School of Medicine

FACULTY OF INTERNATIONAL HEALTH
AND DEVELOPMENT

The Feasibility and Acceptability of a Peer-Support Group Therapy for Mental

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ABSTRACT

Introduction

Mental health is known to be in much higher prevalence in prisoners than the general population, yet they have a much higher unmet need for access to treatment, which is especially true for low-middle income country (LMIC) prisons. Since the election of President Duterte in 2016 his "war on drugs" has significantly increased prison population levels and pretrial detention lengths, therefore mental health support is needed more than ever. This shows the importance of investigating the acceptability and feasibility of a peer-support group therapy in this context.

Aim

To assess the feasibility and acceptability of implementing and facilitating a group therapy for mental health in Filipino prisons.

Methods

Data collection occurred through observations and semi-structured interviews. Participants recruited included six secure-environment healthcare workers, eight prisoners and six ex-prisoners. Both prisoners and ex-prisoners were identified through gatekeepers and informed consent was gained. Interviews were transcribed before coding and themes identified. Ethical approval was granted.

Findings

Bureaucracy and corruption were the main barriers to the potential successful implementation of a peer-support group therapy, which were emergent themes and unexpected to be so significant. Space, time and staff were all themes identified that may help facilitate the group. It was noted that there is a significant lack of knowledge surrounding what mental health is and its causes. Stigma and discriminatory actions were also noted by many participants as barrier to the group.

Discussion

There were many differences found between the current literature on feasibility of healthcare in prisons to what was found in this project. This can be explained by the current database being heavily informed by research in high-income country (HIC) prisons. However, attitudes found in this project were concurrent with this database, with an emergent theme of a few participants showing basic knowledge on mental health. Criticisms of this project include significant exposure to respondent and social-desirability bias throughout data collection.

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LIST OF ACRONYMS

LMIC – low-middle income counties

HIC – high-income countries

WHO – World Health Organisation

NGO – non-governmental organisation

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GLOSSARY

Recidivism – the tendency of a convicted criminal to reoffend.

Forensic Clinical Staff – clinical staff that work with prisoners.

Social Desirability Bias – when participants respond to questions in a way that they believe will be viewed favourably by others.

Respondent Bias – when participants respond to the question untruthfully in order to provide an answer in which they believe the interviewer will approve of.

Stigma – a mark of disgrace against a person for having an attribute.

Cell Leader – an elected cell mate that oversees that cell.

Barangay – the local non-official police in the Philippines.

Jail Warden – the leader of that prison.

Lockdown – when prisoners are locked in their cells in order to prevent riot or unrest.

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To add, I am grateful to everyone at the Philippine Outreach Christian Ministries for their help during my stay and welcoming me into the team.

GROUP PROJECT STATEMENT

This project was originally designed with the intent of being completed singularly. However, due to many data collection complications, interviews with ex-prisoners and prisoners had to be combined with 200830745, which is explained within methodology limitations. Interview questions were not altered, each researcher's questions were joined end-to-end, however the information sheets and consent forms were combined. Interviews with healthcare workers at Integritas Healthcare and observations of their prison clinics were completed alone and no changes were made. Data from 200830745's interview questions were not transcribed or used in the production of this report.

1.INTRODUCTION

1.1 Mental health in prisons

In prisons the prevalence of severe depression is up to 10-12%, which explains how suicide rates are estimated to be five times higher than the general population (Fazel and Yu, 2011). However, unlike the general population, prisoners have a high unmet need for mental health support, where around the world 33% receive no treatment at all (Trestman et al, 2007). This can be estimated to be even

worse in LMIC prisons, as they have more of the factors described by WHO and the International Red Cross as being detrimental to mental health (Sarkin, 2015). These include (Beynon and Drew, 2016):

- Overcrowding
- Violence
- Enforced solitude or lack of privacy
- Inadequate health services

The consequences of this are high levels of stigma from officers/prisoners, higher risk of suicide and recidivism (Binswanger et al, 2011; Baillargeon et al, 2009). In a review, prisoners were found to be 40% more likely to reoffend if they were mentally ill, showing that treatment plays an important part in their rehabilitation and keeping occupation levels down, which is particularly important in LMIC (Fazel et al, 2011). However, there is a significant dearth in the literature surrounding mental health in LMIC prisons, and reviews have recommended research be done in this setting (Fazel and Seewald, 2012).

1.2 Philippine Prisons

Since election in 2016, President Duterte has enforced severe policies towards drugs and associated crime, including extrajudicial executions (Reyes, 2016). This "war on drugs" has undoubtably increased the prison occupancies to a national average of 463.6%, which is the highest throughout Asia, and the length pretrial detentions (Simangan, 2017; WPB, 2018).

Unfortunately, mental health provision in Filipino prisons is almost non-existent. Only 20% of prisons have at least one prisoner-per-month in contact with a professional for their mental health. To add, less than 20% of prison officers have participated in mental health training in the last five years (WHO, 2006). Therefore, provision often falls to non-governmental organisations (NGOs) and international organisations, such as *Integritas Healthcare,* my host NGO.

1.3 Attitudes towards mental health in the Philippines

The Asian culture is unforgiving towards mental illness. It is seen as a disease of the family and any association devalues the family name (Tanaka et al, 2018). This isolates the sufferers into not talking about problems, making the topic 'taboo', due to these severe social consequences. This stigmatising behaviour is even seen in medical professionals, meaning creating a rapport with mentally ill

prisoners to discuss their issues is difficult due to their fears of discrimination (Lauber and Rossler, 2006). Therefore, is it uncertain how acceptable a group therapy for mental health will be for the prisoners and the officers involved.

Considering this, understanding whether a group therapy will be logistically feasible and acceptable in this cultural context will add to the lacking knowledge on this topic.

