuals is both an internal activity and an external practice.

Prisons limit personal agency and constrain opportunities to earn redemption and, therefore, to atone for previous wrongdoing. However, all of the caregivers were able to identify the meaning that their role added to their existence. For practical reasons, the performance of peer caregiving brought the potential to gain a greater sense of existential purpose and structure, through actions such as taking responsibility for others in need, making practical decisions and the performance of empathy. Several

caregivers suggested the fulfilment of purposeful roles evoked an increased sense of agency which mitigated the effects of institutionalisation.

At an individual level, being placed in a position of responsibility for providing care appeared to motivate some caregivers to improve and develop their embodied knowledge and practices. The advancement of knowledge and experience that came with learning to perform the role also appeared to change the caregiver's relationships with other prisoners and staff, and this too is believed to have the potential to be personally transformative. For example, officers were more likely to listen to an experienced, knowledgeable caregiver, which altered their standing with their peers and, in turn, their self-opinion.

The caregivers wanted to show that they could change and be trusted, and caregiving represented a rare mechanism for the performance of phronesis and redemption. The extracts allude to a desire to be seen to make good or to evidence atonement. These drives connect with narrative theories of self-development, such as 'wounded healer' (White, 2000) and 'helper narrative' theories (Gartner and Riessman, 1984). Surfacing such narratives helps to show how the practice of caring helped the caregivers to develop self-awareness and self-knowledge, and to reposition themselves in relation to their biographic trajectories.

Comparisons between their historic selves and their current 'prisoner' identities were implicit within the transcripts, and these hint at a desire to change to preferred self-representations along with aspirations for their futures. As McAdams (1985) suggests, self-narratives serve to influence behaviour, as people act in ways that are consonant with the stories they create about themselves. In these ways, the performance of caregiving helped them to detach from the bestowed identity of 'prisoner' (Ugelvik, 2014), presenting hope for an agentic present and crime-free future. In caregiving and learning to care, the desire for existential change meets an opportunity for re-scripting; as with helper narrative theory, helping others is shown to help the self.

This process is reinforced in, ‘Learning in Landscapes of Practice’, where Wenger-Trayner and Wenger-Trayner (2015), discuss the journey of learning in relation to the fulfilment of longer-term aims and identity change. In rehabilitative terms, caregiving can encourage prisoners to identify with something other than the status of ‘offender’. Thus, understanding the participants’ views on their biography, situated identity, their involvement with care and preferred futures became a key strand of the analysis of factors that support and sustain the motivation to care. In the context of individual moral careers and life course trajectories, the processes of caring and opportunities to learn to care are shown to overlap and lead to greater self-awareness, changes in social status and intra-personal change, presenting an opportunity to fulfil an alternative identity.

Social learning: morality, instability, discontinuity

Even though personal care can involve complex interactions, there was, ordinarily, no training and guidance was extremely limited. Although valued, the training delivered in the pilot was shown to rely on external experts, and the local staff did not feel confident enough to continue the training. Notably, the caregivers during the pilot study were much more experienced and embedded in the role. Prisoners are transferred between jails as their security classifications change and they also complete their sentences, meaning there is always movement within the system. Consequently, none of the original trainees from the pilot study were fulfilling the same role on my return to the site.

The rate of change within the caregivers’ teams in HU1 meant that the transmission of learning between experienced and newer group members was disrupted and competence development was impeded. To put this another way, the time and input needed to support learning was insufficient and information could not be memorised or transmitted between group members – consequently, continuity was interrupted. The loss of collective memory, knowledge and practices impacted on the performance and reputation of the team, and this was shown as a source of frustration for senior caregivers and ODPs. Therefore, it was observed that tacit

knowledge associated with caregiving was held at a social level within the practice of the community of caregivers and some written artefacts, but this process was affected by a rapid turnover of personnel.

We learned that in HU1 there was greater instability and levels of disharmony within the community of carers, whereas in HU2, HU3 and HU4 it was observed that the caregivers were more mature, their ages were similar and, generally, they appeared to get on well with one another. It was also noted that when prison governors attempted to allocate ordinary prisoners to caregiver teams, the imposition of new group members was met with resistance by the caregivers and poorly received by the ODPs. The combination of these issues made it more acceptable for caregivers in HU1 to resort to technical-rational, practical activities, such as cell cleaning, rather than the more cognitively and emotionally laborious responsibilities of listening, attending and responding to the ODPs.

The communities of caregivers were seen to have internal hierarchies, with the most experienced caregivers shouldering greater levels of responsibility. Experience led to competence, and this was associated with higher status within the group. Strong personalities were observed to be influential, and the more experienced group members regulated newcomers' centripetal movement towards full group membership. In Chapter 7, the extracts show that practice was shaped by regimes of competence, regulated by disciplinary processes in the form of verbal disapprovals and disapprobation, leading to an internal community morality. Social dynamics such as attachment, belonging and maintaining an internal morality were also shown to shape the caregivers' attitudes and, subsequently, how they delivered the care. These processes were often subtle, but they were seen to affect individual caregivers' self-perception and their views on how the work should be performed.

Competence, conflict and change

Human interactions, particularly those that involve suffering, are often messy and innately uncertain. The needs of the ODPs were not beyond the purview of the

officers, yet as mentioned, the performance of peer caregiving was often unrecognised and taken for granted. Peer caregiving was shown to meet with resistance from officers and was deprioritised to discourses of security and managerialism, which fitted together both instrumentally and functionally. Coercive power was expressed through asymmetric social relations which mitigated away from care and job satisfaction.

According to Wenger's (1998) theory, the hierarchical distribution of power is related to the development of knowledge and regimes of competence. Tronto (2010) also suggests that care processes can induce conflict through mixed agendas, power differentials between individuals and groups and the allocation of resources. The distribution of power and conflict are features of social theories of learning and ethics of care, and therefore form a common link between the theories and the analysis of practice. For differing but related reasons, learning and caregiving was shown to lead to conflict between individuals and interconnecting, peripheral communities of practice. For example, there were differences between the needs of the ODPs (receiving care) and the priorities of the officers (maintaining good order and efficiency), showing how purpose and power interact to account for conflict. Moreover, practices of caregiving were shown to compete with the efficient operation of the prison, and there were tensions in relation to the allocation of resources.

Differences between knowledge and experience levels also brought caregivers and officers into conflict. Medical emergencies brought levels of competence to the fore and provided critical moments to reflect on situated decision-making. Through their day-to-day work with the ODP population, it was often the caregivers who had developed more confidence in relation to the management of health crises. However, in such instances, the acceptability of prisoners displaying greater levels of competence appeared to challenge the officers' sense of authority. Coercive power was then exercised as a means of superordinating their authority, and this was experienced as disempowering and demotivating. In the absence of expertise, it was ultimately the officers who had the power to set the immediate agenda by deciding what actions to take. The tensions reflect the divergent trajectories of the peripheral

communities, yet given the relationship between conflict and change, the tensions could be a sign that the organisation needs to change its trajectory towards greater care.

The above factors all point to the effects of social processes on learning and practice, hinting towards a need to focus not strictly on classroom-style tuition but systemic processes, such as balancing workload and involving the caregivers with recruitment processes, and making better use of senior carers' knowledge in the form of shadowing and mentorship. Retaining group members over the longer term seems key to group cohesion and competence development, implying that space for the communities of caregivers to share learning, process differences, prepare for uncertainty and make use of reflection and critical thinking may be beneficial – this could be supported by focused workshops to sharpen learning as needed. Moreover, ethics of care recommends examining the experiences of both the caregivers and care receivers, and this suggests involving the ODPs in a range of co-produced educational processes, (see Chapter 11, Developing caregivers via social approaches to learning, p.182).

Interestingly, several exemplary studies outlined in the literature review discuss the difficulties of implementing and sustaining traditional training courses owing to staff shortages (Brooke and Rybacka, 2020; Tracey, Haggith and Wickramsinghe, 2019; Forsyth et al., 2019). Therefore, a connection can be observed between the lack of supervision and impediments to learning processes and broader macroeconomic policies in justice services – for example, reduced expenditure, NPM ideals and reduced manpower. These factors are shown to impede continuity and will be discussed in greater detail in the following sections.

The effects of neo-liberal political choices on peer caregiving and receiving in prison

In reviewing peer care in an English prison, this thesis has taken into consideration a broad range of practical, ethical, political and moral questions raised by the needs of

the ODPs, their caregivers and custodians and the arrangements for their support. In combination with the identified theoretical perspectives, the analysis has exposed numerous causal tendencies impacting on caregiving and sheds light on potential solutions. The research generated a range of findings that not only unmask landscape issues relating to the safety and security of older prisoners, practices of peer caregiving and learning to care in prisons, but clearly demonstrates that such issues are difficult to separate from the wider issues of populist public perceptions towards older offenders, sentencing policy, ageing and disability, and macroeconomic policies.

In the following section, the micro-picture of constrained caregiving and receiving is situated in relation to dominant ideological and political discourses, within the context of prevailing neo-liberal policy imperatives. Dominant discourses are shown to influence the processes of peer care, for example, by reducing dedicated officer and health care staffing levels, resulting in reduced access to health and social resources, and grand narratives that position older people as dependent and burdensome. These ideological positions reflect a shift from welfarist and rehabilitation-orientated approaches to a NPM orientation, and shift the analysis of peer care to moral and political levels.

Wacquant (2010, p39) argues that welfare and criminal justice are two modalities of public policy toward the poor. Although ODPs and prisons are not its primary focus, the participants experience of precarity is more broadly the consequences of how individuals are constructed and how economic policy is shaped. There is evidence from the wider literature that environmental limitations and reduced choices can affect individuals' self-esteem and negatively impact on their health (Coburn, 2004; Navarro, 2007; Pickett et al., 2006).

Analysis of the data shows this occurs through the following mechanisms: first, political drives to prosecute and punish historic sex offences and longer sentences mean there are higher numbers of vulnerable ODPs in the prison system for longer periods of time. Second, there are cultural and discursive associations between older adulthood and dependence. In the context of the hypermasculine prison culture, this

means that care receivers (and caregivers) occupy a low profile within the organisation, and their needs are de-prioritised in relation to the majority population. Third, by zooming out from the micro-level picture, a connection can be made between the lived experiences of the ODPs and caregivers and broader macroeconomic imperatives, through the adoption of NPM ideals, the privatisation of prison health care services and austerity, leading to reduced staffing and access to health and social services.

All prisoners occupy precarious existential positions and lack civil, political, economic, social and cultural rights; however, ODPs endure additional risks and uncertainty in terms of their immediate and longer-term futures. They have behaved abusively and inhumanely to others, so there is scant public sympathy for offenders. As we emerge from the COVID-19 pandemic into the deepest financial crisis for 300 years, my sense is that the country will be in no mood to hear about the rights of MCSOs. As pointed out by Turner et al. (2018) and Ismail (2020), it is easier to other specific groups rather than address the structural roots of criminality and the causes of offending. However, prioritising care has the potential to de-centre prevailing (neo-liberal) ideologies and facilitates a critique of existing processes. Peer care is a relatively new discourse in prisons, and it is in tension with more dominant, better-established discourses of security and managerialism, leading to friction between individuals and groups. As Zeeman and Simons (2011, p712) observe, ‘New professions (roles) might be perceived as chipping away at occupied territory’ – consequently, introducing change is difficult.

Punishment, incarceration and retribution

The data raises several moral and ethical questions on the incarceration of ODPs, foregrounding wider debates on the role of punishment and prisons. It is clearly right and proper to punish people if they have committed a crime, but is it just or moral to condemn ODPs to environments that cannot support human rights, basic levels of care or, in some cases, where they might die, bringing the distinct possibility of de facto life sentences.

For example, why punish people with advanced states of illness, some of whom do not have the mental capacity to know they are being punished? It is clearly not about protecting the public through risk management or rehabilitation; the situation speaks to a retributive, punitive approach over diversion or rehabilitation. Prisoners can be transferred to hospital under the Mental Health Act (1983), or temporarily if they are physically unwell, so why can they not be transferred to care services on the grounds of extreme vulnerability or frailty? Recognising that a balance needs to be struck between the need for care and justice for the victims, health and social care agencies need to intervene more robustly and transfer extremely VPs to places of safety where their rights can be upheld.

Rights and reasonable adjustments

As Kittay (2001) suggests, ODPs are still people, they are sons, brothers and parents. They are entitled to NHS care and they have human rights, for example, not to be degraded and access to services; they are entitled to reasonable adjustments to their environment under the Equality Act (2010). Most people would agree that rights legislation is a good thing, but there is a clash between these ideals and the current conditions for the most vulnerable in this specific group. It is as if the formal services have either become blind to the level of need or, after years of underfunding, become complacent towards it.

Compassionate release schemes are rarely activated, and a cynical view might point out the high cost of community care in comparison to the lower cost of a prison placement. There is an equivalent clash of logic between macroeconomic principles of cost saving and providing a decent level of care and conditions (Casalini, 2019). While it is beyond the scope of this thesis, I am not saying do not punish or exact retribution, but I am saying that the circumstances either need to be changed for the better or the government needs to take a fresh look at alternative methods of punishment.

Peer care and sentencing

The officers and, more specifically, the caregivers are being placed in a difficult, unwinnable position. They are being asked to perform a role but are not trained or resourced to respond to the issues, and the current systems and material environment are unsuitable. There are consequences to the performance of peer support, namely caregiver burnout, the potential for accidents and poor practice; therefore, the current situation represents a moral failing and a social justice issue.

While this situation is ethically questionable, the peer caregivers' existence makes it possible for the courts to hand down custodial sentences to vulnerable offenders. Statutory social services have not filled the gap and health care services have been privatised and reduced – arguably, the justice system depends on an internal social care service to justify sentencing and the continued incarceration of ODPs. Care in prisons continues to be situated within punitive managerial frameworks, but until care is afforded greater status, change will be difficult to put into effect. However, as outlined above, care and learning to care can be helpful to the caregivers and care receivers, bringing the prospect of a hopeful solution and adding weight to arguments for developing their learning and support.

Given the balance of issues described above, there is good reason to believe that, under the right circumstances, working within the right frameworks (placing care at the centre of decision-making and applying theories of social learning), that a greater sense of mutuality and care could be fostered and developed. The analysis offers a strand of practice that can help to ameliorate the issues. A visual formulation of this situation is represented in Chapter 11, page **Error! Bookmark not defined.**.

Chapter summary

In this chapter, I have summarised and discussed the landscape observations and underlying causal mechanisms that influence peer caregiving in an English prison. The research presents new insights on the constraints to peer caregiving and strategies to promote learning to support peer caregiving. A constructive alignment

can be made between the problematisation of peer care in prisons, the aims of the study, the data collection methods and analysis, leading to the conclusions.

Chapter 11 sets out the recommendations for organisational changes and future educational practices, presenting a visual summary of the research and final conclusions.

Chapter 11. Conclusions, recommendations and final summary

Chapter introduction

In this concluding chapter I present an outline of the strengths, weaknesses and limitations of the research; I summarise the contribution the research makes to the field and present the recommendations for educational interventions, operational changes and future research. The final section presents a diagrammatic summary of the findings and meta-reflections.

Strengths, weaknesses and practical limitations

Although the research adds to the literature on peer caregiving in prisons, it is not without its limitations. From a practical perspective, the journey time to the research was, on average, four to five hours each way, meaning either a very early start and late finish time or staying in a hotel near to the research site if I was required before 10.00. There was a minimum of five interchanges between the differing forms of public transportation, and a short delay at one connection had the potential to impact on the next. Moreover, a lengthy regional train strike frequently extended the journey time. These issues led to occasional lateness to the research site and, in the context of working full-time, tiredness during data collection. Although I was eventually allocated prison keys, I endured time-consuming identity checks before entering functional areas of the prison, sometimes for up to an hour before reaching my point of destination. Security activities, such as alarm bells and headcounts, led to spontaneous lockdowns, causing frustrating waits and lost hours.

