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Method and methodological reflections concerning the conduct of interviews with NHS mental healthcare patients/prisoners in HM Prison Service, UK

Melanie Jordan

Abstract

Purpose – This paper aims to explore qualitative semi-structured interviews – conducted with NHS mental healthcare patients/prisoners located in one HM Prison Service (HMPS) establishment. The methodological reflections, whilst not directly related to the content of the interviews, seek to offer a debate about interview data in relation to the processes of their creation.

Design/methodology/approach – The dialogue is designed primarily for those who conduct, or have an interest in, mental health-orientated research, particularly those who undertake studies in secure settings with mental health service users as participants.

Findings – Regarding interview method as a tool for data collection/creation, methodological foci for discussion include the structure of interview questions, participant unfamiliarity with the process, body language and non-verbal communication, plus discussions concerning conversational turn-taking and interviewee agency.

Originality/value – This article stems from a small-scale empirical fieldwork study in one prison setting and offers a debate about interview data in secure settings with mental health service users.

Keywords Mental health research, Interview method, Interview practice, Mental health service users, Prisoners, Mental health services, United Kingdom, Prisons

Introduction

This paper presents an exploration of the method of qualitative semi-structured interviews conducted with mental healthcare patients/prisoners located in a prison. It debates the separation of interview content and data analysis from theoretical and methodological reflections. This pursuit occurs as a result of reading Mol’s (2002) work – a study of ontology in medical practice.

Nature of the social science interview

Semi-structured interviews are used extensively and successfully in prison-based health research. De Viggiani (2006) utilises semi-structured interviews to explore aspects of the prison environment inmates feel have a negative impact on their health. Condon et al. (2007) also deploy semi-structured interviews to explore the opinions of inmates; in this instance in relation to their views concerning prison health services. Both Gately et al. (2006) and Mills (2002) implement semi-structured interviews in their work that investigates inmates’ experiences of long-term mental healthcare in prison.

Interviews in social science research are often “presented as enabling a special insight into lived experience” (Rapley, 2004, p. 15). However, a convoluted understanding of both the
strengths and weaknesses of interviews is required in order to produce rigorous and valid qualitative research findings.

For example, interviewers must consider whether what they are asking is unjust or unreasonable, as “at best we are supplicants, and at worst, invaders demanding booty of captive audiences” (Toch, 1971, p. 500). Social science interviewers must remember they are the privileged “recipients of non-reciprocated information” (Toch, 1971, p. 500); this lack of give-and-take renders the interview an unusual human interaction. Rapley (2004, p. 16) considers interview data to reflect “a reality jointly constructed by the interviewee and interviewer”. Interviews are both interactive and situational processes. The collection/creation of data via this method is not a passive process; it is, instead, a construction process. This assembly process requires as much analytical attention as the (eventually coded, themed, and disseminated) content of the participants’ responses.

It is important to remember that spoken language is a social medium; therefore, an interview transcript constitutes a joint accomplishment of both interviewer and respondent. A research interview, like all research knowledge, should be considered critically in respect of its social, political, historic, economic, etc. contexts. Researchers who implement interviews should note “every conversation has its own balance of revelation and concealment of thoughts and intentions: only under very unusual circumstances is talk so completely expository that every word can be taken at face value” (Benney and Hughes, 1956, p. 137). In addition, interviews are often “governed by the proprieties of interpersonal relationships between people who do not know each other” (Hughes and Sharrock, 2007, p. 99). Therefore, “it is not merely a tool of sociology but a part of its very subject matter” (Benney and Hughes, 1956, p. 138). Notably, interview is not a simple social science method.

Radley and Billig (1996) question what individuals are actually doing when speaking about their state of health and argue “health talk” (p. 220) defines “social fitness” (p. 220) and “everyday notions of health and illness” (p. 222) actually “reflect ideological values” (p. 222). Individuals are understood to “construct their state of health as part of their ongoing identity in relation to others, as something vital to the conduct of everyday life” (p. 221). Therefore, “health beliefs are ideological in that they are sustained within a wider social discourse that shapes not just how individuals think, but how they feel they ought to think” (p. 227). Radley and Billig’s (1996) proposal – that health accounts are socially negotiated and setting specific – supports the premise of this article, as considering the construction of health-orientated interview data by participants is legitimised as a worthy endeavour.