2.AIM AND OBJECTIVES

2.1 Aim

To assess the feasibility and acceptability of implementing and facilitating a group therapy for mental health in Filipino prisons.

2.2 Objectives

1. To identify the logistical issues faced in implementing and facilitating healthcare in Filipino Prisons
2. To explore attitudes towards the potential implementation of a peer-support group therapy for mental health in Filipino Prisons
3. To provide logical recommendations from my findings to aid in the set-up of future peer-support group therapies for mental health for prisoners in the Philippines

3.METHODS

3.1 Data Collection

A qualitative approach was taken to provide enriched information and give voice to those whose experiences are rarely heard (Bryman, 2012).

Data collection occurred throughout June 2019. Five observations of clinics at four prisons occurred across Luzon in the Philippines, including:

- Olongapo 164
- Pampanga
- Iba (two observations)

- Angeles

Twenty semi-structured interviews were carried out with six healthcare workers, eight prisoners from jail A and six ex-prisoners from Calapandayan (the local area). Interviews with secure-environment healthcare workers occurred at Integritas House, as it is a central building for all workers whilst volunteering in the Philippines; with ex-prisoners at participants homes; and with prisoners on a separate table in the same room as the clinic. These were the only feasible options for data collection to occur.

An interpreter was required for interviews with the ex-prisoners/prisoners. A professional interpreter would have been desirable to avoid potential bias, but this was only possible for three ex-prisoners, due to short notice. For the other three interviews with ex-prisoners the caretaker of my host's property was used. These interviews were checked by a professional interpreter to ensure quality of data. Any questions interpreted inaccurately were discarded. Interviews with prisoners in jail A were interpreted by a prisoner with good English. Prior to data collection the interpreter was briefed on the importance of respecting participant confidentiality and the sensitivity of the topic.

Interviews lasted between 10-30 minutes and observations were determined by the length of the clinics. Consent for interviews to be audio-recorded was sort after and gained before data collection. The interviews were semi-structured and guided by previous study approaches to avoid potential influence of participant responses, shown in appendix. A pilot interview with one healthcare worker and one ex-prisoner took place to ensure the data produced was focussed towards the aim, but no changes were made. 200830745 was present for all interviews with ex-prisoners/prisoners.

3.2 Sampling

Secure-environment healthcare workers were recruited by a purposive-convenience technique. A gatekeeper was not required due to ease of accessibility to this population due to shared accommodation. This could have incurred respondent bias (Bryman, 2012). No declinations.

Prisoners at jail A were recruited through a purposive-convenience technique, through a gatekeeper. Mental health sufferers were identified through the clinic being ran by Integritas and asked to participate in the study. The gatekeeper could have incurred respondent bias, as she was a caregiver to them (Bryman, 2012). More eligible prisoners were also identified through a snowball technique. However, this created a highly unrepresentative sample as the clinic was ran in the women's sector and participants were mainly being drawn from one cell. There was one declination due to illness.

The ex-prisoners living in Calapandayan were recruited by purposive-snowballing technique through a second gatekeeper, who was the caretaker of our host's property. He was essential in helping us effectively identify and gain the trust of the ex-prisoners in this local area to carry out these interviews at short notice. However, this does expose the data collected to potential biases as he was well-known in the area. Two participants declined to take part; one due to sensitivity of the topic and one due to fear of re-arrest.

Inclusion criteria for prisoner/ex-prisoners:

- Mental illness
- Mental capacity to give informed consent
- Not vulnerable or known to be violent
- Over 18 years old
- Currently or previously detained

3.3 Ethical Considerations

Information sheets and consent forms were provided to participants 48 hours prior to data collection, shown in appendix. Withdrawal without consequences, anonymity and support available to them was reiterated at the start of every interview.

Ethical approval was granted by the University of Leeds prior to data collection. In-country ethical approval was granted through my host Dr Rachael Pickering.

3.4 Data Analysis

The audio recordings of interviews were transcribed naturalistically as soon as data collection finished. This was quality assured as they were re-read with the audio recordings. Analysis was iterative as all interviews were read twice to find initial ideas and then to form codes. From these, emerging themes were identified, and codes were submitted to a thematic framework to organise data, shown in appendix. This was to ensure informed conclusions were drawn and that the themes were grounded in data.

This method avoided having a guided view of the data from existing literature and allowed participants answers to be fully coded (Oliver, 2005). A thematic approach was chosen as it is flexible to be inclusive of incidental findings and is a method that a first-time researcher can confidently use (Braun and Clarke, 2006). Using data from both observations and interviews, which included

healthcare workers, prisoners and ex-prisoners, a comprehensive understanding of the situation was gained. When data from these sources were contradictory, both were used to inform findings.

3.5 Limitations

On arrival to the Philippines changes to data collection methods occurred. This is because the warden of the prison was replaced and therefore our permissions had been revoked. Consequently, the group therapy being assessed could no longer take place within the prison and the research topic shifted to a prospective view. This also meant that interviews with prison officers could not occur, who would have been some of the most information-rich participants. Many alternate options fell through, causing data collection to occur over three days and saturation was not reached.

Observations of clinics only occurred in prisons where my gatekeeper had strong relationships, producing bias data. To add, interviews at jail A took place within close range of prison officers which could have affected participants responses due to social desirability bias. The researcher was provided with uniform from Integritas, which was the sole provider of the participants healthcare, therefore when asking about attitudes towards a group therapy to be provided by this organisation, it is possible this incurred response bias (Bryman, 2012).

It is important to note the inexperience of the researcher. Many of the questions and prompts became leading in ensuring a useful answer from participants, see example in appendix. Also, as the topic was sensitive, drawing in-depth answers from the participants was challenging and rich data may have been missed. This was exacerbated for prisoner/ex-prisoner interviews as having to combine with 200830745 increased the interview length, therefore participants began to lose interest.