As mentioned above, prison research projects are referred to a local research coordinator to assist with the study implementation. The research coordinator disagreed with the research plan on three points: verbal acquisition of consent, use

of recording equipment and an insistence on the use of an encrypted laptop. A decision was taken relatively quickly to relent to these requests; however, the research coordinator became essentially unresponsive to emails and phone messages. The coordinator later agreed that I could use a personal laptop to take anonymised notes and recording equipment to record interviews, on the proviso that the data was deleted before leaving the prison. Resolving these issues resulted in a frustrating six-month intermission and impacted on the quality of data collection.

Restrictions caused by the COVID-19 pandemic limited visits to my desk area, the university library and prevented an opportunity to present the outcomes of the research to the participants at the site.

I believe that an ethnographic methodology allowed me to play to my professional subjectivities and enabled me to minimise the distance or 'objective separateness' from the participants (Guba and Lincoln, 1988, p94). For example, greater time at the research site facilitated productive and trusting relationships and mitigated power differentials with the participants. However, this approach may be in contradiction to my adopted critical realist position, as this implies a more distant, objective reporting of events. I wanted to observe quietly, but people engaged with me; moreover, I needed to clarify the participants' perspectives and my own impressions. I feel I was able to avoid 'interpretive omnipotence' (Van Maanen, 2011, p51) through member checking and presenting a broad mix of observations, quotes and data extracts.

There were several other methodological concerns. The research was restricted to one all-male prison, with an older population and a specific function. The sample size was relatively small, and 10 of the 12 interviews took place in one residential area. Larger samples and research in other types of prisons could provide a more expansive portrayal of the phenomena. Some researchers have suggested semi-structured interviews can lead to under- or over-reporting, bringing their credibility into question (Kunselman et al., 2002). The sample may have been skewed as, owing to convenience sampling, most of the interviewees were ODPs who did not attend prison employment. The ethnography was undertaken over a six-month period, and it felt to me that data saturation had been achieved, although it is

possible that extending the research over the space of year may have yielded different data.

Despite these limitations, the results of this investigation add to the evidence based on the processes that constrain or enable peer caregiving and receiving, as well as learning to peer care in prisons. The research may provide practitioners seeking to develop peer caregiving schemes with a better understanding of the complexities of motivation, caring relationships, the costs/benefits of caregiving, safeguarding issues and the possibility of desistance from crime on release.

Original contribution and significance of the research to the field

The data, analysis and theorisation address several relevant and under-researched areas, thus contributing to the literature on prisoner peer caregiving and receiving, learning to peer care, the experience of ageing in prison and the macro-economic causes of added disadvantage to the respective groups of participants. These issues are clustered into the following subsections:

The research describes the lived experience of peer caregivers and care receivers, as well as nuanced aspects of their roles and relationships. The analysis extends to the experience of ageing, frailty and disability in the context of prison culture, prison masculinities, institutional processes and environmental limitations. This includes the ODPs' views on the uncertainty and precarity faced in relation to their health trajectories, personal safety, the possibility of dying in prison and concerns about their longer-term futures on release. The research exposes emotional exchanges and expressions of care between prisoners therefore challenging traditional notions of hegemonic masculinity.

The research describes the roles of influential individuals and interconnecting peripheral communities of practice, providing examples of interpersonal and systematic factors that enable or impede caregiving. It develops understandings of the characteristics of individual peer caregivers, extending the existing definitions of

the role to encompass transition mentoring, advocacy and safeguarding. The research uniquely features informal prisoner-to-prisoner horizontal care, bidirectional care between ODPs and caregivers, as well as shedding new light on officer attitudes towards ODPs, care and peer caregiving.

The research provides a discussion of the intrinsic and extrinsic pains and gains associated with peer caregiving and being cared for. Moreover, the work discusses the factors that motivate and sustain involvement in peer caregiving, which was found to relate to factors that maintain and manage aspects of the self in prisons. This refers to the influence of internal and external perceptions on self and identity, bringing the possibility of personal transformation, atonement and hopes for pro-social futures.

The work demonstrates mirroring between aspects of social care in prison and external community social care, inclusive of resourcing issues, how care is valued, rewarded and recognised. The study discusses how perceptions on ageing, prison culture, macroeconomic policies and sentencing policies intersect to construct and intensify an age and ability binary, affecting the way older adults are perceived and influencing care practices. The research discusses practical, ethical, moral and social justice issues relating to peer caregiving in prison. For the caregivers, this related to a general lack of reward, recognition, training, safeguarding and supervision, and for ODPs these related to inadequate material conditions, marginalisation and breaches of rights and legislation.

Insights are presented on how individuals and communities of caregivers learn to care in a context of power, legitimacy and hierarchy, and the research makes recommendations on how to develop and sustain learning processes, through informal or horizontal forms of learning. The thesis critiques national guidance instructions on peer assistance, making suggestions on changes to policies and other operational changes to support and improve peer caregiving in prisons.

Critical social theories are used to surface power flows in the environment, demonstrating how purpose and power interact to cause conflict and constrain

caregiving. Connections are made between the plight of ODPs and caregivers in prisons in the context of deeper, underlying political imperatives. For example, micro and macro positions were adopted to represent practical and discursive elements of the findings in relation to criminal justice policies in the context of the broader political and economic agendas. These positions are meaningful in terms of the experience of peer care and the preparation and organisation of peer caregiving. Moreover, the research critiques contemporary HMPPS processes by adopting a critical approach to distributive social justice and morality.

In the concluding sections I set out my vision and recommendations for how this could be achieved, and this will be followed by a reflective conclusion.

Operational recommendations

This research has generated numerous suggestions and recommendations for strands of practice that may help to mitigate the effects of an increasingly ageing and frail prisoner population. As discussed above, the problems faced by the participants were practical and relational in nature, but were caused by deeper, underlying mechanisms. Therefore, the recommendations are suggested at organisational and systemic levels. Given the number of recommendations, these are set out at Appendix 11: Operational recommendations, page 298.

While I acknowledge a need for realism in terms of what can be achieved, particularly at a time of limited resources, some practical changes can be implemented relatively expediently. Nonetheless, these changes will require coordinated, multi-agency action between a wide range of stakeholders, supported by local governance arrangements and significant financial investment. Moreover, local changes to practices and the implementation of new training and education systems must be initiated in tandem with changes to national instructions. It may be that third-sector organisations are better placed and more responsive to the delivery of training recommendations.

To address the systemic issues outlined in this study, HMPPS needs to initiate and invest in deep and lasting changes to its practices, culture, systems, policies and philosophy. These may involve a shift in current discourses towards a welfarist framework. The recent impacts of the COVID-19 pandemic could represent a catalyst for action, meaning a window of opportunity is now open.

Developing caregivers via social approaches to learning

The operational and educational recommendations are mutually reinforcing and should be read in conjunction with each other. Key staff at the research site should consider implementing the following training recommendations in support of peer caregiving:

The research shows that experienced caregivers occupied positions of relative trust and had accrued considerable skills and knowledge. As we have seen in Chapter 5, page 89, this was visible but went largely unacknowledged and unrecognised. Their experience could be put to better use in support of new learners and the communities of caregivers in several ways. For example, in accordance with security processes, senior caregivers could be trusted to collaborate with staff on decisions relating to the recruitment of new caregivers, and are well placed to advise on caregiver/receiver matching processes. Moreover, the organisation should consider affording them extra responsibility by adopting a more structured approach to the shadowing and mentoring processes. Experienced caregivers could play a role in training sessions by relaying valuable first-hand accounts of practice issues and dilemmas. These processes have resources implications, and time would need to be allocated to enable them to fulfil these additional roles and responsibilities.

The caregivers expressed the view that they benefited from being brought together with their colleagues from other accommodation areas, to share good practice and in support of a mutual debriefing facility. A continuous programme of supported meetings could be provided to support the caregivers to attend to personal learning, self-awareness and resilience, by promoting individual and group reflective practice.

This could be planned to enable some members of the caregiver teams to remain in their accommodation areas, while others participate with learning on a rotational basis. The well-being of the caregivers should be safeguarded with training on the limitations of their roles, when to report issues and by providing information on dealing with the effects of loss and stress.

Regular experienced-based learning groups could be supported with intermittent focused workshops, making use of evidenced-based packages of learning, such as those outlined in the literature review (Forsyth et al., 2019; Stewart and Lovely, 2017). These could be delivered by a conjoint community/prison social care coordinator (see point 10, Appendix 11, page 299). The literature shows that US prisoner peer caregivers are trusted to undertake a broader range of clinical interventions, such as taking physical observations. This implies that when carefully selected and trained, UK peer caregivers have the potential do more than the current guidance permits (the national guidance would need to be adapted to allow for such a change). Staff at the research site should continuously evaluate the training and develop a robust, sustainable training infrastructure.

The research found the best way of supporting the ODPs was to develop age-appropriate methods of upholding their sense of independence and age-identity; training should be sensitised to the subtleties of these needs through discussion of collaborative, person-centred care planning. The ODPs' experience of being cared for could be harnessed to develop case studies and, where possible, the delivery of co-produced workshops. As the majority of ODPs were admitted to prison later in life, training materials should include issues relating to the 'transition' process and material to support culturally responsive care should be developed. Training should be developed and delivered to ordinary prisoners, officers and managers, to increase their awareness of the needs of the ODPs and responsibility for their care.

Suggestions for future research

Future research should develop empirically supported knowledge to progress the evidence base for peer caregiving in prisons in the following areas:

Future research should aim to better understand how to develop operational processes, resources and capacity in relation to the provision of sustainable, age-sensitive and culturally sensitive peer care. This should be supported by a continuous approach to the evaluation of sustainable peer social care training in prisons with both similar and differing functions and populations, to develop the best educational practices. More specifically, this research recommends the initiation and evaluation of 'older and disabled people' awareness training for ordinary prisoners, officers and managers, inclusive of ongoing evaluation.

Given the results of the literature review and the research, researchers should develop and evaluate methods of supporting caregiver resilience, using an action research framework. Moreover, the research suggests the piloting and evaluation of a bespoke, joint community/prison social care coordinator.

The research findings suggest institutional processes mean that ODPs are, at best, marginalised and, at worst, discriminated against on the grounds of age and ability. Future research could focus on a richer discussion of discrimination, focusing on how much it differs or aligns to the lived experience of other vulnerable groups in prisons, such as those with intellectual or mental disabilities.

A research investigation could be initiated to evaluate the attitudes of offender health and social care commissioners, particularly in relation to funding and governance of peer caregiving.

The research recommends the development of a longitudinal qualitative study to examine the effects of the peer caregiving role post-release in respect of longer-term crime desistance and rehabilitation. Finally, the research recommends that studies

could be undertaken in collaboration with researchers in countries where peer caregiving is less common.

Coda, final summary and meta-reflections

This research was undertaken before the global COVID-19 pandemic of 2020, a crisis which has concurrently resulted in a sudden visibilisation of the need for social care and the effects of neo-liberal imperatives on health, justice and social policies. Data was collected and analysed using qualitative, reflexive methods to trace the constraints to supportive practices, and micro and macro positions were assumed to inform recommendations for changes to practices.

Older prisoners incarcerated in later life face the double burden of longer sentences with increasing health and social care needs. Increased numbers of frail and vulnerable prisoners expose the limitations of current health and social care provision as well as the operational, cultural and environmental limitations in prisons. Services at the research site were simply not designed or configured for high numbers of dependent ODPs. Despite the best efforts of many individuals, the systemic responses to dependent prisoners were seen to be affected by reduced resources and uniformed leadership – consequently, the provision of personal care was piecemeal.

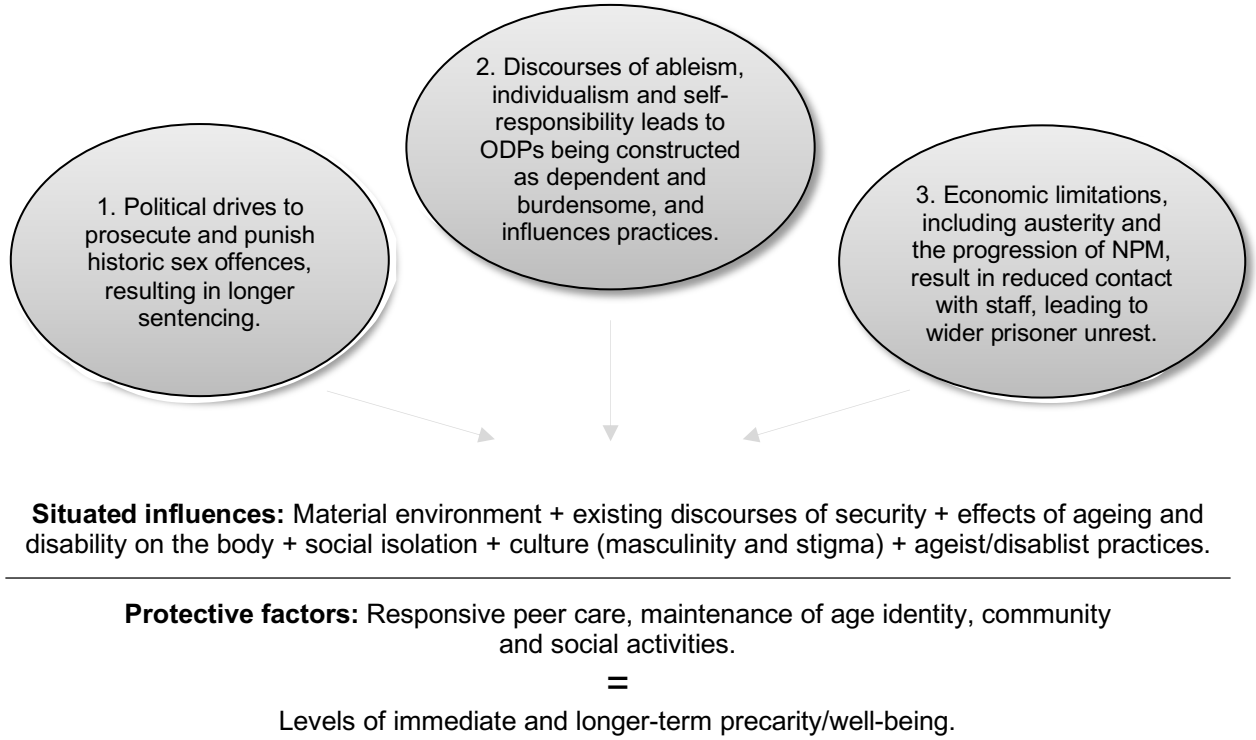
Fundamentally, this research suggests that, when enabled to flourish, peer caregiving brings practical, relational and rehabilitative benefits to individuals and communities. It is established within the literature, and this research, that processes aligned to caring and learning to care can help to promote the well-being of caregivers and care receivers in the face of institutional limitations. The research supports a view that meaningful roles and social relationships, whether via communities of care or communities of learning, are key to the development of a pro-social, replacement self. Peer caregiving has the potential to be developed at low cost and as a collectivist activity, and it has the potential to offset discourses of individualism.

At their best, peer caregivers are skilled helpers, and their role in prison extends to supportive mechanisms beyond what would normally be expected of community care workers. In the context of waning formal services, peer caregivers are possibly the best-placed group to provide low-level, preventative support for the social needs of dependent ODPs. However, the process was found to be insufficiently regulated, poorly resourced and supported – indeed, the caregivers and officers were often placed in frustrating and unachievable positions. Many caregivers already struggled with their own health and social issues and are often left with nowhere to take the emotional baggage associated with the role.

The ODPs' experience of prison life, precarity and care has been aligned to neo-liberal policies and discourses and practices in justice, health and social care. Analysis of the causal mechanisms points to a clash of principles between the needs of the participants and neo-liberal approaches to public services. The combination of these macro-political factors, with existent processes such as undifferentiated regimes, the material environment and prisoner culture, result in prisons being particularly unsafe places for older and disabled adults.