This study has its roots in medical sociology and adopts a case study approach (Gerring, 2007) in one prison. This PhD work was exploratory in nature and aimed to investigate how prison mental healthcare could be developed. Regarding underpinning methodology, the study implemented an inductive approach to the datum-theory relationship, a constructionist ontological position, and an interpretivist epistemological orientation.

Attention was devoted to social and institutional arrangements that permeated the prison locale. These included prisoner-staff relations and prison regimes. Notably, aspects of the custodial treatment setting were important and this included the experienced working environment at the healthcare setting in the prison. To précis, mental healthcare provision and receipt experiences and environments were important for clinicians and patients/prisoners alike. Thus, cultural and structural contexts are crucial to the provision of mental healthcare in the penal milieu (Jordan, 2010). The three-way relationship between prison culture-mental health-mental healthcare is complex and influential (Jordan, 2011). Indeed, the prisoners’ experiences as mental healthcare users are inextricably linked to the nature of their existences in the prison setting, as social and institutional aspects of the prison environment affect their mental health and mental healthcare. Therefore, the term patient/prisoner is utilised throughout this article to reflect that interviewees were both patient and prisoner, and that these two aspects of their existence in the prison should not be deliberated as distinct or disassociated.
Sampling and ethical considerations

In total, 21 semi-structured interviews were conducted in a male category B prison with varied NHS healthcare centre staff, clinical and non-clinical prison staff, and patients/prisoners. This number of transcripts represents four patient/prisoner, 12 NHS staff, and five HMPS staff interviews. This paper focuses on the patient/prisoner transcripts only, as it is these interviews that produced data specifically apt for method reflection. The excerpts utilised for debate here are taken from patient/prisoner interviews and not prison staff interviews. Within these patient/prisoner transcripts, where clinicians are discussed, the genders of these members of healthcare staff are neutralised to uphold confidentiality and anonymity. This results in the “s/he” annotation within the interview excerpts. A convenience sample was utilised for this study. Prisoners receiving secondary-level mental healthcare were recruited via their Secondary Mental Health Team (SMHT). Prisoners receiving primary-level mental healthcare were recruited via their Registered Mental Nurse (RMN). Similar to healthcare in the community, this split between secondary and primary care denotes the severe and/or enduring nature of the patient’s illness. Secondary-level mental health service users were interviewed in rooms on prison wings in the presence of their clinician (i.e. a member of the SMHT); whereas, primary-level mental health service users were interviewed in rooms in the prison’s NHS Healthcare Centre in the presence of their clinician (i.e. a RMN). In general, the NHS clinicians remained verbally absent from the transcripts. However, their body language during the interviews and their physical presence in the interview rooms was considered to effect the interviews – as discussed subsequently in this paper.

Ethical deliberations were crucial for this study, as prisoners who were also mental healthcare patients were recruited. Issues concerning their legal capacity to consent were not directly relevant to this study, as the prison did not house any persons subject to guardianship under the Mental Health Act 1983/2007. However, the ethical principles stated by Murphy and Dingwall (2003) were crucial throughout the study. Murphy and Dingwall (2003) consider correct ethical practice to ensure non-maleficence, beneficence, autonomy, and justice. These four principles underpinned the conduct of the fieldwork. All participants attended interviews as volunteers. No coercion was deployed. Participants were assured confidentiality and anonymity. In accordance with the prison establishment’s request, interviews with patients/prisoners were conducted in the presence of the patient’s mental healthcare clinician. This raises questions regarding the validity of interview data, thus implications are debated in this paper. Prior to interview, the participant information sheet was reviewed verbally with the participant. The nature of their participation was outlined by the interviewer then the patient/prisoner was given the opportunity to ask questions. All points of the consent form were discussed and understanding was acknowledged by the interviewee. The consent form was then signed by both interviewer and interviewee. Regarding access, fieldwork clearance was obtained via both NHS and HMPS routes. Ethical, safety, and security rules and regulations provided by both the host prison establishment and the HMPS Psychology Research Ethics Committee were upheld.

Method and methodological analysis of interview transcripts

Prior to the analysis of transcripts, it is worth summarising the findings from the patient/prisoner interviews briefly in order to construct a backdrop for the subsequent method and methodological reflections:

Patients/prisoners report positively that relationships between themselves as service users and their mental healthcare professionals are valued highly. An enjoyable, flexible, individualised, caring, and relaxing therapeutic clinician-patient/prisoner rapport is narrated.