There are situational limitations to note. Many of the interviews were interpreted through a lay person which creates inaccuracies. In interviews with two of the ex-prisoners in Calapandayan, a local man who was a part of the Barangay (the non-official police) insisted on being present. This may have significantly affected the responses of those participants in discussing problems faced in prison.

Due to the inaccessibility of the prisoners/ex-prisoners, respondent validation was not logistically feasible. This means themes were not completely cross-checked, which increases validity of conclusions of researchers' interpretation (Barbour, 2001).

4.FINDINGS

Findings are presented according to themes found from interviews and observations. Each direct quote from transcripts is labelled with the participant code (HCW = healthcare worker, EXP = ex-prisoner, PRN = prisoner).

4.1 Feasibility

4.1.1 Space

Three healthcare workers, one ex-prisoner and observations from two prisons deducted that there would always be a space available for a peer-support group therapy, even if the space may not be appropriate.

"the spaces they have are different, but we've always managed to find somewhere' – HCW4

However, four healthcare workers and one ex-prisoner denoted feasibility issues with the space provided that would not be considered in Western prisons.

"sometimes there's been a dog fight next to us" – HCW1

"in the monsoon season the area where we normally work suddenly gets flooded" – HCW2

A space was not prepared on observation at the remaining two prisons, one due to the usual space not being available and the other as the officers were reluctant to permit entrance due to a significant dispute between prisoners and officers occurring.

4.1.2 Staff

All six healthcare workers denoted times when the prison officers facilitated the running of the healthcare services they were providing. This was supported by what was viewed at observation of clinics at three of the prisons, where everything was prepared for the clinic to begin straightaway and refreshments were provided to clinical staff.

However, due to the incompetence of officers sometimes this facilitation was often a hinderance. To add, no comments described helpful staff in the implementation stage. Two healthcare workers described problems with officers:

"you will arrive to find they have decided that they thought it would be much better that you do your clinic somewhere else apart from where you stipulated in your letter" – HCW2

they'll keep their eyes on you and make sure that you're not like trying to figure out stuff about the prisons" – HCW5

Observation of jail C showed significant problems, to the extent the clinic was almost withdrawn due to tension between lead prisoners and officers.

Barriers to the feasibility of the clinics in this setting were also created through the lack of professionalism of prison officers. For example, respecting confidentiality and controlling prisoner's behaviour was not well managed. This was noted by two healthcare workers and observed in two prison clinics.

"they assume that certain conditions they have a right to know everything about and mental health is one of those" – HCW2

4.1.3 Time

When clinics have been established and agreed upon, allotted time for the clinics was generally maintained, as described by three healthcare workers and was noted at all observations. It was clear the healthcare workers decided when the clinics would end, and many overran due to high demand. However, the dates on which these take place may vary depending on organisation of the prison.

"some days they be like oh you can come this day but then next week you won't be able to go that day" – HCW4

4.1.4 Bureaucracy

This was the main barrier to feasibility noted in data collection. Three healthcare workers, two prisoners, one ex-prisoner and one observation at jail B highlighted problems with bureaucracy. This seemed to be a recurring problem especially during the implementation. The Philippine prison system is centred on a strict hierarchy and it is their main priority to appease this, whatever the consequences are.

"one thing is the prisoners don't really talk when the guards are really close, there is sort of a hierarchy and some of them look like they're scared of the guards"- HCW2

"every time a warden is replaced, they will scrap all their predecessors' permissions and plans and everything, which means we have to start again" - HCW1

"if the mayor is coming it would look better on the warden to make the prisoners dance for him, and the healthcare can go hang" - HCW3

From observation of jail B and enquiry as to why the clinics was only run in the women's section of the prison, HCW2 stated that the male officers struggled with a woman in a position of authority, and as Integritas has a female clinical executive the officers were difficult. This caused the clinic to drop out of the male compound of jail B.

4.1.5 Identification of need

This was mainly raised as a barrier logistically due to reliance on cell leaders to bring forward the neediest patients, therefore prisoners are filtered before clinical staff can triage. This is exacerbated by lack of insight prisoners have to their mental health and what a doctor can help with.

"there could be someone in their cell that's really ill that they choose not to give you" – HCW1

At jail D, lesbians are separated into a different cell and none were being brought forward for triage. Many of them were found to have the most severe needs when investigated, showing how this can be a significant barrier.

4.1.6 Corruption

This was a barrier for identifying the neediest patients, as three healthcare workers and two ex-prisoners describe officers accepting bribes and tolerating discriminatory views towards mental illness from gangs. This can significantly hinder the success of a peer-support group for mental health, as the most in need may not be reached or gang culture can uphold significant resistance to its implementation.

"sometimes in the jails they put forward the prisoners that are in the highest social standing who need medical treatment, but these might not be the most severely unwell people" - HCW6

4.2 Attitudes

4.2.1 Knowledge

Knowledge from prisoners/ex-prisoner communities in the Philippines was lacking, aside from a few individuals.

It was noted that participants understood mental illness as people with severe untreated conditions, such as a schizophrenic that is very psychotic. While milder forms of mental illness such as

depression was termed as 'emotional or spiritual distress'. There was a strong link between religion and feelings associated with poor mental health, therefore help was often sort after from a pastor. Every participant interviewed highlighted a problem with lack or no knowledge on mental health, shown in table 1.