The research exposes the effects of such imperatives on the ODPs' experience of care and well-being, as set out visually below.

Figure 2: Macro-political generative mechanisms



How a society treats its most vulnerable is always a measure of its humanity (Rycroft, 2015), or, more specifically, 'A society should be judged not by how it treats its outstanding citizens but by how it treats its criminals' (Dostoyevsky, 1860, p191). Under these auspices, what happens to ODPs and caregivers in prisons has profound consequences for our society. The research findings reflect contemporary social values which are, effectively, what we, as a society, value at this point in our history. The research appears to indicate that we have come to value money as the central denominator for all kinds of transactions, and this extends to the commodification of aspects of social life. The research on peer caregiving in prisons shows that we have gone too far down the road of foregrounding capital over the value of people, relationships and dignity.

Prisons are usually cast as austere environments where care is sparse. Punitive discourses are normally regarded as antithetical to care; however, in this research, care in prisons is shown to be diverse and diffuse. Practice, planning and policy remains largely behind the experiences of ODPs, peer caregivers and others involved in this kind of supportive activity. Current HMPPS philosophies, policies and practices effectively condemn ODPs to greater levels of precarity, both within prison

and on release, as evidenced in breaches of equalities and human rights legislation. Ultimately, prison administrators are failing to recognise peer caregivers adequately and not fulfilling their duty of care to the caregivers and care receivers. Moreover, without peer care, it would be difficult for the courts to hand down custodial sentences to vulnerable groups.

In conclusion, the NHS and HMPPS cannot continue to overlook this pressing collection of issues. HMPPS needs to work with health and social care agencies to take greater moral responsibility for the issues. Changes to the demography and increasing dependence confront HMPPS with the need to reorientate its role, and discourses of security and efficiency need to be carried out with greater parity to discourses based on rehabilitation, intersubjectivity and mutual care. As Toch (2000, p276) suggests, ‘Prisons have a great deal to gain – and little to lose – in multiplying the opportunities for inmates to engage in altruistic activities that add a human face (or a humane face) to corrections’. I acknowledge that it can take years to reverse or implement new policies; however, HMPPS needs to live up to its values of looking after those in its care with humanity, by promoting equity, safeguarding the vulnerable and providing prisoners with opportunities to develop. This ethic of care should be extended to all disadvantaged and disabled groups in prisons, such as those with mental or intellectual needs.

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Appendix 1: Research context

1.1. Abbreviations and glossary of terms

ADL: Activities of Daily Living. For the purpose of the thesis this will be taken to mean: fundamental skills required to manage basic physical needs, for example, eating, grooming, hygiene needs, transferring, ambulating, toileting.

Care: For the purpose of this thesis, I will adopt Tronto and Fischer's (1993) definition of care: 'On the most general level, we suggest caring can be viewed as a species activity that includes everything that we do to maintain, continue and repair our 'world' so that we can live in it as well as possible. That world includes our bodies, our selves, and our environment, all of which includes our bodies, our selves, and our environment, all of which we seek to interweave in a complex, life sustaining web'. The term is interchangeably with support, help or occasionally assistance.

Care UK: Private health provider, known to provide around 80% of prison health care services; (recently rebranded to Practice Plus).

Cognitive impairment: Alzheimer's or another form of dementia, learning disabilities, or neurodiversity.

Cell: Prisoner accommodation, a single room for one or two prisoners.

Con: Convicted prisoner.

DH/DHSC: Department of Health and Social Care (formerly Department of Health, or DH).

Disability: For the purpose of the thesis I use the United Nations Convention on the Rights of Persons with disabilities definition, this can be found at: convention_accessible_pdf.pdf

Full life sentence: a life sentence without a tariff, or life without parole (meaning full life).

HCM: Health Care Manager, operational lead for health care services within the research site. For example, there is a 16 bedded in-patients unit (medical ward), a 24-hour outpatients service for each residential area and pharmacy service on site.

HMPPS: Her Majesty's Prison and Probation Service (formerly HMPS)

House Unit: accommodation block. Similarly, 'Wing' residential area.

IHU: Integrated Health Unit: A physical location in the prison, including the in-patient's department and pharmacy service, also referred to as the Health Care Centre (HCC). Nursing and medical services are generically referred to as 'health care'.

Formal care/carers: Personnel in a pad capacity eg. nurses, social care workers and peer caregivers.

Governor (or No. 1 Governor): Senior managerial/administrative grade. The lead Governor or 'governing governor', leads the senior management team of other functional heads.

IPP: Imprisonment for Public Protection, indeterminate sentence length, (now defunct).

IRAS: Integrated Research Application Service. Provides the mechanism to apply for ethical reviews.

Jail craft: tacit skill and experience of officers.

Landing: floor or level of a residential area.

Life sentence: A mandatory life sentence with a 20-year tariff, prisoners with life sentences are referred to as 'lifers'.

Local Authority: Social Services Departments

'Local' prison: A holding prison serving a local magistrate or crown court in a region, security categories B, C and D.

Lockdowns: Moments when the prisoners are required to be locked in their cells, reason might include a range of operational reasons, including emergencies or through unsafe or insufficient staffing levels.

MCSO: Males Convicted of Sex Offences

NHS: National Health Service

NOMS: National Offender Management Service. Recently rebranded back to HMPPS.

ODPs: Older and disabled prisoners: participants in need of support with their ADLs, aged over 50 years with frailty, one or more long-term medical conditions, or mental, sensory or physical impairment or disability.

Peer caregiver: known locally and in some other prisons as a 'buddy', (these terms will be used interchangeably throughout the thesis). A peer caregiver is defined as a prisoner who is employed or formally undertakes domestic or personal care, at a social, emotional and physical level (Stewart and Edmond, 2017). Examples of peer social care of older prisoners include wheelchair ambulation, encouraging out of cell activities, social interaction, assistance with administrative activities such as completion of forms, and advocating on their behalf, (Prison Service Instruction PSI 17/2015).

Personal care – a contestable term. In the PSI 17/2015 it appears to encompass both low-level, domestic help and basic personal care, in external adult social care there is a delineation between low-level domestic help and personal care. There are differences between the way the HMPPS and local authorities define personal care. Some of the activities I have read about in SS reports under personal care, would be regarded as **intimate care** under PSI 17/2015.

Pilot: Stage One of the Educational Doctorate, equates to Masters in Research (MRes) Social Research Methods.

Preventative services or Low-level services: "Services which prevent or delay the need for more costly intensive services such as nursing home care or, services which promote the quality of life of older people and engagement with the community", (Clark, Dyer, and Horwood 1998).

Regime: prison operational timetable, rules.

Screw: Prison Officer.

Security Categories:
Cat A – High secure (AA = the highest security category)
Cat B – High secure. Those who pose a risk to the public but may not require maximum security but for whom escape needs to be made very difficult.
Cat C – Medium secure (can include training prisons)
Cat D – Lowest security category (mostly open conditions)

Social care: The provision for non-medical needs; 'helping people to live ordinary lives through practical support'.

Stand fast role check: a security procedure rather like a headcount to confirm the numbers of prisoners in a specific area or the whole prison.

SOTP: Sex Offender Treatment Programme, (superseded by the Kaizen course).

Spur: Corridor of cells

Vulnerable prisoners (VPs): This groups includes sex offenders, police informers, ex-police officers, magistrates, and those prisoners who simply cannot cope with life on the wings. As a result of threats from other prisoners, they are segregated from the rest of the prison population.

1.2. Key participants

Health Care Manager (HCM): Operational lead for health services in the prison, and possibly the main gatekeeper.

Gov 1: Original governor overseeing social care at the research.

Gov 2: Second / replacement governor designated to oversee social care at the research site.

DLO 1: Disability Liaison Officer allocated to oversee the work of the peer caregivers in HU1

DLO 2: Disability Liaison Officer allocated to oversee the work of the peer caregivers in HU3

Disability Liaison Officer. Prison Officers with additional responsibilities for providing information and supporting prisoners with disabilities; for example, DLO's can make referrals to LA social services departments for social care assessments.

1.3. Reflective notes on the motivation to undertake the study

The first of the motivations emerged from my professional experience as a dually qualified registered mental health nurse and prison officer, and later as a prison HCM (between 1996–2004). At that time carefully selected prisoners were employed

to work within the ‘In-patient’ (ward) area. This role was considered to be one of the most prestigious jobs in the prison and it was reserved for the most trusted of prisoners, owing to the highly sensitive activity within the location. It was my observation that this group undertook more than simple cleaning responsibilities, for example, they gave advice and reassurance to newly admitted prisoners, provided them with items such as newspapers and tobacco, they shared information with both the patients and the staff in relation to care needs. In short, their helping roles extended beyond practical tasks to the relational elements of care, and it appeared that there was the potential to develop their role further.

Between 2008 and 2010 I was seconded to ‘Offender Health’, a policy group based within the DHSC, supporting training and educationally focused workforce projects. I participated with several working groups, one of which was the ‘Older Prisoners Action Group’ which reported to the Primary and Social Care sub-programme board. This was led by a civil servant and consisted of representatives from service-user groups, pressure groups such as National Association for the Care and Resettlement of Offenders (NACRO), Prison Reform Trust, (PRT); experts such as gerontologists and researchers. Investigating the possibility of developing prisoner peer-to-peer social support for older adults in prison became an objective of this sub-group. A project was initiated to investigate the possibility of developing carefully selected, able-bodied prisoners to provide home-help style support for prisoners in need of low-level social support. The work stream evolved for just under two years between 2009 and 2011, (see Stewart, 2011). These ideas and aims were developed as part of the Ed.D. in 2015.

1.4. Textual illustration of the research site

For the purpose of this thesis the research site will be known as HMP A. It is an amalgamation of two co-located prisons, occupying a substantial geographic footprint.

The new accommodation blocks (including HUs 1 and 2) were built in the 1950s. HU1 is a relatively modern building based on a horseshoe design holding 88

prisoners on three levels. The ground floor is designated as the social care area, accordingly a high concentration of ODPs are accommodated in this location. Many of these prisoners live with frailty, cognitive and sensory impairments and co-morbid, long-term health conditions. At the time of writing there were approximately 28 ODPs located in single cells on the ground-floor landing. In this area the cells have been adapted to include a shower unit, this is rare within the prison system. The cells measure approximately 10 feet by 7 feet, meaning there is limited space to store medical equipment, or to manoeuvre a wheelchair. At the time of data collection, two cells on each spur were being adapted to provide in-cell wet rooms to further the provision of social care at the site. Six prisoner peer caregivers were allocated to attend to this group's needs. The caregiver's accommodation cells are located on the higher levels of HU1 however, they spend their working day on the ground floor, to be in closer proximity to the ODPs.

HU2 is known as the 'induction wing'. Prisoners usually spend six to eight weeks here undertaking induction-style activities before being moved to reside on other wings for the longer term. It has two permanent peer caregivers with a low but variable number of ODPs (approximately eight). There are no in-cell showering or toileting facilities; cells are furnished with portable chemical toilets for use during lockdowns or at night. During quiet periods prisoners are given a fixed amount of time to use external toilets; this can be problematic for frail, disabled and cognitively impaired prisoners.

HU3 is situated in the original section of the prison site, most of the accommodation is composed of early Victorian, gallery wings built on five landings (with no lift facilities). The wings are laid out in line consecutively rather than in Bentham's preferred radial design (MacLaughlin and Muncie, 1996). HU3 has a maximum roll of 130 MCSOs of mixed ages, the regime is also undifferentiated by age and ability. It has 28 ground-floor cells. At the time of writing there were four buddies overseeing eight ODPs between them, and a larger number of less dependent inmates to observe and support. The showering facilities are situated on the ground floor between the wing entrance and the wing office, meaning visitors have to pass this

area if undertaking any kind of administrative task. There was a multi-purpose open space at the end of the wing, which was utilised for training purposes.

HU4 is a smaller Victorian wing on the same site. It has a maximum roll of 79 prisoners, there were two caregivers with around eight ODPs between them. In all locations in HMP A the ODPs occupied single cells; most of the caregivers occupied shared cells. The caregivers had other wing-based responsibilities such as wheelchair ambulation and collecting meals trolleys and this detracts from their peer-support activities. HMPPS guidance (PSI 06/2012), was used to guide selection and employment procedures.

1.5. The participants trajectory through the criminal justice pathway
Typically, the participants would have been to be held on remand at a 'local' (holding) prison in their regions while their case was being heard, initially at a Magistrate's Court, then referred to regional Crown Court. The timeframe can vary greatly, and VPs are often accommodated on 'ordinary location' or standard accommodation. When convicted they are transferred from the 'local' prison to begin their sentence at a specialist training prison dedicated to vulnerable prisoners. HMP A has specialist psychology facilities which are able to provide specific rehabilitation courses, named as, 'Kaizen' and 'Horizon'. These were called and are still referred to as 'Enhanced Thinking Skills' (ETS) and the 'Sex Offender Treatment Programme' (SOTP). When the local parole board decides a prisoner's security classification can be reduced, they can be transferred to a category C prison. Before release they can be transferred to a category D open prison however, there are only three category D prisons in England equipped to deal with convicted sex offenders (HMIP, 2019).

1.6. Health and social support arrangements

Support for frailty or through the ageing is regarded as 'social care'; support allocated on the basis of a medically diagnosed illness is regarded as 'health care', 'medical care' or 'nursing care'. There is an NHS commissioned, on-site health care service based in the Integrated Health Unit (also known as the Health Care Centre), contracted out to a private care provider. This is a 24-hour service and includes a

range of services, including a 16-bed health care in-patient facility, a two-bedded end-of-life suite, a pharmacy service, allied health clinics, and a nurse-led primary care service.

An individual's level of need for a supportive intervention can change according to fluctuations in their health status. ODPs requiring intimate care can only receive care from external social carers, provided by the LA. At the time of data collection two ODPs received statutory social carers to support their activities of daily living. There were numerous accounts in which the peer caregivers provided assistance beyond the level of personal care. Statutory funded social care is provided by the LA; however, there is anecdotal evidence of tension around the mechanisms for assessment and the threshold for allocating state funded social care. Most of the ODPs needed low-level (preventative) domestic assistance, (some needed low-level assistance and personal care).

The process for referral and allocation of support is broadly: the ODPs can either self-refer (anecdotally known to be a rare event), or are referred by a prison officer, DLO or nurse, to the LA for assessment, they are then assessed by a LA SW. If they do not meet the criteria for statutory social care, the LA and local staff make a decision regarding whether they have some level of need, if so a care plan should be devised, they are allocated peer support in line with the HMPPS "Duty of Care" – which would be classified as 'personal care' (or low-level) but not 'intimate' care; this basically amounts to domestic support.

1.7. Earlier cycles of investigation and context of the current study

The findings from each of the previous phases helped to shape and inform the current thesis. In all three phases training was delivered to prisoners working in untrained peer-support roles as means of a reciprocal arrangement between the researcher and the establishment. The following sections summarise the activities and findings from these phases, as well as the relationship between the phases.

Cycle 1 (2008-2011).

At this time it was known that there were few reported cases of formal, state funded social care in prisons (Williams, 2012). It was also known that a narrow range of buddy development projects were developing in a localised, uncoordinated fashion, in prisons in various parts of the country (Moll, 2013). For example, the charity Re-Coop had generated some training materials in support of older adults, although there is no evidence that this work has been evaluated. Moreover, the literature searches yielded studies on emotional support, end-of-life and dementia care but no examples of research on generic peer social care.