Clinician-patient/prisoner meetings are seen as sites of trust and experienced as comforting in a social interaction sense. Patient/prisoner power is discussed in relation to dictating the topic selection and pacing of the clinical conversation. The notion of understanding is argued to be the most essential aspect of clinician-patient/prisoner rapport.

The experience of collaborative working between patient/prisoner and healthcare professional is noted, and mental health accomplishments are perceived as multiparty achievements.
Contrastingly, genuine prisoner-prisoner rapport is noted as not often formed by the patients/prisoners in this study; connecting emotionally with wing mates is highlighted as difficult and infrequent. Notably, an absence of mental health knowledge amongst the prisoner social group is an oft repeated component of the prison social environment.

Poignantly, the NHS services and NHS staff are perceived by patients/prisoners as significantly different to HMPS services and HMPS staff. The majority of prison staff are perceived to lack sufficient mental health-based knowledge, understanding, and empathy. Crucially, it is argued that HMPS staff should possess these attributes; this is noted as in addition to their security-orientated roles and responsibilities (see Jordan (2012) for further focus on these patients'/prisoners' narratives; debated concepts include: understanding, care, trust, flexibility, cooperation, conversation, relaxation, enjoyment, and patient power).

Three transcript excerpts are now utilised to debate aspects of these patient/prisoner interviews. These three examples are selected as they introduce and illustrate the concepts for discussion well, yet also provide both the patient/prisoner and their clinician confidentiality and anonymity. Notably, the gender of the clinicians is neutralised in all quotes and identifying names/places are replaced with X.

**Excerpt 1 analysis**

Interviewer: So you make use of the mental healthcare here, at primary level, so you work with X [his clinician] here, what aspects of that do you find useful, or enjoyable, or, what do you feel is working well for you?

Participant: Just discussion. Discussing things. Like, how I feel, and [trails off].

Interviewer: So, it's almost as if you like having someone to talk to, that's what you find beneficial?

Participant: Yeah, yeah.

Interviewer: So, you must have a relatively good rapport, a good relationship, with X?

Participant: Yeah, yeah.

(Comments in square brackets added by analyst.)

Excerpt 1 demonstrates three aspects poignant to the patient/prisoner interviews.

The nature of the interviews with patients/prisoners is markedly dissimilar to the nature of the interviews with other participant groups (e.g. prison-based NHS staff) involved in the study and examples of this dissimilarity are explored in this article; indeed, the first aspect debated below exemplifies one difference.

First, the initial question posed by the interviewer appears long and unstructured, plus it also presents multiple questions to the participant. This can be regarded as a relatively poor interview question. However, what the above quote does not demonstrate is the temporal aspect to the interviewer's lengthy utterance. The convoluted question is not vocalised swiftly; rather, the interviewer speaks slowly and elaborates the nature of the question at multiple points in response to the participant's non-verbal communication. Each comma in the question can be considered an attempt by the interviewer to re-introduce the topic or purpose of the question (as a result of the participant's body language). This occurs frequently in the patient/prisoner interviews. Other participant groupings (e.g. prison governors) recognise immediately the topic and purpose of interview questions; however, patients/prisoners appear often to be unsure or unfamiliar with aspects of interview questions, and the interviewer re-phrases multiple times.

Crucially, this should not be considered a suggested flaw of the participants, but rather a failure on the part of the social scientist. The clinical and academic language utilised by the interviewer is often inappropriate for the patients/prisoners involved in this study. For example, the concept of rapport is familiar to both healthcare clinicians and prison staff due to the nature of their occupations and training; however, this concept is seemingly less familiar to patients/prisoners. There is no indication of correct or incorrect possession of knowledge intended here, but the differentiation in vocabulary and language utilised by the dissimilar participant groupings is evident in the interviews, and it is the fault of the interviewer that the questions are often lengthy, re-worded, and pose numerous questions. This issue of interview question suitability is re-raised in the implications section of this paper. For an interesting debate regarding language and power, see Fairclough (2001).
Second, the participant’s initial utterance concludes with (trails off). It is relatively common in the patient/prisoner interview transcripts for participants to construct short (and descriptive only) answers that end abruptly, trail off, or are not complete sentences. Furthermore, experiences/opinions, etc. are professed but an explanation or analysis of the situation under discussion is not often offered. This contrasts with other social groups of participants (e.g. HMPS staff) who regularly detail an issue and then provide possible reasons for its occurrence. Once again, this aspect is not regarded as problematic for the study or an error of the participants, but it does highlight the familiarity versus unfamiliarity of the distinct participant groupings involved in this study in relation to the purpose, nature, and intended outcome of interviews of this nature. HMPS prison governors, for example, recognise that when asked to debate an issue the interviewer is usually asking about its descriptive facets, but also perceived reasons for its presence, and suggested resolutions to its existence. Notably, these facets of the interview process are often assumed to be pre-existing knowledge shared between interviewer and interviewee. This presumed intersubjective approach to the interview as a mode of social interaction and a knowledge creation process is shown as not apt for the patients/prisoners in this study.