Table 1. Examples of prisoner/ex-prisoner ideas about mental health

Participant code	Quote
PRN1	"so all I understand is physical health"
PRN4	"bad experiences cause it"
PRN6	"mental illness is when you're crazy" "hunger causes it"
PRN7	"actually, I have no idea about mental health"
EXP1	"mental health is behaviours and drugs cause it"
EXP2	"it's caused by a weak mind, family and thinking too much"
EXP4	"drugs maybe"
EXP6	"when you have the ability to beat someone up" "it's caused by boredom"

However, three healthcare workers, three prisoners and on observation of jail B, basic knowledge of mental health had been noted.

"I know it's a mental disorder which umbrellas probably depression, schizophrenia, obsessive compulsive and it's caused by emotional and environmental factors" - PRN3

4.2.2 Attitudes towards group therapy

When prisoners/ex-prisoners were asked how they felt about a peer-support group for mental health and whether they would join, the response was significantly positive. Seven prisoners and five ex-prisoners stated they thought it was a good thing and that they would join. This is supported by the healthcare workers predictions.

because there are a lot of people who are suicidal in here and that would be a comfortable place for them to talk to people" – PRN8

"it's good because you would talk about it and there is nothing else" – EXP4

However, seven prisoners stated how they would fear other prisoners' attitudes towards them, if they did join.

Negative responses towards the group therapy was from officers due to suspicion and prisoners not involved due to jealousy. This was stated by two healthcare workers and one ex-prisoner.

"I think the officers won't accept it because they don't want everyone to say bad things about the officers" – EXP2

4.2.3 Stigma

From participants responses it is clear there is a significant stigma towards mental health in the Filipino culture, by use of derogatory terms and discriminatory actions. Two healthcare workers denoted terms that are used to describe mentally unwell people, which included crazy, retarded and insane. These terms were used by all the prisoners in the interview and one ex-prisoner.

There were 22 accounts of discriminatory actions recalled from 20 interviews, denoted by four healthcare workers, three ex-prisoners and three prisoners. This included exhibiting prisoners to beyond inhumane living conditions and deliberately causing harm.

"they put the mentally ill prisoners in a tiny tiny cloakroom with no water no light" – HCW1

"mentally ill men that had been kept in the dark for about 5 years… one of them was rubbing his finger down to the bone on the bars, in order to self-stimulate to remind himself that he was still alive" – HCW2

"they're in the separate cell I know it's not good, but I haven't seen it" – EXP5

All healthcare workers, seven prisoners and three ex-prisoners noted times where they experienced or witnessed stigma.

"he said they're bad people anyway and bad people shouldn't get good healthcare" – HCW2 paraphrasing a prisoner

"There is just one person with mental problems, so we just didn't take notice of them and we didn't talk about it" – EXP1

This shows the strong negative and ignorant view towards mental health that would need to be overcome in order to convince officers and fellow prisoners that providing support is a positive step. This could be a large barrier to overcome before a support group of this kind could be implemented.

5.DISCUSSION

The findings will be discussed in comparison to existing literature and its relevance to international health, as well as critiqued. Researching the feasibility of healthcare in Filipino prisons is a very specific topic, therefore the literature base is notably lacking, and comparisons have been drawn from prisons worldwide, including HIC. Attitudes towards mental illness including knowledge and stigma have been compared to findings from research done in the Philippines, however attitudes towards the group therapy again cannot be compared due to its specificity.

5.1 Feasibility

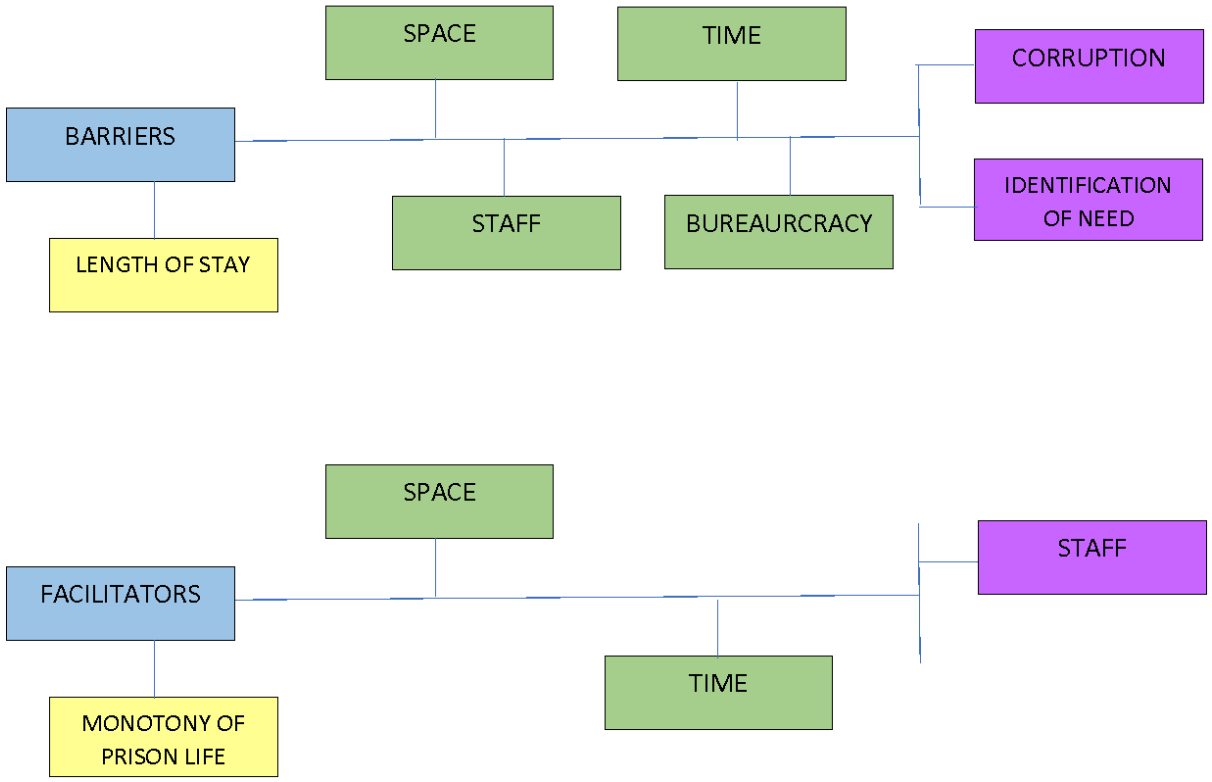

Figure 1. Feasibility themes. (Key – blue = topic, yellow = literature review only, green = both, purple = emergent themes)