The development work was eventually undertaken and evaluated in three prison sites in England. An ethics application was lodged with the NOMS; however, the work was regarded as an evaluation rather than research. Owing to the politically sensitive nature of allocating resources to stigmatised older prisoners, permission was granted from the HMPPS head of security. A considerable amount of groundwork was undertaken before the training could be delivered, including the recruitment of trainees, security screening, and the engagement of a third-sector organisation to provide appropriately qualified teachers and assessors. The first activity was delivered in a training prison with a small and relatively static population. A small number of prisoners, some of whom were already working as Age UK representatives, were offered the opportunity to undertake a National Vocational Qualification (NVQ) in Care (at level 2). This included six initial training days followed by broadly six months portfolio development.

It was realised that although thorough, this model was lengthy and resource intensive, and therefore difficult to implement in prisons with higher prisoner churn. On this basis, a shorter 5-day unaccredited, bespoke training programme was developed and subsequently two courses of training were delivered to learners at two ‘local’ prisons. The evaluation of this training revealed several lessons for example, that the majority of participants felt the training was too short. The buddies suggested that the opportunity to share stories, and practice tips had never previously never been provided, and that simply being brought together to discuss their work, to hear and share their dilemmas was beneficial. The participants

suggested that their current level of support and guidance was insufficient, but supervision could be provided locally relatively cheaply, (Stewart, 2011).

In all three prisons the training was well received by local stakeholders. However, this original work was considered to be an evaluation, it became evident that greater credibility could be gained from a more robust research plan; it therefore became an ambition to repeat the project with a more in-depth research methodology. These ideas and aims were developed as part of the Ed.D., in 2015.

Cycle 2 – (2015/17). Ed D Stage one.

Owing to its rehabilitative function for MCSOs, HMP A accommodates an over representation of older prisoners; it was therefore identified as a suitable site for the next phase of investigation. In the pilot stage of the project a total of 25 days was spent in HMP A, in two residential wings, HU1 and HU3.

It was subsequently identified that an action research methodology could be implemented to support the planning and implementation of the training, evaluating and reflecting between the cycles in order to amend the training plans. In total three courses were delivered. Differing formats and content were piloted and evaluated over the three cohorts in different wings. The process of reflecting on each of the training cycles helped to inform and refine changes to the following waves of training. Typically, hard copies of power-point slides on a range of care-orientated topics were provided to learners, followed by application of the theory to inductive discussions of activities and incidents (see Stewart and Lovely, 2017 for the training templates).

A total of 25 prisoners undertook the training and four members of staff were involved in observing and subsequently assisting with the implementation of the training. These were a prison nurse manager, a nurse, and two prison officers. The balance of staff was planned to incorporate a multi-disciplinary approach to the training. The data corpus consisted of the transcripts of nine interviews with peer caregivers, two members of staff, and researcher field notes. A convenience

sampling strategy was adopted as many of the participants were already working as untrained buddies.

The work in the pilot phase complimented ongoing work by local operational managers to develop peer social support, namely the development of a policy to guide local practice. Several operational recommendations were made in relation to the advancement of peer social support and future training (Stewart and Lovely, 2017). The results were interpreted by making use of practice theory, literature from the criminological tradition and situated learning theories (Stewart, 2018). The work established new knowledge in relation to the connection between the individual narratives of the caregivers, their motives for undertaking peer care work and the possibility of identity change. In reviewing the limitations of the study, it was noted only care providers had been consulted, therefore further recommendations were made in relation to the inclusion of the recipients of caregiving in the next stage of research.

Cycle 3 (2018-20). Summary.

Appendix **Table A: Summary of the previous project cycles**

Phase	Establishment	Method	Total no. of participants	Total number of trainees
2009-11 Offender Health funded project	3 prisons in England and Wales, (x1 public 'local' prison, x1 private prison, x1 'training' prison)	Training evaluation	4, 8, 8	4, 8, 8
2015-16 Pilot phase Ed.D	HMP A	Action research, interviews	9 PCC + 4 staff	25
2017-18 Thesis phase Ed.D	HMP A	Participant observations, interview	10 ODPs 16 buddies 3 key staff	10

1.8. Local changes to peer caregiving between the pilot and thesis projects

The way in which social care was being overseen and delivered at HMP A had developed between the pilot and thesis data collection phases (between 2016 and 2018). For example, the work appeared slightly more systematic; some basic documentation had been introduced; the buddies wore distinctive blue polo-style T-shirts with 'buddy' written on the front and back; the buddies seemed clearer on parameters of their role; there was evidence of more material items in support social care, for example, there were many more serviceable wheelchairs, and the construction of the two cells with wet rooms on each spur. A 'live in' buddy had been accommodated on each of the spurs in HU1 with the aim of providing greater levels of accessibility during lockdowns or at quieter times in the regime. The gym officers facilitated three 'older prisoner' sessions per week which included 'remedial' gym, carpet bowls and a choir. There appeared to be a higher number of DLO's and a greater degree of engagement with the LA via a higher number of requests for social care assessment completed by DLO's.

However, attitudes to caregiving and working practices were found to vary significantly from wing to wing. Communication and support between the staff and caregivers was still felt to be poor and leadership within the buddy teams was problematic. The approach to the caregiving work in HU1 had drifted towards task orientation which foregrounds practical tasks for, example, cell cleaning over social engagement, or person-centred, relational work. I had anticipated that some of the buddies from the original training would have still been working in the prison, but this was not found to be the case, therefore all of the prisoners working in a helping capacity were untrained.

Appendix 2. Search process

An outline of the scoping searches (28.12.20).

To commence the literature review process, a stepwise approach was adopted; this was broadly in line with benchmark literature review processes, for example, the PICO formulation.

First, scoping searches were initiated to establish whether there was enough high-quality literature on peer care working in prisons in the available literature:

1. Google Scholar search, using the terms ‘learning to be a peer caregiver’. This produced some interesting results, for example, papers retrieved linked to issues such as ‘caregiver self-care’, ‘caregiver support’, ‘caregiver resources’ thus acknowledging the burden of peer caregiving.

2. University of Brighton ‘OneSearch’, a ‘simple’ search was undertaken using the terms, ‘Peer social care, training’, this yielded 291, 671 initial results; the search parameter ‘last five years’ was applied and this reduced the number of results to 107, 422. The titles and abstracts of the first 120 titles and a reasonable number of interesting papers were found, confirming there is sufficient depth and quality of research on prisoner peer learning/caregiving within the literature.

3. University of Brighton OneSearch, using the search terms, ‘Peer care, training’ retrieved 393,120 initial results; the search parameter ‘last five years’ was applied, reducing the total to 137,725 results. Applying the additional parameters of ‘Full text online’; ‘Scholarly and peer reviewed’; ‘journal article’ parameters produced 98,042 results. The titles and abstracts of the first 120 papers were reviewed, there were numerous duplicates with the search above.

4. In the next stage, ‘Peer caregiver training’, was added to the University of Brighton OneSearch. The parameters ‘last five years’; ‘full text online’; ‘scholarly and peer reviewed’; and ‘journal article’ was applied providing 18,731 results. The first 55 titles and abstracts were reviewed producing 0 hits. ‘

Synonyms

On satisfaction of this stage of searching, the research question was deconstructed to identify key terms, synonyms were then generated for the following key terms:

Learning: training, training intervention, education, mentoring, development, pedagogy.
Peer working: Peer worker, mentor, coach, volunteer, peer to peer, peer support, peer mentor, buddy.
Care: This area was subdivided in to:
1. Process: care, social care, informal care, horizontal care, social support.
2. Population: carer, caregiver, support worker, buddy, officers. (Some of these terms were slightly problematic as they could refer to formal caregivers such as nurses or social care workers; the term ‘informal’ was also problematic as it could refer to family members).
Older/disabled prisoners: older prisoners, ageing prisoners, elderly prisoners, frail*, disabled prisoners.

Search terms were developed into search term strings, or combinations of terms.

Parameters

The search parameters for these searches were set to include ‘peer reviewed’, ‘primary’ and ‘secondary’ research papers, published in the last ‘five years’, in the English language.

- Searches were limited to between 2015 and 2021 in light of the literature review undertaken in support of the pilot study.

- Truncation symbols were applied for the search terms Old*, Care*, Learn*, Prison* (there was less use of Boolean or MeSH terms).
- As recommended, care was taken to make use of ‘simple’ and ‘complex’ searches (Bettany-Saltikov, 2010).

Databases

The main search domains cover criminology, education, health and social care sources, therefore the selection of databases was needed to reflect the breadth of these domains.

Health	Cinahl plus, Psychinfo, HRPC, Cochrane.
Education	ERIC
Social Care	ASSIA
Criminology	Criminal Justice Abstracts, Criminology and Criminal Justice,
Grey literature	British Library (EThOS), Ministry of Justice, Home Office.

Inclusion/exclusion criteria

An inclusion and exclusion criteria was developed to assist with the process of assessing and sifting the retrieved papers:

Exclude	**Include**
Community re-entry schemes, violence reduction, young prisoners, veterans, civilian mental health, homelessness, families, forensic nursing settings, parenting, IT/telephone-based peer interventions, and literacy prison-based peer interventions.	Prison-based, social care/support, frailty, ageing, care, learning, development, older prisoners, disabled prisoners, mental and emotional support, end-of-life care, dementia.

University of Brighton One Search, 'complex' searches

The terms: 'peer training, prisons' & 'peer training, care, prisons' yielded similar results (2,008 results with parameters applied).

The terms: 'prisoner peer care training', yielded exactly the same results. Articles by Stewart, Bagnall et al., Depner et al, and Collica all feature highly.

The terms: (peer support) and (prisoner education), in brackets, ticking, social science, education, nursing, social welfare and social work, and all of the above mentioned parameters, produced 2,348 results.

Each of the titles was reviewed in conjunction with the inclusion and exclusion criteria.

'Communities of practice, prisons' in OneSearch, (low yield, 0 results, 0 hits)

'Theories of social learning, prisons' in OneSearch, (2 possible hits)

Cinahl plus – catalogue search.

Complex search, 2015-2020, 'peer and care*' and 'prison*' (107 results – hits: 10).

Criminal Justice Abstracts + Eric, complex search with five year and parameters, using the terms: 'Peer + care* + prison*' produced 73 results.

Criminal Justice Abstracts + Eric: using 'peer, education, prisons' produced 58 results.

Searches using the terms 'prisoner peer/peer working' yielded a high number of results but brought the possibility of drift towards volunteering and other peripheral

peer activities, e.g., toe-by-toe, and literacy mentoring, which was of interest but has been well covered elsewhere in the literature.

Systematic literature reviews normally are rejected from literature reviews on the grounds as they are regarded as secondary data collection methods (Bettany-Saltikov, 2010). However, the inclusion of literature reviews in this study has helped to develop a landscape understanding of activity in the field, and map activity and connections between authors, organisations and geographic regions. References lists were also checked for relevant papers.

Numerous papers were received, duplicates were removed, and titles were clustered into groups. See Appendix 3 below for the results and data matrix.

Papers describing theories of learning and care in criminal justice settings were retrieved through reference list searches, extending the parameters to accept papers from between 2000 and 2021.

Appendix 3: Retrieved papers

Appendix **Table B: Retrieved papers**

Article details	Method	Intervention	Findings	Conclusions and recommendations	Other information, characteristics.
Social care and caregiver interventions					
Webber and Evans (2020). 'Prisoner caregiving programs: supporting older prisoners.'	Mixed approach: systematic literature review, textual examination of caregiver journals, and interviews.	An extensive project to develop preventative, personal peer care for older adults in prison. The development peer carer learning materials – workbook.	Proposes the development of peer caregivers as means of mitigating the effects of an ageing prisoner population in Australian prisons.	Recommends numerous practical and educational processes to support a more standardised approach to caregiving across the region. Numerous recommendations were made in relation to processes related to planning and documentation, safeguarding and training.	Australia, (second author Canada). Didactic teaching methods, caregiver workbooks, skills framework. Discussion of models of personal transformation. Skills framework approach to prisoner employment and care delivery.
Stewart (2018). 'What does the implementation of peer care training in a U.K. prison reveal about prisoner engagement in peer caregiving?'	An action research approach to training development, thematic analysis.	An evaluation of two bespoke training interventions. Introduces a sustainable training template for peer carer's working in support of ODPs.	Outlines the benefits to the peer caregivers and recipients, and on relationships with staff.	Discussion on the themes effects of training, environmental factors, the relationship between policy and practice, social learning, and life narrative. Theories of social learning, criminological theories of self-development.	England. Discusses individual and community approaches to learning and development. Based on the finding of a literature by Stewart and Edmond, (2016), and links to papers by

Article details	Method	Intervention	Findings	Conclusions and recommendations	Other information, characteristics.
					Stewart and Lovely, (2017).
Einat, (2017). 'The wounded healer: self-rehabilitation of prisoners through providing care and support to physically and mentally challenged inmates.'	Semi-structured interviews and thematic analysis using grounded theory.	Examines the emotional, mental and therapeutic effects of peer care in a prison for offenders living with mental health problems. Describes the contribution to the community, and the benefits to peer carers to their self-perception.	Promotes the participants ability to find existential meaning; contributes to their rehabilitation; has a positive impact on their relationship with staff.	Caregiving as an activating event for transformative learning. Helps to manage feelings of frustrations and despair. Recommends prisons make maximum use of similar programmes within related areas.	Israel Makes reference to underpinning theories of learning, for example, Bandura. Refers to criminological theories of self-development.
Forsyth, Archer-Power, Senior, Meacock, et al. (2017). 'The Effectiveness of Older Prisoners Health and Social Care Assessment Pathways (OHSCAP): A randomised control trial.'	Randomised control trial with nested qualitative study of professionals and older prisoners, across 10 prison research sites.	Provides an evaluation of a health and social care service delivery framework for older prisoners, for improvements in functional health, ADLs, cost effectiveness, and depressive symptoms.	OHSCAP difficult to deliver owing to inadequate staffing levels, prisoners rejected officers as competent professionals.	Recommends an analysis of training needs, joint MDT training. Recommends a focused ethnography to assess how the environment, officers and younger prisoners interact to affect the lived experience of ODPs.	England and Wales. An extensive NIHR study. Didactic approaches to learning.
Lee, Tracey, Haggith, Darshan, Carter, Kuhn, van Bortel, (2019). 'A systematic integrative review of programmes	Systematic integrative review, using principles consistent with a PRISMA	Describes a review of social care needs of older prisoners, this transpires to draw heavily on the end-of-life,	Comments on staff and managerial resistance to peer interventions, based on a clash	Peer care programmes report on a reduction: in medical use, behavioural problems;	A review of the international literature. Reference to peer development without

Article details	Method	Intervention	Findings	Conclusions and recommendations	Other information, characteristics.
addressing the social care needs of older prisoners.'	systematic review methodology	operations, accommodation and peer social care literature.	of ideals, and caregiver burnout as a source of inadequate training.	increases in confidence compassion, activeness, and QoL, but highlights methodological shortcomings of the majority of papers.	underpinning models or theories of learning or care.
Tucker et al. (2018). '**Social care in Prison: Emerging Practice Arrangements consequent upon the Introduction of the 2014 Care Act.'**	Audit review paper.	Reviews two social services survey of social care in prisons (ADASS and Social Care in Prisons, SCiP).	Discusses the variability of the implementation of the Care Act, 2014, by region. Describes the view that care needs are being met by the prison regime, use of various civilian workers, some staff not skilled enough to know when to refer on.	Recognises the role of peer carers, highlighting concerns in relation to the training and competence of peer workers. Highlights the potential for an over-concentration on ODPs when there are younger prisoners with learning disability, cognitive problems and LTCs.	England. University of Manchester. Mentions the use of MDT training for staff and the development of an e-learning module in one social service region.
Levy, Kumari Campbell, Kelly, Fernandes, (2018). 'A new vision for social care in prisons.'	Mixed methods, literature review, interviews with staff and prisoners in three Scottish prisons, audit of social service directors and governors,	Focuses on generic social care in prison and to a lesser extent on release, peer caregiving features as part of a wider set of	Prisoners uncomfortable asking peers and colleagues for assistance. Existing training for staff deemed inadequate.	Makes 17 recommendations, presents a vision for co-produced learning, to create a new culture shifting away from	Scotland. University of Dundee. commissioned by the Scottish Government for the Scottish Prison Service.