Third, the patient’s/prisoner’s second and third responses are merely one-word confirmations of the interviewer’s suggestions (concerning good clinician-patient/prisoner rapport). The validity of the short but positive affirmation is worthy of consideration, as it is possible that the participant does not identify genuinely with the content of the question but, rather, responds positively to the interviewer’s optimistic tone or encouraging body language. Moreover, it is questionable whether a patient/prisoner would critique overtly his clinician in his/her presence (particularly in a custodial environment). However, for this study, the analysis process and the conduct of fieldwork was undertaken by the same researcher; therefore, additional knowledge from the interviews is utilised to enrich and develop analysis – as the transcripts alone do not detail the experienced human-human interaction. In this example, therefore, it is evident throughout the interview as a whole that the patient/prisoner does experience an amicable, appreciated, and enjoyable clinical relationship with his healthcare professional. This is, however, demonstrated via both (recorded) audible speech and (unrecorded) body language. It is recognised that these data (i.e. body language and non-verbal interactions between clinician and patient/prisoner) could have been collected, as non-verbal social behaviour can be video recorded and subjected to video analysis in qualitative research (Heath et al., 2010). However, the utilisation of visual recording techniques for research is generally not permitted inside the UK’s HMPS establishments.

**Excerpt 2 analysis**

The nature of conversational turn-taking is striking, as during the interviews conducted with patients/prisoners the participant can be seen to interject often and verbally interact (i.e. overlap) before the interviewer’s question is completed:

**Interviewer:** So a minute ago, before we began officially, you were talking about things that you’ve found really helpful about working with X [his clinician], and you suggested things like your relationship with X, which you ﬁnd quite easy, and relaxing, and you’ve found that beneﬁcial [overlaps]

**Participant:** I do, yes. I ﬁnd that. I must say, X is very good. Very professional. I would say s/he’s very professional at her/his job. Very understanding as well, err, I’ve had some bad times, but s/he’s very understanding, and we sit and discuss it, you know. We get there don’t we [looking at X]. Eventually. At my own pace. X does it with me, at my pace.

That patients/prisoners do not adhere strictly to the turn-taking behaviour usually conformed to in an interview situation is important, as this deviation from the orthodox verbal conversation style is not evidenced in interviews with other social groups involved in this study (e.g. NHS healthcare clinicians).

Schegloff (2000) provides a detailed empirical account of verbal interaction organisation that explores the notion and effects of overlapping talk and focuses on this turn-taking behaviour in conversation. Schegloff (2000) defines interviews as a specialised form of talk-in-interaction. Turn-taking organisation represents the most common element of speakership: “one party
talking at a time’’ (Schegloff, 2000, p. 1). Turn-taking represents not politeness, but a socially organised “enabling institution for orderly commerce between people’’ (Schegloff, 2000, p. 1). Overlap management devices are debated, as multiparty simultaneous talking must cease, and the paths to curtailment are relevant. Schegloff (2000, p. 4) states:

one or more of the parties to the simultaneous talk should stop talking; and to display that it is the overlapping talk that is the grounds for stopping, they should stop talking before coming to a possible completion of the turn-constructional unit they are producing. But which one should stop? Aye, there’s the rub! That is part of what an overlap management is about.

As noted previously, interviews constitute context-specific modes of talk-in-interaction. In relation to this study, the interview transcripts demonstrate that it is always the interviewer who ends their utterance in order for the interviewee’s speech overlap to continue and reach its intended fruition. As suggested above by Schegloff (2000), the interviewee’s affected utterances can be seen to exemplify the lack of complete turn-constructional unit production. It is always the patient/prisoner that overlaps and always the interviewer who resolves the turn-taking irregularity.