5.1.1 Barriers

Figure 1 highlights how length of stay was a barrier to successful running of psychological therapies found by Bilderbeck et al (2013) and Pratt et al (2015) but this was not found in this project. This is explained as the two studies from the literature review were both based in England where approximately 70% of prisoners are released before four years and only 46% were serving the full length of this sentence (Sturge, 2018). Whereas in the Philippines, pretrial detentions can last on

average 528 days, therefore participants would more than likely be available for the whole of the group therapy even before justice (Narag, 2018).

Space, time, bureaucracy and staff were all concurrent themes found from both the review and in fieldwork. These were barriers in both but often for different reasons; for example, in the Philippines staff would be a hinderance by lack of professionalism, but in the review it was due to underemployment or disciplinary acts such as 'lockdowns' (Johnson and Zlotnick, 2012; Hutchinson et al, 2017; Moore et al, 2018; Wolff et al, 2012). These reasons for problems with officers facilitating the healthcare would never have happened in the Philippines as it was clear there were more officers than required and the prisons didn't have the facilities to run a 'lockdown'. This highlights the lack of generalisability of results found from research in prisons internationally, due to their uniqueness in facilities and judicial systems. If more studies have been completed on feasibility of healthcare in LMIC's, it would be interesting to note whether these barriers are concurrent in all under-resourced prisons, and therefore is a recommendation for future research.

Corruption and problems with identification of the neediest prisoners were not expected to be as significant barriers as they were in the successful running of healthcare in Filipino prisoners. These were emergent themes, however as already noted most of the literature is based in HIC prisons, therefore this may not have been emergent in comparison to other LMIC prisons.

5.1.2 Facilitators

Unlike the barriers, the facilitator themes found in both the review and fieldwork were grounded from similar reasons, as discussed in the findings. More interestingly, monotony of prison life was noted in the review by Mak and Chan (2018) and Eseadi et al (2017) as facilitators of the successful running of the therapies, which were based in HIC where the ability to provide a fuller timetable is feasible, but this was not noted by participants in the Philippines. However, monotony of life was not specifically asked in this research, which it may have been in the studies from the review, increasing its likelihood of it being reported. This could also be the reason why staff was an emergent theme from the review.

5.2 Attitudes

The findings from this research regarding attitudes towards mental illness in the Philippines was concurrent with the literature. Tanaka et al (2018), Alonso et al (2008), Rivera and Antonio (2017), Tuliao (2014), Boling et al (2018), Lauber and Rossler (2007) and Seeman et al (2015) all noted

significant stigma towards mental illness in Filipino culture, stating similar problems such as the use of derogatory terms and discriminatory actions.

However, basic knowledge on mental health was noted as an emergent theme in this project. This could be because the studies included in the review were at the latest conducted in 2017 and since then positive changes in the knowledge base may have occurred. This was noted by one of the participants as being due to the recent influence of social media. This could be an interesting future research topic.

Attitudes towards the group therapy proposed to prisoners/ex-prisoners was significantly positive, even though stigma was acknowledged as a barrier. This finding however must be taken with precaution due to response and social desirability bias that was not controlled in data collection, as discussed in methodology limitations. This is a significant criticism of this research.

6.RECOMMENDATIONS

From the findings and discussion four SMART recommendations have been developed, specifically with the aim of aiding the future implementation of a peer-support group therapy.

1.Mental Health Education in Prisons

To provide a mental health lecture once a month by 2020 in the prisons where the group therapy is taking place for all prisoners and officers.

- This will require permission and support from the national police and wardens of the prison
- A committed and knowledgeable teacher
- To be primary school standard
- Use the techniques POCM use to preach

2. Stigma Reduction Seminars

To provide seminars on stigma reduction once a month by 2020 in the prisons where the group therapy is taking place for all prisoners and officers.

- This will require permission and support from the national police and wardens of the prison
- A committed and knowledgeable teacher
- To be culturally appropriate

3. ‘Emotional Support’

To name the peer-support group therapy in terms of ‘emotional support’ to be culturally appropriate and potentially more successful, by 2020.

- Promote the group therapy in the prisons
- Identify prisoners who have a need for the group
- Inform officers and prisoners what ‘emotional support’ means and who/how they may benefit

4. Future research

Consider researching the positive and negative effects of the peer-support group therapy on the well-being of the participants and attitudes towards mental health throughout the prisons it has been implemented.

- Propose to a future International Health BSc student from the University of Leeds
- Ethical and risk assessment approval sort after
- Recruit participants through gatekeeper at Integritas with specific inclusion criteria (participants took part in this research project in order to obtain meaningful comparisons)
- Findings to appraise the support group to ensure its usefulness and to guide its future within the prisons

7.CONCLUSION

The findings highlighted many barriers but with perseverance this peer-support group therapy could be feasible. The main barriers that will be difficult to control are bureaucracy and corruption, however once approval from jail wardens is provided there should be no problems with staff or time allocated for the facilitation of the therapy. There is still a significant amount of stigma and discrimination towards the topic of mental health, as far as complete ignorance. However, this project has hopefully noted the beginnings of change in attitudes, even though there is a long way still to go. The peer-support group therapy will be reducing a high unmet need for mental health services in these prisons and if ran successfully with positive effects, will be an example for other prisons across the Philippines and other LMIC prisons.