Article details	Method	Intervention	Findings	Conclusions and recommendations	Other information, characteristics.
	thematic analysis.	recommendations.	Use ex-offenders with disabilities as peer supporters.	perceiving disability as problematic or a barrier to participation in prison life.	Presents/situates a model of personal development/transformation.
End-of-life care					
Depner, Grant, Byrwa, Breier, Lodi-Smith, Luczkiewicz, Kerr, (2018). 'People don't understand what goes on in here': A consensual qualitative research analysis of inmate-caregiver perspectives on prison-based end of life care.'	Qualitative – semi structured interviews, analysed using consensual qualitative research.	Review to recommend a standardised approach to end-of-life care in American prisons.	Discusses three main elements: Programme description; motivation; connection with others. Nursing staff feeling supported.	Sets out carer perceptions and motivations to perform end-of-life care. Bonds develop through trust, openness, active listening. Likens caregivers to surrogate families	USA Connects to Depner et al: Post 'Traumatic growth…' Refers to criminological theories of self-development. Learning models not discussed in depth; care models linked to E-o-L.
Cloyes, Supiano, Berry, Routt, Llanque, (2017). 'Caring to learn and learning to care: Inmate hospice volunteers and the delivery of prison end-of-life care'.	A qualitative case study making use of grounded theory principles. Data gathered from interviews, informal conversations and observations.	An evaluation of an ongoing end-of-life care facility.	Five main themes: patient-centred care; the volunteer model; safety and security, shared values and teamworking.	Presents 'The Inmate Hospice Volunteer Model' based on four components or concepts: Peer-to-peer care; direct 1-1 care; beyond orderlies; education experience. Acknowledges the possibility of practice transforming the self and the importance of practice and	USA Several interconnecting publications by the same cluster of authors. Educational programme Offers structure/model of (hospice) care

Article details	Method	Intervention	Findings	Conclusions and recommendations	Other information, characteristics.
				learning on wider cultural change.	
Loeb, Wion. Penrod, McGhan, Kitt-Lewis, Hollenbeak, (2018). 'A toolkit for enhancing end-of-life care: An examination of implementation and impact.'	Participatory action research and qualitative outcome measures.	An evaluation of the implementation, impact and quality of an end-of-life care pathway of dying prisoners.	Highlights organisational outcomes, such as barriers and challenges, costs, sphere of influence, readiness for change, sustainability.	Endorsement from senior staff is essential, inclusive of public endorsements of peer caregivers. Projects benefit from strong leadership and visible champions. Highlights benefits for inmate caregivers in terms of intrinsic gains and behavioural change.	USA The study links to SR Wion, loeb et al, (2016), and 'Developing educational modules to enhance care of aged and dying inmates' (Computer Based Learning Project).
Prost et al, (2017). 'The perception gap in prison health care: correlates of inter-rater agreement of patient quality of life'.	Quantitative, self-rating QoL scales and questionnaires. Bivariate statistical analysis.	Discusses care for older prisoners and older prisoner approaching end-of-life. Self-assessment for quality of life, patient and caregiver inter-rater agreement for the assessment of symptoms.	Weighted towards end-of-life. Little agreement between inter-rater groups.	Recommendations in relation to matching further studies focusing on the phenotypes of patients and caregivers leading to more effective matching.	USA Links to numerous related studies by Prost et al. PhD thesis requested and reviewed.
Supiano, et al. (2014). 'The Grief Experiences of Prison Inmate Hospice Volunteer Caregivers.'	Qualitative descriptive inquiry and interviews. Makes use of meaning	Aimed to elicit hospice caregivers experience of death, they describe the	Three themes or patterns: experience with death, death of patients in hospice care, the	Volunteers were able to seek support from peers and use individual methods of	USA Links to the numerous papers published by

Article details	Method	Intervention	Findings	Conclusions and recommendations	Other information, characteristics.
	reconstruction theory.	meaning and impact, their experience of grief and whether they are supported with it.	grief experience of volunteers.	coping, self-reflection and spiritual contemplation, death challenged and motivated caregivers. Volunteers formed deeper levels of relationship with peers.	Prof Cloyes, et al. Considers the emotional health of caregivers, costs and gains.
Depner et al, (2018). 'A Consenual Qualitative Research Analysis of the Experience of Inmate Hospice Caregivers: Posttraumatic Growth While Incarcerated.'	Interview using consensual qualitative research framework.	To explore caregivers' perceptions on meaning and purpose, attitudes to death and participation in care.	Suggests caregiving may facilitate personal growth that matches aspects of post traumatic growth model.	Caregiving leads to an openness to personal vulnerability, less judgemental and emotionally volatile, increase in empathy and compassion. Stresses the importance of training and support.	USA. Links to Depner et al, above. New research should focus on support for caregiver's emotional and mental health.
Turner and Peacock, (2017). Palliative Care in UK Prisons: Practical and Emotional Challenges for Staff and Fellow Prisoners.	Interviews, from an extensive HMPPS, NHS and MacMillan Cancer Support research project.	Discusses how the issues of ageing and dying are being managed in prisons in England, and the effects of officers, health care staff and prisoner caregivers.	Current provision is linked to a reduction in staff numbers and experience in the wake of austerity government benchmarking.	Views prisons through the lens of neo-liberalism. Links made between neo-liberal/new public management and lower levels of officer/(older) prisoner interaction. Discusses officer's perceptions of	England, (north-west). Links to numerous papers involving the same authors, see Turner and Peacock (2018). Turner, Peacock et al, (2018). Peacock, Turner and Varney, (2017). All link to various aspects

Article details	Method	Intervention	Findings	Conclusions and recommendations	Other information, characteristics.
				working in care homes.	of staff/caregiver resilience, and the effects of neo-liberal policies highlighted.
Ageing and dementia care					
Tracey, Haggith, Darshana Wickramasinge, (2019). 'Dementia friendly prisons: a mixed methods evaluation of the application of dementia-friendly community principles in two prisons in England.'	Mixed methods, pilot, study specific questionnaires, Alzheimer's dementia friendly criteria, semi-structured interviews and focus group schedules.	To implement and evaluate dementia friendly principles in a custodial setting. Development of user-friendly study materials and workshops.	Awareness raising and a statistically significant increase in attendee's knowledge, some environmental changes on the basis of the intervention.	Study needs to be rehearsed on a grander scale. Government underfunding can lead to a deprioritisation of this vulnerable group.	England, (third author based in Sri Lanka). Authors acknowledges the difficulties or researching in prisons.
Di Lorito, et al. (2020). The individual experience of ageing prisoners: systematic review and meta-synthesis through the good lives model framework.	Systematic search, extraction and categorisation via NVivo, thematic analysis and meta-synthesis.	Ageing in prisons in the context of the Good Lives Model (GLM).	Three themes; The hardship of prisons; addressing the health and social needs of older adults; routes out of prison.	Promising new initiatives emerging; inconsistent social, physical and emotional care;	International literature search. University of Nottingham. Makes recommendations on areas to improve on. GLM forms the model for discussion and analysis.
Brooke and Jackson, (2019). 'An exploration of the support provided by prison staff, educational, health and social care professionals, and prisoners for prisoners with dementia'.	Qualitative study, focus groups and interviews.	Aims to gain an understanding of the lived experience on MDT staff and peer caregivers involved with the support of older	Reports on three themes: diversity in training; diversity within roles; diversity within the regime.	Suggests mixed views that prisons can support people with dementia and can have a negative impact, monitoring for	England (one author from Australia). Links to Brooke and Rybacka (in learning). Recommends MDT training,

Article details	Method	Intervention	Findings	Conclusions and recommendations	Other information, characteristics.
		adults with dementia.		peer carers needed, officers suggest their focus is younger prisoners who could be disruptive to the regime.	emotional support for caregivers, challenge perceptions of officers.
du Toit, et al, (2019). 'Best care options for older prisoners with dementia: a scoping review.'	Systematic review of the international literature.	To discover from the existing literature which interventions best support older adults in prisons with dementia.	Eight themes: 1. Early/ongoing) screening. 2. Specialised services. 3. Specialised units. 4. Activities. 5. Adaptations. 6. Early release. 7. Training for younger prisoners. 8. Training for staff.	Suggests the need to move from opinion to empirically reviewed interventions to guide future practices. Barriers to change include cost, prison-specific resources and staff skills.	Mixed geographic regions, mostly Australian authors, one author from University of Manchester, one author from University of Leeds.
Chu, (2016). 'Greying behind bars: The older ale offender's experience of prison life and preparedness for resettlement'.	Observations, focus groups and informal conversations.	Investigate the experiences of older male prisoners), how they perceived their future, whether they felt prepared from resettlement, to explore whether there is a need for separate accommodation.	Focus groups and interviews not audio recorded. Lower security and not as likely to have an LTCs.	Although marginalised, older prisoners had a positive view of the future. Differences in needs, should be translated into policy.	England, (based on a dissertation).
Forsyth, Heathcote, Senior et al, (2019). 'Dementia and Mild Cognitive	Based on a RCT and qualitative study.	Found a high and under recognised levels of cognitive impairment and	Suggests multi-agency working is limited by poor information	The study develops and recommends a training package	England and Wales (Based on: Dementia and Mild

Article details	Method	Intervention	Findings	Conclusions and recommendations	Other information, characteristics.
Impairment in the prison population of England and Wales: Identifying individual need and developing a mixed-methods study skilled.'		mild dementia in the prisoner population, and finds untested, locally developed initiatives likely to fail	sharing and agencies working in silos.	for staff and peer workers to be used in conjunction with a care pathway for older prisoners with dementia	Cognitive Impairment in the prison population of England and Wales: Identifying individual need and developing a skilled, multi-agency workforce to deliver targeted and responsive services). Puts forward teaching packages on care of prisoners with dementia.
Learning and peer care					
Brooke, Rybacka, (2020). 'Development of a dementia education workshop for prison staff, prisoners, health and social care professionals.'	Training evaluation, mixed methods, pre- and post-intervention questionnaire and interviews.	The development and delivery of dementia awareness training for prisoners and staff in one English prison.	Workshops were well received, helped to offset various misconceptions related to ageing prisoners.	Standalone training sessions will not be enough to alter existing practices. Attention needed for environmental factors, such as quiet, uncrowded spaces.	Authors from England and Australia.
Behan, (2014). 'Learning to Escape: Prison Education, Rehabilitation and the potential for Transformation.'	Interviews, discussion brings together criminological and education theories.	Discusses the motivations of participants involved with prison educational programmes.	Critical of drives to measure and evaluate outcomes such as learning and change.	Programmes can help to engage in critical reflection which can subsequently influence recidivism. Transformation	Ireland. (From the perspective of a Prison Educator).

Article details	Method	Intervention	Findings	Conclusions and recommendations	Other information, characteristics.
				rooted in everyday practices. Engaging in transformational styles of learning can assist with desistance.	
Perrin, (2019). 'Peer support and individuals with sexual convictions: complementing traditional rehabilitation strategies'.	Based on a systematic review by the same authors (2017), interviews and IPA analysis.	Discussion of peer support in for MCSOs, in the context of rehabilitative programmes such as treatment programmes and therapeutic communities.	Little research in this area, peer working characterised by emotional problem-solving, reciprocal emotional support, reducing anxiety, treatment gains and reduction in recidivism.	Concludes, little research in this area, a need for more research into the negative impact of peer support.	One author from England, two from Australia. Perrin well published in this area, links to several papers by the same authors, notably, Perrin and Blagdon, (2014). (The terms 'treatment' and 'therapy' applied from a rehabilitative rather than health perspective).
Kitt-Lewis, et al, (2019). 'Developing educational modules to enhance care of aged and dying inmates: Set up phase.'	Modified Delphi method and a useability study.	Paper discusses the strategies required to transfer learning from previous studies to a computer-based MDT learning module aiming to enhance care for aging and dying prisoners.	Provides and outline of the potential benefits to ODPs and the various staff groups. Provides an outline of essential pedagogic content, stressing the importance of cultural	Suggests health professionals in the field can 'work to advance a mission of social justice and equitable distribution of health resources.' Kitt-Lewis et al, (2019).	USA. Facilities for computer-based learning simply did not exist at the research site.

Article details	Method	Intervention	Findings	Conclusions and recommendations	Other information, characteristics.
			competency in the context of prisons.		
Thornton, Sedilo, Kalishman, Page, Arora. (2018). 'The New Mexico peer education project: Filling a critical gap in HCV prisoner education.'	Mixed: survey, post education questionnaires, focus groups and interviews.	Hepatitis C peer education. 40-hour training curriculum with ongoing MDT support	Discusses an evaluation of project ECHO: making use of case-based learning; clinical best practices; evaluating outcomes.	Better staff relationships, the acquisition of transferable skills on release.	USA Education can be effective in teaching health literacy skills, and preventative health promotion. Refer to criminological theories of self-development.
Haward, Kavanaugh and Cho (2019). '**I just learned by observation and trial and error': exploration of Young caregiver training and knowledge in families living with rare neurological disorders.'**	Mixed methods, three studies based on child carers of adults with neurological disorders.	Statistical illustrations of relationships and demographic data, the strength of the article is the qualitative comments and analysis.	Studies led to six themes: '1. Patient tells me what to do; 2. Watching and observing; 3. Common sense; 4. Treating patient like a child; 5. Figuring it out. 6. Don't know.'	There was an absolute lack of guidance for these young caregivers, hinting towards the needs for a training package and support, to improve for the recipient and caregiver's well-being.	USA – Experiential learning. The paper is an out-layer, but the theme of poor education and support relates to the experience of caregivers at the research site.
Walker, Mawson, (2019). 'Peer Support for Chronic and Complex Conditions: A literature review'.	Literature review, confined to RCT's and other systematic reviews of peer interventions for LTC's (not prisons).	Updates a previous literature review undertaken in 2011, 33 papers synthesised. Papers fail to mention 'dose-response' effect.	Investigates the effects, values, cost-effectiveness and sustainability of peer support.	Questions the value of using RCT's to research peer interventions, suggesting judging the success of biomarkers such as severity of symptoms is the wrong approach.	Australia. Suggests most training is didactic, some role play, some communication skills. Social support theories suggest social connectedness can support recovery. Social learning theory

Article details	Method	Intervention	Findings	Conclusions and recommendations	Other information, characteristics.
					can help individuals to learn from role models.
Theories of care in criminal justice					
Brown Coverdale, (2020). Caring and the Prison in Philosophy, Policy and Practice: Under Lock and Key. Journal of Applied Philosophy.	From the philosophical tradition. Care exists in prisons, care ethics enables us to know it differently, micro and macro processes simultaneously.	Contrasts contemporary liberal penological theories with a more ethics of care which is presented as a relational, situated, 'practice-based mode of moral reasoning'.	Care ethics allows use to recognise, critique, improve care and (in this case) admit to poor care/conditions.	Ethics of care offers a more accurate account, recognising and critiquing the presence of inadequate penal care. It implies support for less harmful forms of punishment and support for resilience building.	UK Philosophy Links to Brown Coverdale, (2017).
Gregory, (2010). Reflection and Resistance: Probation Practice and the Ethic of Care	A discussion paper based on interviews with probation officer's perceptions of changes to influential discourses.	Contrasts EoC and phronesis as distinct to technical-rational conceptions of self and caring for others. Good discussion of Foucauldian power in the context of accepting new practices/discourses.	Care involves a relational subjectivity/relational self-conception, care as a moral-relational, not instrumental, technical-rational.	Recognises care workers as needing to balance justice and care; reflective practice can mitigate the 'worst excesses of punitive-managerialism'. Caregivers cannot discard their impact on situations	UK Probation. Connects criminal justice work to changes towards technical-rationalism; discussion of the role of power and the need to resist change and for relational subjectivities.
Tronto, (2010). Creating Caring Institutions: Politics, Plurality and Purpose.	Discussion paper based on the evaluation of care institutions.	Develops a framework to assess institutional care according to three themes: the	Situated in relation to the four phases of care. Highlights the dangers of paternalism and	Institutions needs, moral, ethical and political rhetorical spaces to interpret struggle.	USA Ethics of care. Links to several other books and