This talk-in-interaction device utilised by the researcher does not represent a planned aspect of the interview process; however, neither does it symbolise a process that the interviewer practices intentionally once the fieldwork is underway and this facet is recognised. Instead, it is only on reflection during the analysis phase of the study that this feature is noticed and considered.

Arguably, this aspect of the patient/prisoner interviews demonstrates a tacit method tool permitting interviewees to emit the maximum volume of knowledge (i.e. opinions, ideas, perceptions, beliefs, etc.), and at a juncture in the interview dictated by the participant. This hints at interviewer politeness, consideration for participants’ views, and an attempt at interviewee agency provision in the social interaction – all laudable pursuits.

However, there are also perhaps additional – almost deviant in comparison – reasons for this action. To generalise, interviews are conducted for the benefit of the interviewer and their study (e.g. resolution of social issues, social change, patient care developments; changes in healthcare practice; academic publications, future funding application beneficial ramifications, career progression, etc.). It could perhaps be argued that social science interviews are not wholly altruistic pursuits. Therefore, there is sense in permitting an interviewee to produce speech (i.e. data) whenever they wish, as all participant utterances possess potentially study-relevant knowledge. When an overlap occurs, interviewer utterance curtailments could be seen to represent action that allows the researcher to wield the maximum volume of data for analysis and, therefore, acts as a – slightly devious – method tool (albeit conceivably unintentionally).

Returning to excerpt 2, another aspect of interviewing persons who are unfamiliar with the research interview as a process of social interaction is demonstrated. In this instance, as soon as the patient/prisoner enters the interview room he commences praising his clinician and the nature of the mental healthcare provided before the digital voice recorder is turned on, the consent form has been signed, etc. This is not a suggestion that the participant is at fault in any way, it is just to highlight the unfamiliar nature of the formal interview process for the patients/prisoners interviewed in this study.

As excerpt 2 demonstrates, the participant in this interview turns often to his clinician for non-verbal communication interactions (these consist of his clinician smiling and nodding in an enthusiastic and encouraging manner). This interaction – notably set in motion by the patient/prisoner – appears to act as affirmation of a certain issue’s occurrence (e.g. a mental health service user’s diagnosis), but also a form of corroboration concerning a joint successful act (e.g. effective clinical discussion of traumatic events). The non-verbal communication exemplifies an appeal for event verification, but also authentification of patient/prisoner – healthcare professional collaborative working. Here, the clinician’s involvement in the data creation process is considered to be of importance for the interviewee. For this study, these interactions in the interview from the patient’s clinician appear to represent overt encouragement for the patient, and to reassure them that their
interview performance is apt, correct (factually), and of worth. For these patients/prisoners, the presence of their clinicians in the interviews is experienced as providing appreciated support during the interview process.

Notwithstanding this positive aspect of the clinician’s presence as noted in this study, it is of course possible that restrictive or negative ramifications may occur when interviewing patients alongside their healthcare providers – particularly in a custodial environment. This issue is debated at length elsewhere. Thus, for this work, it is worth highlighting that participants utilise manners, language, conduct, and communication modes that are exceedingly polite and respectful towards interviewer and clinician. Whereas, where issues concerning the prison establishment or prison staff are described, the tone and idiom of the discussion is not as reserved and courteous. Therefore, patients/prisoners in this study did feel able to discuss negative experiences and attitudes regarding their prison existence. Indeed, where narrating aspects of the prison regime, these interviewees express numerous development suggestions and critical reports.

Excerpt 3 analysis

Interviewer: So you make use of healthcare obviously here, via X [his RMN], it’s primary mental healthcare, did you use this service when healthcare was based over in the old area?

Participant: I did use the old centre, but it’s this new one now only, yes.

Interviewer: What is it that you prefer here?

Participant: It’s more like a hospital environment.

Interviewer: So, more, sort of, like, a therapeutic setting?

Participant: Yeah, yeah.

In relation to the $R$ sections in the patients/prisoners’ interview transcripts and the associated analyst comment in italics above, the study’s Consent Form contains the paragraph: “All participants are reminded that any disclosure of Prison Rule breaking, criminal activities and/or harm to self or others would be reported to the Governor. In addition to this, the Security Department reserves the right to review the interview transcripts for such instances and/or any other concern which could be indicative of a threat to the security of the prison”. The content of the Consent Form is prescribed by the host establishment. Prisoners read this section prior to consenting to the interview. This stipulation is also explained verbally by the interviewer. Furthermore, prisoners are made aware that the prison’s Security Department will read all transcripts. This is a requirement of the host prison. However, on occasion, prisoners begin to discuss potentially difficult issues (e.g. criminal convictions). Where this occurs, the interviewer alters the topic swiftly.