8.REFLECTION

Planning and Fieldwork

I want to specialise in Forensic Psychiatry, therefore this project proposed by the University was perfect, especially as I was apprehensive about organising the project due to my inexperience. Unfortunately, my host experienced significant misfortune on the run up to our arrival, which led her to become uncontactable from December up until we arrived in the Philippines. This meant that I had no confirmation of my project or how I was going to collect data, which was highly unnerving and minimal planning could be done. If I had organised this myself, I would have re-organised my project with a different host, but as the University was confident and consistently reassuring due to many years of their successful partnership, I committed. On reflection, this significantly affected the quality of data collection as nothing had been organised and it was rushed in the last three days of my fieldwork due to my host's struggles. This was out of my hands as I was completely reliant on my gatekeeper in this context.

To add, I had to be completely versatile on my project topic as it was changed multiple times throughout fieldwork due to data collection options not being organised. This taught me how to stay motivated and dedicated to the research even after multiple setbacks.

In future, I will have the confidence to be more independent in my planning and decisions regarding alterations of my research project. I will listen to advice but remember that I am able to make the final decision regarding what I think will be best. Ultimately, this has matured me significantly in my decision-making skills and how I view my academic path, from a student to a researcher.

Writing

Having never completed qualitative research previously, I read heavily into the correct methods and techniques. I had minimal problems with thematic analysis in identifying codes and organising them into a framework. I felt it was logical and allowed my findings to present themselves easily. Therefore, in future I feel confident in writing up a project like this again and look forward to developing these skills further.

Even though I experienced significant setbacks and challenges in my planning and fieldwork, having the opportunity to see inside Filipino prisons and complete interviews in some of the most horrific

conditions people could be exposed to living in, I am truly grateful for. It has opened my eyes to the extreme poverty that exists in parts of the World, and how important doing projects and research alongside my clinical work is, however small. My host is a role model of this attitude to ensuring that as doctors we try to make a difference to those in the most need. I am excited to see how this shapes my future career.

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APPENDICES

Example consent form and information sheet for HCW

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Faculty of Medicine and Health, School of Medicine,
Leeds Institute for Health Sciences

Consent form – Interviews

Secure Environment Healthcare Worker

Consent to take part in: **The feasibility and acceptability of a Peer-Support Group Therapy for Mental Health in Filipino Prisons**	Add your initials next to the statement if you agree
I confirm that I have read and understand the information sheet dated _____ explaining the above research project and I have had the opportunity to ask questions about the project.	
I understand that my participation is voluntary and that I am free to withdraw without giving any reason and without there being any negative consequences up	

until 48 after interview. In addition, should I not wish to answer any particular question or questions, I am free to decline. Lead researcher: Bethany Platford Email: hs18bp@leeds.ac.uk Telephone: 07803741492 Host: Dra Rachael Pickering I understand that any information recorded during an interview will be securely discarded should I choose to withdraw from the study following the interview, up until 48 hours after.	
I give permission for members of the research team to have access to my anonymised responses. I understand that my name will not be linked with the research materials, and I will not be identified or identifiable in the report or reports that result from the research. I understand that my responses will be kept strictly confidential.	
I agree for the data collected from me to be stored and used, which may be in the form of audio recording, in relevant future research in an anonymised form.	
I understand that other genuine researchers will have access to this data only if they agree to preserve the confidentiality of the information as requested in this form.	
I understand that other researchers may use my words in publications, reports, web pages, and other research outputs, only if they agree to preserve the confidentiality of the information as requested in this form.	
I understand that relevant sections of the data collected during the study, may be looked at by auditors from the University of Leeds where it is relevant to my taking part in this research. I give permission for these individuals to have access to my records.	
I agree to take part in the above research project and will inform the lead researcher should my contact details change during the project and, if necessary, afterwards.	

Name of participant	
Participant's signature	
Date	
Name of lead researcher	
Signature	
Date*	

to be signed and dated in the presence of the participant.
Once this has been signed by all parties the participant should receive a copy of the signed and dated participant consent form, the letter/ pre-written script/ information sheet and any other written information provided to the participants. A copy of the signed and dated consent form should be kept with the project's main documents which must be kept in a secure location.

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Faculty of Medicine and Health, School of Medicine,
Leeds Institute for Health Sciences

Secure Environment Healthcare Workers Information Sheet

Project - The feasibility and acceptability of a Group Therapy for Mental Health in Filipino Prisons

My name is Bethany and I am a medical student. I am carrying out some research into the feasibility and acceptability of group therapies for mental health in Filipino prisons as part of my university studies, and I am inviting you to participate in this research. This project has been approved by the Ethics Committee of the University of Leeds. This information sheet will tell you more about the project, and what you will be asked to do if you take part. Please read this sheet in full and take some time to consider whether you would like to be involved. Thank you.

Background
This topic has been chosen as little research has been done surrounding mental health therapies in Filipino prisons. Therefore, I will aim to find out if there are any logistical issues and what the attitudes towards it are. This information could be very useful for the successful running of future therapies.

Why have you been chosen?
You have been chosen as you are involved with providing healthcare in the prisons and your experience will be very valuable in order to understand issues with the successful running of it.

Do you have to take part in the study? What will you be asked to do in the study?
Your participation is completely voluntary. If you agree, this will mean I will observe the clinic where I will just be in the background and not interrupt. I will also interview you and ask you a few questions on your thoughts of logistical issues and attitudes towards mental health in Filipino prisons. If at any point you decide to withdraw up to 48 hours after the observation or interview, this can be done without giving any reason or there being any negative consequences. In order to do so, please contact myself or Dra Pickering through the contact details found at the end of this form or in person.