Article details	Method	Intervention	Findings	Conclusions and recommendations	Other information, characteristics.
		purpose of care, recognising power relations, pluralistic care.	parochialism. Care institutions best understood in the context of power differentials and conflict.		papers by the author.
Ward and Barnes, (2016). Transforming Practice with Older People Through an Ethic of Care.	Discussion paper, draws on two studies, a participatory action research project and material from a knowledge exchange project.	Uses ethics of care to consider caregiving and receiving for marginalised (elderly) groups	Uses ethics of care to transform relationships through hybrid spaces which can foster care-full deliberation. These can produce more responsive and attuned care.	Reflective spaces can balance procedural methods of working. Care central to the generation of well-being. Allowing time for storytelling is central to deliberation. Listening and accompaniment more valued than choice.	UK Psychology Both authors link to numerous articles relating to Ethics of Care and Older adulthood.
Ward and Salmon, (2011). The Ethics of Care and the Treatment of Sex Offenders.	Discusses how EoC perspectives can contribute to work with MCSOs.	EoC helps professionals to view offenders more holistically. Offenders respond well to interest and concern, increasing likelihood of change.	Empathy and a common factor between Engster's care virtues (attentiveness, responsiveness and respect and Care Roger's core states.	A helpful feature of EoC is attentiveness to carer's needs: supervision, learning, and a reflective, nuturing self-attitude.	UK Links papers by Ward and Maruna. (Caregiving as an activating event for transformative learning, links to Brockbank and McGills framework).
Lloyd, L. (2006). A caring profession? The Ethics of Care and Social Work	Stresses some of the political dimensions of ethics of care in relation to social	Ethics of care as a challenge to the abstract ideal of the independent,	Ignoring service-users voice can lead to providers becoming less responsive/focus	Derides 'rights talk' in the absence of resources. Ethics of care as an	UK Social work and older people. Political applications of

Article details	Method	Intervention	Findings	Conclusions and recommendations	Other information, characteristics.
with Care of the Elderly.	work and its position to 'care'.	autonomous individual.	ing on voice can promote connectedness and solidarity, leading to empowerment.	alternative to associations of age and weaknesses, needing to be controlled, it is part of our nature.	ethics of care, collectivism.
Personal development/desistance narratives					
South, Bagnal, Woodall, (2017). 'Developing a typology for peer education and peer support delivered by prisoners.'	Based on generic prison-based, health promoting peer roles/interventions.	Typology developed in recognition of the heterogeneity of peer roles.	Suggests four main categories of peer-based approaches: peer educators, peer supporters, peer mentors and bridging roles.	Offers a typology to build on and develop the evidence base and future research, suggests there is scope to develop theory regarding how peers mitigate risk.	Based at University of Leeds. This paper is based on the systematic reviews (and other papers) by the same authors. Based on Bagnall et al. (2015) and, South, J. Woodall, J. Kinsella, K. Bagnall, AM. (2016).
Buck, G. (2018). 'The Core Conditions of Peer Mentoring.'	Interview and observations, guided by an interpretivist philosophy.	Reviewed activities in several peer mentoring services, probation, care leavers, women's employment service.	Discusses the effects of results driven paradigm. Highlights emotional costs of caregiving.	Develops three core states based on Rogerian principles: 1. Caring; 2. Llistening; 3. Encouraging small steps.	England. Suggests a miss match between the aims of peer mentoring and results-driven way of working. Focuses on women's and community, use of 'care' differs.

Article details	Method	Intervention	Findings	Conclusions and recommendations	Other information, characteristics.
Collica-Cox, (2018). 'Female offenders, HIV peer programs and attachment: The importance of prison-based civilian staff in creating opportunities to cultivate prosocial behaviour'.	Based on a previous study (Collica-Cox, 2016). Review of the relevant literature then predominantly interview with some quantitative measures relating to pre- and post-intervention assessment of attachment to external workers.	Peer HIV educators and groups workers, female population.	Positive attachments to civilian educators in prison and the community supports the possibility of crime desistance over the longer term.	Describes the benefits of civilian mentors rather than prison workers and educators, both sides of the wall in terms of maintaining prosocial behaviour.	USA – educational and criminological traditions. Links to several other papers by Collica-Cox (2016) 'All aboard the desistance express'. Makes use of attachment, social control theories, and theories of crime desistance.
Lebel, Richie and Maruna, (2015). Helping Others as a Response to Reconcile a Criminal Past: The Role of the Wounded Healer in Prison Reentry Programs.	Quantitative: self-completed, fixed/closed questionnaire. Small sample, descriptive statistics.	Focuses on the perceptions of professional-ex prisoners who had become community peer mentors. Examines characteristics such as pro-social attitudes, coping strategies, life satisfaction, overcoming stigma.	The study supported these relationships. Profession-ex prisoners appear to have undergone significant changes, best understood as 'hope', a product of personal redemption.	Activity linked to several other theories of change and development, for example, Eglash's 'Creative restitution' or going the extra mile to assist another. The role of the wounded healer is linked to crime desistance.	USA – Criminology. All authors are considerably well known, Maruna's book 'Making Good' was particularly influential in the pilot.
Perrin and Blagdon, (2014). Accumulating meaning, purpose and opportunities 'drip by drip': the impact of being a listener in prison.	Quantitative analysis of the impact of being a Prison Listener, small sample size, n=6.	Lengthy discussion of other theories of personal growth, in the context of a range of prisoner roles.	Listening instils a sense of trust and hope, psychological resources and gains to a sense of protection from the	Results suggest peer listening results in profound internal change, a shift in self-identity, and gains in purpose and meaning.	UK – Narrative psychology and criminological traditions.

Article details	Method	Intervention	Findings	Conclusions and recommendations	Other information, characteristics.
			negativity associated with prison life.	The role validates the transition to a desired 'good self'.	
Vaughan, B. (2007). The Internal Narrative of Desistence.	Discussion paper.	A re-working of Gidden's agency-structuration theory as applied to individual crime desistance. Is it external life course events or the effect of events on a changed internal narrative?	Simplified: empathy may initiate a 'process of self-appraisal' from which the new person emerges.	Change occurs as a reaction to new roles, which trigger a new narrative. Narrative renders the past as qualitatively different to the present, a narrative identity acknowledges old wrongdoing and new futures.	UK – criminology and narrative psychology. A cornerstone of the desistence discussion, references to Maruna, Goldie, Mc Adams.

Appendix **Table C: Government inspection and other recommendations papers 2015–2021**

Organisation/year	Policy/Title	Function	Other information
HMPPS Instructions and guidance			
NOMS (2015)	Prison Service Instructions 15/2015. **Adult Social Care in Prisons**	Instructions to governors and staff in prisons.	Removed from the MoJ website at time of writing.
NOMS (2015)	Prison Service Instructions 16/2015. **Adult Safeguarding in Prison.**	Instructions to governors and staff in prisons.	Accessed at: https://www.justice.gov.uk/offenders/psis/prison-service-instructions-2015
NOMS (2015)	Prison Service Instructions 17/2015. **Prisoners Assisting Other Prisoners**.	Instructs to governors and staff in prisons to mobilise younger, fitter prisoners in support of older prisoners. Criticised in several papers above.	Accessed at: https://www.justice.gov.uk/offenders/psis/prison-service-instructions-2015
HMPPS (2018).	**Modes of Delivery – Older Prisoners. Supporting Effective Delivery in Prisons**	Provides suggestions for activities relating to the	(Published after data collection).

	(2018). Version 1.0. April 2018.	treatment and management of older prisoners.	
Government recommendations papers			
Association of Directors of Adult Social Services, ADASS, (2016).	**Seeing Prisoners as Assets. Peer to Peer Support as a Means of Identifying and Responding to Prisoners with Social Care Needs – Building Future Capacity.**	Discussion and recommendations, generally in favour of the use of peer support workers/caregivers.	Social Work
HMIP (2016). HM Inspectorate of Prisons. London.	**Life in Prisons: Peer Support, A Findings Paper (2016).**	Refers to over-crowding, number of hours being spent in cells, insanitary conditions, lack of activities.	Accessed at: https://www.justiceinspectorates.gov.uk/hmprisons/inspections/?s+older+prisoners
Prisons and Probation Ombudsman. PPO (2017).	**Independent Investigation: Learning from PPO Investigations, Older Prisoners**	Highlights the difficulties faced by older adults in prisons	
HMIP (2019). Her Majesty's Inspectorate of Prisons, (Scotland).	**Who Cares? The Lived Experience of Older Prisoners in Scotland's Prisons. A Thematic Study Carried Out by Her Majesty's Inspectorate of Prisons, (Scotland).**	Draws attention to some good practices but also numerous impacts of incarceration in later life, isolation, boredom, feelings of being a burden, lack of activity.	https://www.prisonsinspectoratescotland.gov.uk/publications/who-cares-lived-experience-older-prisoners-scotlands-prisons?page=2
HMIP (2019). Her Majesty's Inspectorate of Prisons. London.	**Management and supervision of men convicted of sexual offences. A thematic report by Her Majesty's Inspectorate of Prisons.**		Accessed at: https://www.justiceinspectorates.gov.uk/hmprisons/inspections/?s+older+prisonersN
Her Majesty's Prison and Probation Service, and the Care Quality Commission. (HMPPS + CQC) (2018).	**Social Care in Prisons in England and Wales, A thematic report.**	Identifies some positive practice. Sets out gaps in provision; a lack of support for older adults with needs; disparity between internal and external facilities.	
House of Commons (2020). House of	**Ageing Prison Population, 5th report of session 2019-21.**	Ongoing select committee on the care and treatment of older prisoners from 2013.	

Commons Justice Select Committee.			

Appendix **Table D: Summary of the grey literature and popular media**

Date	*Source*	*Title*	*URL*
09.06.20	*BBC News*	*Lewes prison inmates in cells 'for more than 22 hours per day'*	*www.bbc.co.uk/news/uk-england-sussex-529848867*
25.03.20	*BBC News*	*Coronavirus: Inmates could be freed to ease virus pressure on jails*	*www.bbc.co.uk/news/uk-52029581*
22.10.19	*BBC News*	*Ageing prison population 'sees officers working as carers'.*	*www.bbc.co.uk/news/uk-england-50082036*
11.11.10	*The Times.*	*Dementia-friendly Makeover for Jails*	*https://www.thetimes.co.uk/article/dementia-friendly-makeover-for-jails-mbhx8ncps* *Ford, R. (2019).*
25.07.17	*BBC News*	*Elderly prisoners' needs are not being met, SPS report says*	*www.bbc.co.uk/news/uk-scotland-47657416*
18.09.14	*BBC radio 4*	*Disabled and behind bars*	
26.10.12	*BBC radio 4*	*Dying on the inside*	*www.bbc.co.uk/blogs/radio4/entries/357ebd4-8c12-3d51-1742a0a96bdb*
20.06.17	*The Guardian newspaper*	*Prisons taking the role of care homes and hospices as older population soars.*	*Amelia Hill*
20.06.17	*The Guardian newspaper*	*Buried Alive: the old men stuck in Britain's prisons*	*Amelia Hill*
16.08.20	*The Guardian newspaper*	*Prisoner's age more quickly than the general population*	*Jamie Grierson*
21.06.17	*The Guardian newspaper*	*What our prison population says about our society*	
12.04.13	*The Guardian newspaper*	*Dementia among inmates poses a growing challenge for prisoners*	*Adam Moll*
25.02.12	*New York Times*	*Life, with dementia*	*Belluck, P.* *www.nytimes.com/2012/02/26/health/dealing with-dementia-among-aging-criminals.html*

Appendix 4: Timeline and activity audit trail

Visit no.	Date	Location	Interview (ODPs)	Shadowing	Meetings with key staff
1.	30.05.18	IHU		Initial planning meeting	HCM & Gov1
2.	07.06.18	HU1	Bobby	Familiarisation in HU1	Meeting with DLO1
3.	12.06.18	HU1		General observations, inclusive of group discussion (x5 buddies) HU1	Meeting with wing manager
4.	19.06.18	HU2		Observing in HU2. Meeting with buddies Mark and Dennis	Meeting with HCM
5.	27.06.18	HU1	Sam	General observations	Meeting with HCM
6.	04.07.18	HU1	Jack	Shadowing Mike	
7.	11.07.18	HU1	Ralph	Shadowing Gary	Meeting with HCM
8.	16.07.18	HU1	Eric	General observations	
9.	26.07.18	HU1	Harry	General observations	
10.	03.08.18	HU1	Bernard	General observations	
11.	07.08.18	HU1	Ted	General observations	Meeting with DLO1
12.	14.08.18	HU1	Stan	Shadowing Chris	Discussion with Off.

Visit no.	Date	Location	Interview (ODPs)	Shadowing	Meetings with key staff
13.	05.09.18	HU1		Shadowing Lee	
13.	12.09.18	HU3		Hanging out with buddies (x3), including group discussion HU3	Meeting with wing manager.
14.	20.09.18	HU3	Eddie	Shadowing Brian	
15.	27.09.18	HU3		Shadowing Nick. Lengthy discussion with a participant with a sensory disability.	
16.	01.10.18	HU3		Shadowing Steve	
17.	08.10.18	HU3		Shadowing Brian	
18.	16.10.18	HU3		General Observations	
19.	22.10.18	HU4	Tom	HU4 Shadowing Marv	Meeting with Gov2, DLO2, SW
20.	25.10.18	HU3		General observations.	
21.	01.11.18	HU3		General observations	Meeting with DLO2
22.	05.11.18	HU3		General observations.	DLO2

Appendix 5: Interview schedule

ODPs

Capture biographic data:
Sentenced length? How much time has been served? which prisons? (Generally I am not interested in the nature of their index offence).
Health status: age, how does their disabilities affect their lives in prison, mobility issues. Ballpark data, i.e. not specifics such as diagnosis or medication.
Experience of informal care in prison and in other prisons.

To get things rolling: What were you employed as? Occupation?
Immediate family issues. What was your experience of care outside of prison?
Did you know your father, what did he do?
Do you get visits, from who?

Tell me about your average day, prompts…
How much time is spent in your cell?
How do you spend your average day? Are all days the same?
Describe your frustrations, prompts…
What is the worst thing about being in prison? The regime? the environment?
How do you keep going? What sorts of things bring you hope?
What matters to your life in prison?
Who is supportive of you, practically, socially? How are they supportive? Who do you share a connection with?

How was your health when you first got to prison, on your first entry?
What was your state of mind? How is it now?

Thinking back over your sentence, can you think of a peak experience? What has been the best moment? Describe what this was, how did it work for you?
Describe a low point over the last few years.

Do you have a carer? What is your experience of them? Bad points/good points?
How often do you see them, how do they help you? Give me examples.
What are the benefits as you see them?
When has it not worked for you?
What does the relationship mean to you?
How would life be without them? Do you have any recommendations for their training?

How do you interface with health care staff/social carers,
How do you interface with the officers?
Recite a story of when you were helped by a peer caregiver?
Tell me some more about that… what else, another….
What have you heard about other people's experience?

What do you think about the ageing in prison? What is the best way to cope?
Prompts… staying busy, cutting back.

What's important to you now?
What does the future hold?
What are your worries?
How do you feel about dying? In prison?

Can I ask some more questions next time we meet?