At this juncture, it should be noted that no information relevant to the security, safety, etc. of the prison establishment was discussed by prisoners, and that no prisoners divulge information pertaining to the issues stated on the Consent Form that would initiate Governor involvement.

However, the aforementioned situation is potentially problematic for researchers working in custodial environments, as they can experience two different forms of – moral and ethical – allegiances. In this study, the social scientist has a duty to adhere to the host prison’s Security Department stipulations and the HMPS Psychology Research Ethics Committee rules and regulations. However, the interviewer also experiences an interest in the patient/prisoner’s future welfare in the prison establishment. Therefore, a situation where negative ramifications occur for the patient/prisoner as a result of the prison’s Security Department reviewing a transcript and taking action is to be avoided. Ethical research practice reiterates repeatedly the notion that no harm should come to participants as a result of research involvement. Furthermore, in this study, the interviewer does not wish to be perceived by patients/prisoners
as a potential informant to the prison. Had this been the case, securing interviews with patients/prisoners may have been problematic. The approach adopted in this study aims to avoid any difficult situations – concerning the transfer of prison security-relevant information from patient/prisoner to prison and resultant implications for the participant – by intentionally circumventing any such topics during interview.

The R sections in the patients’/prisoners’ interviews can also denote a section of transcript removed due to a lengthy period of subject irrelevance. It could be argued that all utterances in an interview should be transcribed, as final codes/themes are not generated until the post-fieldwork stage, and therefore these data may become relevant. However, this particular prison study posed significant transcribing difficulties and limitations, due to the nature of the custodial environment and the prohibited use of transcription software and devices in the prison. It was a requirement by the establishment that transcription was conducted on site. Therefore, the omission of prolonged sections of speech that do not relate to mental health, healthcare generally, prison culture, etc. is considered appropriate for this doctoral work. However, it is recognised that certain methodological approaches (e.g. life history, narrative enquiry) would necessitate the inclusion of these data.

To exemplify the occurrence of one type of R section: the patients/prisoners interviewed in this study appear occasionally to regard the interview as an apt opportunity to profess any issues or grievances associated with their lives more generally in the prison establishment. Although it is stressed by the interviewer that the discussions are to focus on the nature of mental health broadly defined in the penal setting, problems not related to mental healthcare are introduced and outlined by patients/prisoners (e.g. the request for the removal of cabbage from the diet). Thus, it is possible that the interviewer may have represented a potential source of issue resolution for these patients/prisoners. However, pre-interview, it was made clear that the interviewer could not resolve any problems professed during the interview. Nevertheless, at certain junctures during the interviews it was necessary to reiterate that, even though the patient/prisoner was devoting their time and knowledge to the study, no changes to their mental healthcare or treatment in the prison more generally was likely to occur as a result of their involvement. This is mentioned here not as a report of a problem with the interviews, or as a record of unbefitting interviewee behaviour (as neither of these are considered to be the case), but to re-illustrate the lack of familiarity with this form of interview process and both its intended and feasible outcomes.

Implications for mental health education, training and practice

- Usage of clinical language or theoretical concepts in interview questions with healthcare users should be appropriate to the particular patient grouping; however, this represents a convoluted pursuit, as sample groups are not homogenous entities with one distinct vocabulary and knowledge skills set.

- Arguably, there is need to recognise the unfamiliarity of the social science interview as a form of social interaction and as a knowledge creation process for some research participant groupings.

- The conduct of ethically fitting interview practice is exceedingly complex; however, a focus on the specific sample group and the creation of culturally responsive interview techniques represents a worthy endeavour. Just as context is crucial to the provision of wholly apt prison mental healthcare (Jordan, 2010), so context is crucial to the practice of wholly apt prison mental healthcare research. Nevertheless, this endeavour is somewhat problematic, as the submission of interview guides to research ethics committees is often required before access to the secure setting is permitted. Thus, at this pre-fieldwork stage, the interviewer may have little or no experiential knowledge of the specific social and structural contexts at the fieldwork site and/or the specific sample group.

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Further reading


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