Who will be present during the interview/observations?
The interview will involve myself and yourself. The interview will be recorded, but this information will be kept securely and strictly confidential. The observation will only involve myself in addition to

the normal workings of the clinic. I will be taking handwritten notes which will be securely kept on my laptop on an encrypted file. All the information you provide will be anonymized; this means your name will not appear in the report identifying you to any of the information you provide.

What are the risks of being involved in the study?
This study does not pose a risk to your health aside from any distress that may be caused by discussing the attitudes, of you or of others, you have experienced in the Philippines and the prisons.

What are the benefits of taking part in the study?
You will not receive any payment in return for your participation. However, the information you provide will hopefully provide an insight into potential mental health provision in Filipino prisons, allowing for future therapies to be better informed and hopefully run more successfully.

What will happen to the research results?
The ex-prisoners in the peer-support group therapy in Manila, other secure environment healthcare workers and the provider of the group therapy in Manila will take part in this study. The information you all provide will be analysed to produce a summary of the logistics and attitudes towards a group therapy for mental health in a Filipino prison. This will be conveyed in a report which may be published in a conference or journal paper. It is important to remember that your name will not appear in any part of this research, now or in the future.

What should you do next if you want to be involved in the study?
If you are interested, please contact me or Dra Pickering. We will be happy to answer any further questions you have.

Contact information
Email address: hs18bp@leeds.ac.uk
Phone number: 07803741492

Host: Dra Pickering, Integritas Healthcare, rachael.pickering@integritashealthcare.com
Supervisor: Dr Pearson, University of Leeds, s.c.pearson@leeds.ac.uk

Thank you for taking the time to read this information sheet.

Example question guide – secure-environment healthcare worker

INTRODUCTION
I would like to start by asking you a little about yourself.
Gender -
Age -
Role –
How long you have been doing this – group therapy for mental health in Philippines
Have you done this before?

FEASIBILITY
I am now going to ask you a few questions on your thoughts regarding the feasibility of providing healthcare in Filipino prisons.
Have there been any logistical issues regarding setting up and running the services you provide?

Prompts:

Usefulness of the prison/staff
Finding appropriate space
Enough prison staff to facilitate
Time – in prisoners timetables/escorting on time/Cut short for any reason?
Behaviour/attention span of prisoners
Recruitment of patients - identifying needy prisoners

Were there any times the services couldn't go ahead or was heavily restricted?

Lockdowns
Discipline
Space
Staffing issues – not bringing prisoners/not enough/were unaware

ATTITUDES

We are now going to talk about attitudes towards mental illness.
What is the general knowledge base on mental health in the prisons?
Prompts:

What it is
Causes
Treatments

Is mental health openly discussed in the Philippines?
Prompts:

Who between
Where – worse in the prisons?

How do you think the group therapy for mental health would have been received by the prisoners?
Prompts:

Attitudes – negative/positive
Actions towards it – avoidance/acceptance
Willingness to be involved/discuss topics/recruitment

How was the group therapy for mental health received by the staff/officers?
Prompts:

Attitudes – negative/positive/varied (dependant on person)
Actions – useful facilitators??

Do you think prisoners get treated differently in prison when they have known mental health issues?
Prompts:

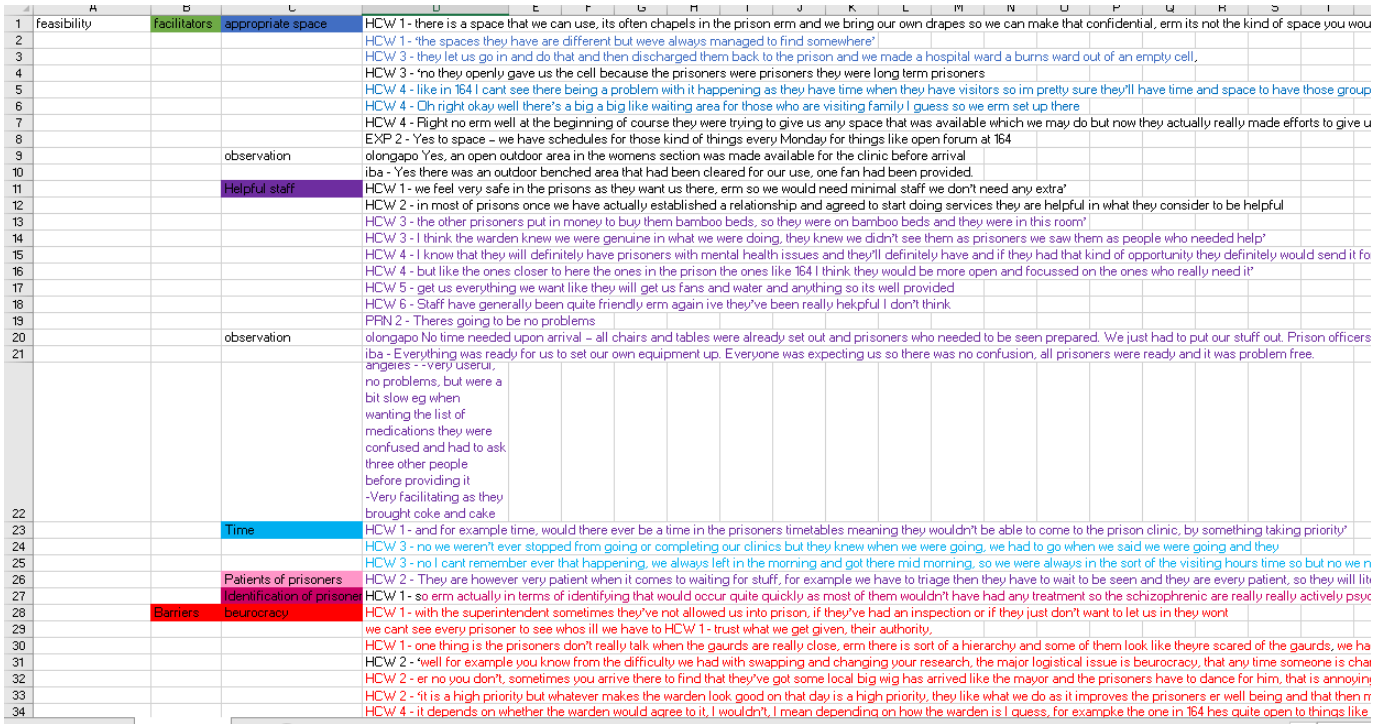
From prisoners/officers/Yourself?
Actions - Violence/negative attitudes/more helpful/encouraged to do things
Avoidance - Not included in activities by staff/socialising with peers