Peer caregiver's
Biographic data: age, sentence length, years served, prisons, courses completed.
Any previous sentences? What for, how long?
Experience of other prisons?
Previous employment.
General health status. Education
What did you do out there? Occupation, family.
What was your experience of care out there, now.

Relationship to caring inside prison – how long? what kinds of capacity. Have you ever been a carer? cared for?

What is your opinion of formal health and social care services?
What equipment do you rely on/use?
How did you learn to perform the work? Who did you learn from?

Reflection… possibly two schedules, starting with 1. practical issues/questions, 2. life history/biographical approach.

How do you spend your average day? Are all days the same?
Describe your frustrations with the regime, the environment.
What/who pisses you off?
What is the main aspect of the PC role?
Has there ever been a time when you wanted to give the role up? Are there times when you have had to make personal sacrifices to deliver care/support?
Who is supportive of you, practically, socially? How are they supportive?
Who do you share a connection with?

Peak experiences are when someone feels epic or uplifted in themselves relating to an issue, change or achievement. Can you think of a peak experience? Describe what this was, how did it work for you?
Describe a nadir, low point in your life, (and or last few years). Send of disillusionment or despair.

Why did you learn to be a carer?
What skills do you value?
What has surprised you about offering care?
What have you learned about yourself?

Why are you a PC, what does it give you, how come you have stuck with it?
How do you keep going, what sorts of things bring you hope?
What does the role mean to you?

In what ways does it give you satisfaction?

How were you when you first got to prison, on your first entry? What was your state of mind. How is it now?
How has caregiving helped you?

Tell me about turning points in your life, (these should be unique to you). Have there been any peak experiences since being sentenced? Why have things changed for you, how?

Staff:

Biographic data: How long have you served? At any other prison?

Describe for me an average day, responsibilities.

What are your frustrations with the job? What are the impediments as you experience them on a daily basis?

How do you get on with the high numbers of ODPs? How does this affect the regime, interfere with your day? What is your personal view? Should they be here, what sort of service do they get, what do they deserve?

How do you perceive peer caregivers? What are your thoughts of prisoners providing support to other prisoners? How does this matter to your role/job… to the prison regime? What has been your experience of working with them? Has there been any times when they have been helpful, how were they helpful? Alternatively, got in the way, caused a problem. What are the benefits, what are the difficulties/costs?

Do you have any understanding of their training/what is your perception of this?
Have you noticed any difference in their working practices?

Can you recite any occasions when things become difficult with an ODP or when the PCs were particularly helpful? What happened?

Appendix 6: Extract from the reflective diary

The challenges of taking field notes.

My notes appear to say much about the contextual factors which shape the ODP/caregiver's relationships and the material factors in the environment.

What is best, taking notes during the observations or after? In the event, I did both. Both strategies assume different ways in which observations distort 'truth'; either way, 'truth' is mediated through our senses and interpretation, therefore mediation cannot be eliminated. As noted by Emerson, Fretz and Shaw (2001, p.352) and Walford (2009), 'there is very little agreement amongst ethnographers regarding how to go about recording what is happening in the field'.

I took descriptive, impressionistic notes with the intention of capturing as much detail as possible, but exactly what was I capturing? I captured what I found noteworthy or interesting, what was familiar or unfamiliar, things that I felt were atypical or built a picture of the participants personality or identity, or more specifically, their ability to self-care. There were textual clues, for example, pictures/posters/artefacts; how were they presenting themselves and what were the reasons for these displays? There were behavioural clues, for example, how did they hold themselves? How did they want to be perceived? I tried to capture an impression of the environment, the ambience, activity, light, smells, the basic, austere surroundings.

While in the participants cells, I was effectively in other people's homes. I did not feel as though I was being overtly voyeuristic, but I was careful to ask permission to enter, to sit and jot down notes. Did my observations lead to the reproduction of stereotypes? Generally, I did feel some of the ODPs were attempting to influence the way they were perceived. I sensed a projection of, 'stand up type of guy', 'I was respected in the community', 'family man' narratives within their responses.

I took notes sitting on their beds or in a chair, or on the hoof when with the caregivers, this was not physically easy! I typed notes on the train if it was private enough, completing the rest at home, acknowledging this is a process of selection, filtering and refinement. For example, Emerson, Fretz and Shaw (2010, p353), 'Field notes are inevitably selective, the ethnographer writes certain things that seem 'significant', and hence 'leaving out' other matters. In this sense, field notes never provide a complete record'.

What other factors influenced this process? I was fatigued from the early starts, the journey, from researching and studying alongside working in a full-time post. I had concerns in relation to the practicalities of transcribing/processing the vast amounts of data I was generating; it was extremely time-consuming. Where did the process of analysis begin? Security restrictions meant I was not permitted to capture information via photography or diagrammatic representation. According to Hammersley, (2010, p558) 'What we transcribe, and to some extent how we transcribe it, reflects substantive assumptions about human beings and how best to describe and explain social phenomena'. Van Maanen (1988, p8) contends 'there is no direct correspondence between the world as experienced and … as conveyed in the text', more like 'a sort of stammering relation to its object', (Lather 2001, p487).

Was I engaging in participant or direct observations? 'Analytic auto-ethnography' or 'reflexivity'? Or reflexive auto-ethnography? Does it matter what title we give to the process, isn't it the outcome that matters?

In my notes I frequently adopt a self-reflexive position, acknowledging myself as a white, middle-aged, British, working class (but educated) male, with a history of working in institutions. Van Maanen (2010) notes that the 'reflexive/confessional' have become routine aspects of ethnography, expressing concern that these elements have been taken too far and imply solipsism. Indeed, there are a good deal of moans and frustrations in my notes, about people, circumstances, frustrations in respect of my work and the caregiver development. I did not want to expose my concerns too much or risk reputational damage and used my notes as means of offloading my anxieties.

Appendix 7: Safeguarding action plan

Safeguarding Action Plan. **Form 4 updated 15.02.18**

The four key elements of safeguarding:

Empowerment: People being supported and encouraged to make their own decisions and make informed consent.

Prevention: It is better to take action before harm occurs.

Proportionality: The least intrusive response appropriate to the risk presented.

Protection: Support and representation for those in the greatest need.

1. Identifying abuse or neglect

Abuse is defined as ‘a single or repeated act or lack of appropriate action, occurring within any relationship where there is an expectation of trust, which causes harm or distress to an older person’ (Action on Elder Abuse).

Abuse can take many forms, for example:

Physical, domestic, sexual, financial/material, psychological, modern slavery, age discrimination, acts of omission, self-neglect.

Financial abuse is defined in the Care Act (2014):

- Having money stolen.
- Being defrauded.
- Being put under pressure in relation to money or property.

· Having money misused.

The following action plan provides an overview of the steps to be taken where there is cause for concern:

Action plan:

1. Upon observation or disclosure of abuse, the researcher is to discuss concerns with the person who is the subject of concern to advise them that they are obliged to discuss the issue with members of the on-site research support team, (Head of Diversity, Head of Health Service, DLO).

2. The researcher discusses the matter with the on-site research team.

3. They may make a further visit to talk to the person who is subject to concern, to see whether they would like further action to be taken on their behalf.

4. If it is agreed that further action is appropriate then the team must advise other managers and take action in accordance with PSI's 15/16/17 2016.

2. Safeguarding carers

It is recognised that it is not only those in receipt of care who are at risk but also the people who deliver care. In the event of observed or disclosed abuse the following plans covers an overview of the steps to be taken:

1. The researcher will discuss concerns with the research participant.

2. The researcher will then discuss their concerns with the members of the prison research support team (for example, Head of Diversity, Head of Health Service, DLO).

3. They may then return to discuss the concerns further with the research participant.

4. If it is decided that further action needs to be taken then this will be discussed with the senior member of staff in line with guidance found in PSI's 15/16/17, 2016.

5. The organisers of local caregiving activity will be contacted by the on-site research support team, and an appropriate course of action will then be taken.

Appendix 8: Participant consent form

Participant Consent Form

Title of Project: Developing Peer Caregiving in a UK Prison

Name of Researcher: Warren Stewart

Form 3 updated 15.02.18

	Please initial or tick box
I have read and understood the information sheet for the above study, and have had the opportunity to consider the information and ask questions.	
The researcher has explained to my satisfaction the purpose, principles and procedures of the study and any possible risks involved. I am aware that I will be required to either be observed or participate in an interview.	
I understand that what I say will be kept confidential unless something I say raises serious concerns about my safety or well-being or the safety of others and the researcher may need to contact somebody else who can help, but would discuss this with me first.	

I understand that my participation is voluntary and that I am free to withdraw from the study at any time without giving a reason and without incurring consequences from doing so.

I understand that my real name will not be used, how the data collected will be used, and that any confidential information will normally be seen only by the researchers and will not be revealed to anyone else.

I agree to take part in the above study.

Name of Participant, Date, Signature

Name of Researcher, Date, Signature

Appendix 9: Participant information sheets

Participation information sheet, for peer caregivers (who maybe observed and interviewed) and for ODPs being interviewed.

Updated 15.02.18
Form 2.

Title of Study

Developing Peer Caregiving in a UK Prison

Invitation paragraph

You are invited to take part in a research study. Before making a decision whether you wish to be involved, we would like you to understand why the research is being done and what this might mean for you. Warren Stewart of the University of Brighton, is the primary researcher and he will explain several issues in relation to the work. This should take around five to 10 minutes but please feel free to ask questions for clarification purposes if you are unsure of any aspects of the work. Other staff such as the Disability Liaison Officer (DLO) …..(name)…. and Health Service Manager (HSM) ….(name)…, are helping to support the research and they will be able to assist, if a question or problem occurs to you at a later time. You will be given a period of at least two weeks to think about whether you wish to take part before making a decision. If you initially decide to be involved with the work but later change your mind, it is perfectly acceptable to opt out of the research.

What is the purpose of the study/project?

Warren is an experienced lecturer undertaking a professional doctorate in education, this work contributes towards his qualification. The main aim of the research is to develop peer caregiving locally within the prison by engaging with prisoner peer

caregivers and ODPs in receipt of care, to see what can be done to improve peer care in prisons. The findings of the research will inform the future training needs of prisoner peer care workers.

Why have I been invited to participate?

You have been asked if you would like to be involved with the research as either: you have been trained for the role and are already involved as current caregiver, you would like to undertake the training, or as someone who receives peer support/care. Warren has consulted with local health and social care workers to identify who might be suitable to be involved with the research.

Do I have to take part?

Involvement with the research is entirely voluntary, it is perfectly acceptable to withdraw from the research at any stage. Withdrawal from the research will not jeopardise either the level of care you receive, your role as a peer caregiver, or any other prison employment you choose to engage with.

What will happen to me if I take part?

If you elect to be involved with the research you may be asked if it is okay for Warren to shadow you in the course of your daily responsibilities. It is anticipated this will be no longer than two days. It is likely that you will be asked to be interviewed on one or more occasions; the interviews may be up to an hour in duration. The researcher is interested in your experience as a peer carer or how you have experienced receiving caregiving. Some aspects of your past may be relevant, for example, if you have been a carer in the community; however, the researcher is not interested in your offending history. You do not need to share any information you feel uncomfortable discussing. Warren will be visiting the prison on dates that are mutually convenient to the prison and himself, these are unlikely to be fixed days per week.

Will I be paid for taking part?

There is no extra pay or reward attached to taking part in the research.

What are the potential disadvantages or risks of taking part?

Your personal and psychological safety is important to the research team. In the event that you may feel anxious or uncomfortable during the observations or interview, please indicate that you feel uncomfortable to Warren who will stop the process, either temporarily or all together. Warren and the research team are happy to provide debriefing; however, there are several other local sources of support, including the prison listeners, the Chaplaincy, local health care workers, your personal officer or Disability Liaison Officer.

What are the potential benefits of taking part?

The benefits of the research may not be immediately obvious; however, the longer-term aim will be to use the research to make adjustments to the existing peer care training, this will improve peer care within the prison.

Will my taking part in the study/project be kept confidential?

All of the information gathered will be kept confidentially and be stored carefully and securely. Some information will be recorded into a Dictaphone or in temporary handwritten format. This will be transcribed into digital format and saved on a password-protected computer; the original recording will then be destroyed or deleted. Only the main researcher and the research supervisors will have access to this information. All markers of identification such as names and place names, will be fully anonymised by using codes or pseudonyms. The information will be stored securely over the longer term and may be referred to in future.

In the event of disclosures from participants that indicate harm to individuals, such as abuse, exploitation, threats to security or risks to life, then the research team have a

duty to care and to maintain safety. This could result in the information being shared with the appropriate staff in the prison, (see form 4).

What will happen if I don't want to carry on with the study?

Participants may withdraw at any time without giving a reason, as mentioned there will be no repercussions form your decision to withdraw. You will be asked if your information can be used, if you decide against this your data will be completely erased from our records.

What will happen to the results of the project?

The main aim of the research is to improve local peer care practices therefore, some specific results will be offered to local senior managers at timely intervals. It is also likely that the outcomes will be of interest to other people seeking to develop similar processes in similar areas. Therefore, it is likely that a number articles will be published in relevant journals, and poster and conference presentations will be delivered at relevant events. The results of the work will contribute to the researcher's doctoral dissertation.

Who is organising and funding the research?

Warren Stewart is organising the project in collaboration with the afore mentioned prison staff. The University of Brighton is acting as sponsor for this research. The work is independent of the NHS and NOMS, although ethical approval will be sought from both public bodies.

What if there is a problem?

If you are in anyway troubled by any aspects of the research or wish to speak to a member of staff, please do not hesitate make contact the Disability Liaison Officer or the Health Service Manager by making a written application in the usual way, at the wing office. Warren can be reached but may not always be on site, please ask the wing staff to pass on a written message addressed to the DLO and HCM. If the issue is of a more immediate nature please speak to the wing office staff or your personal officer who will contact one of the research support team.

Contact details

To contact the Health Service Manager or Disability Liaison Officer please submit an application to the wing office between 0830 and 0930.
Disability Liaison Officer.
Health Service manager.
Warren Stewart, (written application to Integrated Healthcare Centre).

Who has reviewed the study?

Please be reassured that the research has received approval from following ethical review bodies:

1. The University of Brighton external research ethics committee.
2. The NOMS research ethics panel.

Participation Information Sheet for key members of staff participating with the research.
Number 2.
Updated 15.02.18

Title of Study

Developing Peer Caregiving in a UK Prison

Invitation paragraph

I would like to invite you to take part in a research study, as titled above. Before making a decision whether you wish to be involved, I would like you to understand why the research is being done and what this might mean for you. Warren Stewart of the University of Brighton, is the primary researcher and he will explain several issues in relation to the work, this should take around 10 minutes. You will be given a period of at least two weeks to think about whether you wish to take part before making a decision. If you initially decide to be involved with the work but later change your mind, it is perfectly acceptable to opt out of the research. You may take this sheet away with you.

What is the purpose of the study/project?

Warren is an experienced lecturer undertaking a professional doctorate in education, this work contributes towards his qualification. The main aim of the research is to develop peer caregiving locally within the prison by engaging with prisoner peer caregivers and ODPs in receipt of care, to see what can be done to improve peer care in prisons. The findings of the research will inform the future training needs of prisoner peer care workers.

Why have you been invited to participate?

You have been asked if you would like to participate in the research as your role has a direct bearing on the work of the prisoner caregivers and you are in a position to influence decisions made about how they work. In this respect, your experience and ideas on peer caregiving is viewed as valuable and may contribute to developing their role in future.

Do I have to take part?

Involvement with the research is entirely voluntary, it is perfectly acceptable to withdraw from the research at any stage.

What will happen to me if I take part?

If you opt to participate in the study it is likely that you will be asked to be interviewed on one or possibly two occasions, the interviews may be up to an hour in duration. The researcher is interested in your experience and involvement peer caregiving and what value you think it has. You do not need to share any information you feel uncomfortable discussing. Warren will be visiting the prison on dates which are mutually convenient to the prison and himself, these are unlikely to be fixed days per week.

Will I be paid for taking part?

There is no financial incentive or reward attached to taking part in the research.

What are the potential disadvantages or risks of taking part?

Your personal and psychological safety is important to the researcher and support team. In the event that you may feel uncomfortable during the interview, please indicate that you feel uncomfortable to Warren who will stop the process, either temporarily or all together.

In the event of disclosures from any participants that relate to harm or abuse to individuals, exploitation, threats to security or risks to life, then the research team have a duty to care and to maintain safety. This could result in the information being shared with the appropriate staff in the prison, (see form 4).

What are the potential benefits of taking part?

The benefits of the research may not be immediately obvious however, the longer-term aim will be to use the research to make adjustments to the existing peer care training, this will improve peer care within the prison.

Will my taking part in the study/project be kept confidential?

All of the information gathered will be kept confidentially and be stored carefully and securely. Some information will be recorded into a Dictaphone or in temporary handwritten format. This will be transcribed into digital format and saved on a password-protected computer; the original recording will then be destroyed or deleted. Only the main researcher and the research supervisors will have access to this information. All markers of identification such as names and place names, will be fully anonymised by using codes or pseudonyms. The information will be stored securely over the longer term and may be referred to in future. Further guidance on data management and storage is available in the University's Research Data Management Policy and in its Data Protection Policy.

What will happen if I don't want to carry on with the study?

Participants may withdraw at any time without giving a reason, as mentioned there will be no repercussions form your decision to withdraw. You will be asked if your information can be used, if you decide against this your data will be completely erased from our records.

What will happen to the results of the project?

The main aim of the research is to improve local peer care practices therefore, some specific results will be offered to local senior managers at timely intervals. It is also

likely that the outcomes will be of interest to other people seeking to develop similar processes in similar areas. Therefore, it is likely that a number of articles will be published in relevant journals, and poster and conference presentations will be delivered at relevant events. The results of the work will contribute to the researcher's doctoral dissertation.

Who is organising and funding the research?

Warren Stewart is organising the project in collaboration with other key staff at the prison. The University of Brighton is acting as sponsor for this research. The work is independent of the NHS and NOMS, although ethical approval will be sought from both public bodies.

What if there is a problem?

Your personal and psychological safety is important. In the event that you may feel anxious or uncomfortable during the interview process, please indicate that you feel uncomfortable to Warren who will stop the interview, either temporarily or all together. Warren and the other people involved in the research are happy to provide debriefing, these are the Disability Liaison Officer …..(name)… and the Health Service Manager …. (name)…...

If you are in anyway troubled by any aspects of the research, please feel free to contact Warren as the primary researcher who can be reached by telephone ……, or email …… , if he is not on site.

If you would like to speak in confidence to someone other than Warren, please contact Dr Nadia Edmond, who supervises Warren's work, either via telephone ……, or by email …….. .

Who has reviewed the study?

Please be reassured that the research has received approval from following ethical review bodies:

1. The University of Brighton external research ethics committee.
2. The NOMS research ethics panel.

Appendix 10: Sample of interview data, memos, codes and themes

Code No.	ODP Gordon (HU1)	Landscape codes and memos	Abstract code	Theme
1	Demographic data/offending history: 78 years old; serving a nine-year sentence. Previously located at HMP Winchester for 6/52; HU2 for three months; had been in HU1 for one month. Northern lilt, considerably well educated, disgruntled. 50-minute interview eventually terminated early due to an escorted hospital appointment.	**Memo:** Gordon has an acerbic tone and speaks with a mild Yorkshire brogue, he adopts a rather artisanal style of dress with boots, thick rimmed designer glasses and turned up denims. He is sitting in his prison issue donkey jacket as I enter the cell, he very much reminds me of an Alan Bennett/Tom Courtney-style character. He has a keen intellect and I sense I am going need to change my normal, more affable style so as not to induce more anger. This seems to work for me, but he is blunt to the point of rudeness with a younger officer when he enters the cell to give him information later in the interview.	Gordon's background fits with the PRT model of older males admitted to prison for the first time in later life, e.g., educated, with high expectations.	

Code No.	ODP Gordon (HU1)	Landscape codes and memos	Abstract code	Theme
2	To set the scene, Gordon appeared quite emotionally charged, short tempered. He was angry to start with but became more settled as the interview went on. He felt he was supposed to have a hospital appointment at 1100 which he felt had been forgotten. I knew this was not the case because the appointment was mentioned by the staff in the wing office, but I was unable to tell him this information for security reason, that is, he could arrange to meet someone at hospital. After around 40 minutes of chatting an officer came to tell him to prepare himself for the appointment. We chatted on for around 10 minutes after that.	Security processes interfering with medical appointments, this had visible effect on Gordon's anxiety levels.	Custody versus care tensions	Theme 1 – experience of precarity and its effect on health.
3	I introduce myself, explain the ethical parameters of	**Memo:** I later reflected that he seemed to want to	Triggers reflections on	

Code No.	ODP Gordon (HU1)	Landscape codes and memos	Abstract code	Theme
	the study as per other participants. He looks for his hearing aid and signs a consent sheet. (Gordon grumbles to himself).	be listened to; to be taken seriously and shown some respect, or have his status acknowledged. He was relatively early into his sentence and had been moved from a local prison to HMP A and then from HU2 to HU1. Therefore, he may not have fully psychologically adjusted to his new surroundings and sub-culture. He was less working class, more intellectual than some of the others; I sensed less of the Bligh spirit displayed by the better-established older prisoners, this is perhaps due to him having spent less time at HMP A and being less well adjusted to the environment and culture.	differing educational levels of the sample, what difference this might make to my-self/impression management and eliciting the participants' responses. Process of adaptation becomes visible – Gordon is earlier in the continuum.	
4	R: (I begin by observing that he has hearing and visual disabilities) …. 'So, I'm guessing you have been transferred here	Gordon responds but indirectly.		

Code No.	ODP Gordon (HU1)	Landscape codes and memos	Abstract code	Theme
	from the induction wing quite recently? I can see you have glasses and a hearing aid… do you mind if I ask, how easy is it to manage those in this environment?			
5	Gordon (chimes in quite angrily)… "You see, this, this is bloody typical of this place! Typical. At 1100, I'm supposed to have an appointment at the local hospital to have a cataract removed, and they have forgotten all about me. It's sensitive for me, you see…. I only have one eye and it's not a hundred percent…. I rely on it. It's typical (dismayed). When I was at HMP (previous local prison), I was supposed to have a cystoscopy but they came around to me, and they talked me out of it. They (the officers) said: 'We will have to have two	From an informed, outsider's perspective it seems understandable that the appointment information needs to be restricted from the prisoner to prevent security breaches. From Gordon's perspective the uncertainty is experienced as stressful. Implies a sense of embarrassment at having officers being present during the operation, a massive breach of privacy, and it will compromise his sense of dignity.	Power issues, power staff knowledge over inmate uncertainty. Is Gordon's anger displayed as an expression of identity/or agency.	Theme 2 – expressions of institutional care.

Code No.	ODP Gordon (HU1)	Landscape codes and memos	Abstract code	Theme
	officers at the operating table, imagine that. We will have some stories to tell', which is completely unfair.			
6	Gordon: They said they were late for the appointment and it's a long way to go for a cancellation! (Angry response), I assume that was the appointment cancelled.	**Memo:** Security factors overriding human factors such as privacy, dignity, confidentiality. These processes become personalised during the interactions between staff and prisoner; maybe an explanation may have settled his anxiety? I'm wondering if he is always angry, or whether the display of anger is partially for my benefit.	The scene seems disempowering for Gordon.	Discourses of security in competition with care. Theme 1 & 2.
7	R: 'So, I am assuming the cystoscopy was arranged for you before you were sentenced?' Gordon: Yes... Today there is a problem with external appointments. I've got all sorts of respiratory problems you know…	Displaying his anxiety and vulnerability verbally. I notice Gordon is very open about his medical complaints. I notice his cell unkempt, impersonal, very limited photographs/decorations.		

Code No.	ODP Gordon (HU1)	Landscape codes and memos	Abstract code	Theme
	Researcher: Would that be a form of COPD? Gordon: 'yes' explains…. (spells out) C.O.P.D. – Constructive Obstructive Pulmonary Disease Researcher: Okay, so, so you've been here on 19 for two to three weeks? Can I ask how you got on B wing? Gordon: Yes, better than bloody here! Much better. Researcher: And, is it safe to assume you had a buddy there?			
8	Gordon: It was, I think… Mick… I don't know his bloody name, let me check, I have it written somewhere. As for here, when you leave the wing, look into the place where they serve food, there will be six buddies all sat around with their feet on the tables….	**Memo:** This is a fair observation as I have sat chatting with them. I notice his cell is not as clean as some of the other ODPs cells, it crosses my mind that this could be a consequence of being unpopular with the buddies, i.e. they don't clean his cell because he is critical.		Theme two/possibly three

Code No.	ODP Gordon (HU1)	Landscape codes and memos	Abstract code	Theme
8	R: So, you had a buddy there and they supported your needs better for you there. Can you say what sort of things he helped you with?			
9	Gordon: I've got limited food ... I've got dietary requirements. He went out of his way to get me food that was acceptable to me. He took the job very seriously and he was a constant source of encouragement… for instance my canteen sheet arrived on Saturday morning, it was lost, under my bed somewhere. I later found it under the bed, the officers said to me 'it's too late to put it in now', but you know, I need the extra food, you know crackers and things to supplement my diet. I asked 'can't you fax it, email it or something? I	Gordon compares his relationship and treatment in HU2 with HU1. His buddy in HU2 was able to assist him by resourcefully acquiring some extra items of food. This demonstrates the supportive nature of the role, when the relationship was functioning well.	Highlights the benefits of productive, personalised relationships.	Theme one and two.

Code No.	ODP Gordon (HU1)	Landscape codes and memos	Abstract code	Theme
	found out later they could have done but didn't, they just couldn't be bothered with me.			
10	Gordon: 'I've got curvature of the spine… If you take on the responsibility of caring for someone then you should do it'. (Still looking for the buddy's name). 'No, I wanted to keep his name so that I could write to the governor to say he was a wonderful carer and friend'.	Compares old buddy with new buddy, characterises the old excellent, buddy 'took the role seriously'; with the new 'lazy' buddies.		
11	Gordon: You have guards and prisoners making medical decisions in this place. I shared a cell with an 85-year-old, the most objectionable man I've ever met, no hang on, I take that back, there is one who is even worse down the way here. He never washed or spoke, or interacted, he was totally objectionable…	Prison officers influencing the facilitation of hospital appointments. Examples of criticisms, dehumanised officer attitudes and practices in a different gaol. I'm letting Gordon speak, with occasional para-linguistics.	Aligns with Tronto's framework for assessing the quality of care in institutions.	Questionable, regarding whether the

Code No.	ODP Gordon (HU1)	Landscape codes and memos	Abstract code	Theme
	Now, we'd get called to go and get our medication at the medical room. When he got his tablets he'd take them one at a time, tablet: gulp of water…. it took for bloody ever, he couldn't stand up on his own.			
12	R: What is it about your buddy there (HU2), what sorts of things does your buddy do for you? Gordon: They were sympathetic, they were empathetic. They have everything, my buddy looked for this bowling thing and almost dragged me along to it. And they were helpful with my canteen and diet.	Example of good practice. Emphasis on the interpersonal element of care, the effects of attentiveness and interpersonal skills. Linked to social events.	Evidence of intuition.	Theme two

Appendix 11: Operational recommendations

The following recommendations are based on the findings of the research:

1. The creation of a ‘Prisons Social Care Taskforce’ (similar to that of the ‘Prison Health Taskforce’ of the mid 1990s). This could oversee numerous functions for example, the development and implementation of policies; provide guidance for social care commissioners; the development, implementation and dissemination of good practice guidelines.

2. I encountered many vulnerable ODPs who’s level of capacity made it extremely difficult for them to cope in the environment. Therefore, a greater level of accountability, responsibility and advocacy needs to be taken for the most vulnerable of prisoners, who need to be diverted from court or transferred from prison to accommodation that can uphold their rights and a basic standard of human decency.

3. Review and update the national guidance instructions on peer caregiving, reducing its ambiguity, including references to the importance of preventative, home help-style caregiving activity, with the aim of increasing awareness of caregiver roles, thus increasing caregiver identity and purposivity.

4. In some areas the categories of ‘personal care’ and ‘intimate care’ represented an unworkable binary which was neither audited nor enforced. If caregivers are performing above their role, HMPPS either needs to review the threshold for formal interventions, or the policy should be adapted and caregivers should be trained to enable the fulfilment of a broader role.

5. Develop national (or even international) standards of peer care, and develop a criteria and mechanisms for auditing the level of quality of low-level, preventative peer care.

6. The research site should consider implementing newly developed, evidence-based models of assessing, planning and evaluating care for older adults in prisons (for example, Forsyth et al., 2019; Di Lorito et al., 2019), extending these systems to include prisoners with other disabilities.

7. Some older prisoners felt vulnerable when located near their younger counterparts, due to boisterous or exploitative behaviour, and a fear of accidents. Several of the participants voiced a preference for separate living arrangements, adding weight for the arguments for a differentiated physical space and regime. Therefore, this study lends calls for the development of a specific ‘Older and Disabled Prisoner’ strategy.

8. Step-up investment in the fabric of the prison estate, creating specially adapted cells and making reasonable physical adjustments in line with equalities legislation.

9. Provide greater access to age appropriate meaningful social, recreational and occupational activities.

10. Create new opportunities for HMPPS staff, local social care and prison health care services to work together in support of both caregivers and care receivers, this work could be embodied in a joint HMPPS/social services civilian role, akin to the forensic social worker systems in North American prisons.

11. ODPs and caregivers need a greater voice in shaping the services designed to support them, therefore local forums should be created to provide the discussion space to air relational, ethical, moral, resourcing and practical problems.

12. Often the caregivers had intimate knowledge of the ODPs' needs and were able to advocate for them, for example, when their mental capacity was diminished. 'Safeguarding' relates to being around for the ODPs, understanding what, when and how to escalate issues. Based on the results of the research, I suggest extending existing definitions of peer caregiving to include the functions of 'transitions mentor', to support 'safeguarding', and 'advocacy' functions.

13. Attend to the fears and concerns of ODPs in relation to their arrangements after release by developing post-release care pathways, through the gate mentoring, with sufficient, appropriate and safe provision.

14. The issue of matching caregivers and care receivers is a feature of the US literature but poorly discussed in European research (this may be because of a greater emphasis on vigils and one-to-one work). As relationships have been shown to work better when caregivers and care receivers are responsive to one another's needs and share similar phenotypes, I recommend a more proactive, bespoke approach to matching caregivers and ODPs, and to the selection of new members of the communities of caregivers.

15. HMPPS owes a duty of care towards both the older prisoners and the peer carers. Owing to the shortage of peer carers and the stressful nature of care work, it is recommended that a surplus of peer carers be recruited and trained, to provide respite to the existing peer caregiver workforce.

16. To develop multi-disciplinary care and support plans for older prisoners.

17. The research site should seek the backing of a national pressure group or charity, for example AgeUK or Re-Coop, in support of peer caregivers.

18. Develop the role to cover vigil and specialist end-of-life caregiver responsibilities in prisons with high numbers of ODPs.

19. The social care sector has historic recruitment and retention problems. People with criminal records are prevented from employment in social care roles under the Disclosure and Barring Service guidelines. While I would not suggest that high risk ex-offenders or MCSOs could be employed to care for vulnerable groups in the community, the research does raise broader questions regarding whether all ex-offender groups should be de-barred from this kind of employment, for example, ex-offenders imprisoned for civil offences.