CLOSING QUESTIONS

We have reached the end of the interview.
Is there anything more you'd like to tell me that we have not already discussed?
Do you have any questions about anything we discussed?

Thank you again for your time and for allowing me to talk to you.

Thematic analysis framework



	A	B	C	D
1	feasibility	facilitators	appropriate space	HCW 1 - there is a space that we can use, its often chapels in the prison erm and we bring our own drapes so we can make that confidential, erm its not the kind of space you wou
2				HCW 1 - 'the spaces they have are different but weve always managed to find somewhere'
3				HCW 3 - they let us go in and do that and then discharged them back to the prison and we made a hospital ward a burns ward out of an empty cell,
4				HCW 3 - 'no they openly gave us the cell because the prisoners were prisoners they were long term prisoners
5				HCW 4 - like in 164 I cant see there being a problem with it happening as they have time when they have visitors so im pretty sure they'll have time and space to have those group
6				HCW 4 - Oh right okay well there's a big a big like waiting area for those who are visiting family I guess so we erm set up there
7				HCW 4 - Right no erm well at the beginning of course they were trying to give us any space that was available which we may do but now they actually really made efforts to give u
8				EXP 2 - Yes to space – we have schedules for those kind of things every Monday for things like open forum at 164
9			observation	olongapo Yes, an open outdoor area in the womens section was made available for the clinic before arrival
10				iba - Yes there was an outdoor benched area that had been cleared for our use, one fan had been provided.
11			Helpful staff	HCW 1 - we feel very safe in the prisons as they want us there, erm so we would need minimal staff we don't need any extra'
12				HCW 2 - in most of prisons once we have actually established a relationship and agreed to start doing services they are helpful in what they consider to be helpful
13				HCW 3 - the other prisoners put in money to buy them bamboo beds, so they were on bamboo beds and they were in this room'
14				HCW 3 - I think the warden knew we were genuine in what we were doing, they knew we didn't see them as prisoners we saw them as people who needed help'
15				HCW 4 - I know that they will definitely have prisoners with mental health issues and they'll definitely have and if they had that kind of opportunity they definitely would send it fo
16				HCW 4 - but like the ones closer to here the ones in the prison the ones like 164 I think they would be more open and focussed on the ones who really need it'
17				HCW 5 - get us everything we want like they will get us fans and water and anything so its well provided
18				HCW 6 - Staff have generally been quite friendly erm again ive they've been really hekpful I don't think
19				PRN 2 - Theres going to be no problems
20			observation	olongapo No time needed upon arrival – all chairs and tables were already set out and prisoners who needed to be seen prepared. We just had to put our stuff out. Prison officers
21				iba - Everything was ready for us to set our own equipment up. Everyone was expecting us so there was no confusion, all prisoners were ready and it was problem free.
22				angeles - -very userul, no problems, but were a bit slow eg when wanting the list of medications they were confused and had to ask three other people before providing it -Very facilitating as they brought coke and cake
23			Time	HCW 1 - and for example time, would there ever be a time in the prisoners timetables meaning they wouldn't be able to come to the prison clinic, by something taking priority'
24				HCW 3 - no we weren't ever stopped from going or completing our clinics but they knew when we were going, we had to go when we said we were going and they
25				HCW 3 - no I cant remember ever that happening, we always left in the morning and got there mid morning, so we were always in the sort of the visiting hours time so but no we n
26			Patients of prisoners	HCW 2 - They are however very patient when it comes to waiting for stuff, for example we have to triage then they have to wait to be seen and they are every patient, so they will lit
27			Identification of prisoner	HCW 1 - so erm actually in terms of identifying that would occur quite quickly as most of them wouldn't have had any treatment so the schizophrenic are really really actively psyc
28		Barriers	beurocracy	HCW 1 - with the superintendent sometimes they've not allowed us into prison, if they've had an inspection or if they just don't want to let us in they wont
29				we cant see every prisoner to see whos ill we have to HCW 1 - trust what we get given, their authority,
30				HCW 1 - one thing is the prisoners don't really talk when the gaurds are really close, erm there is sort of a hierarchy and some of them look like theyre scared of the gaurds, we ha
31				HCW 2 - 'well for example you know from the difficulty we had with swapping and changing your research, the major logistical issue is beurocracy, that any time someone is cha
32				HCW 2 - er no you don't, sometimes you arrive there to find that they've got some local big wig has arrived like the mayor and the prisoners have to dance for him, that is annoyin
33				HCW 2 - 'it is a high priority but whatever makes the warden look good on that day is a high priority, they like what we do as it improves the prisoners er well being and that then n
34				HCW 4 - it depends on whether the warden would agree to it, I wouldn't, I mean depending on how the warden is I guess, for exampke the one in 164 hes quite open to things like