Shifting the paradigm of prison suicide prevention through enhanced multi-agency integration and cultural change

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Abstract

This study examines an unusually sustained reduction in suicide rates in a local London prison during the three year period 2008-2011. The likelihood of this reduction taking place by chance was < 2:100,000, and its perceived success was such that the prison service recommended an evaluation of its characteristics. This study arose from that recommendation, and it used a retrospective case study multi-method approach (including factor identification, qualitative interviews, and triangulation with official documentation) to identify factors which had been associated with the reduced suicide rates. The results endorsed a number of factors which have already been internationally identified as best practice (WHO, 2007), along with some local innovation factors. Two further pivotal factors emerged through analysis, and they are key to service improvements. These factors - *senior management support for cultural change* and *cross-professional collaborative working* - indicate that positive leadership and multi-agency integration are vital ingredients.

Introduction

Internationally, suicide is the most common cause of death in prison settings (WHO, 2007), with a rate between three and six times that in the community (Fazel et al., 2011). Yet despite these excessive global rates, the suicide rate in prisons in England and Wales progressively decreased over more than a decade to 2012 (from 140 to 70/100,000 population[1] between 1999 and 2012: Ministry of Justice, 2015). This decrease followed the introduction of a series of measures which were intended to address the problem, principally through central self-harm and suicide management systems[2] (Ministry of Justice, 2013; Shaw & Turnbull, 2006). Additional measures introduced included increased emphasis on suicide prevention training, the duty to preserve life (Ministry of Justice, 2005) and, as part of a related improvement process within health, prison mental health in-reach teams (Forrester et al., 2014).

Although these reducing suicide rates were welcome, there has since been a change in direction, with rates having increased to 100/100,000 in 2014 (Ministry of Justice, 2015). However, neither the earlier rate reduction, nor the recent rate rise, were proportional: some prisons maintained or developed relatively high rates, while others showed reductions, in the absence of obvious changes in population or identified risks (Ministry of Justice, 2015). This raises the probability that differences arise from variations in local culture or polices, and that they could therefore, at least to some extent, be amenable to

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[1] This compares with a general community suicide rate of 11.6/100,000 (Office of National Statistics, 2014)

[2]The Assessment, Care in Custody and Teamwork (ACCT) system, which included a structured care-planning approach to self harm and suicide prevention, was introduced in 2006. It replaced the F2052SH system, which had been introduced in 1999.

local change. As such, it is important to consider the features of both low-performing and high-performing prisons, in order to learn lessons and guide best practice. To date, however, evaluations have tended to be of larger scale (Hadlackzky et al., 2011), with few evaluations of locally implemented suicide prevention strategies, and none from the perspective of those implementing new organisational practices inside prisons.

A disproportionate number of prison suicides occur in adult male establishments, at the very earliest stages of a prisoner's journey (Crighton & Towl, 1997; Hayes, 2012; Paton & Borrill, 2004). The characteristics of these prisoners who commit suicide appear relatively static across time and jurisdiction (Felthous, 2011), enabling the assembly of a series of internationally accepted risk factors (Rabe, 2012; Fruewald et al., 2003; Jenkins et al., 2005; Suto & Arnaut, 2010). These factors are important to consider when shaping service delivery, and they are outlined in table 1 below:

Insert table 1 here

Yet although it is helpful to identify risk factors, they are so prevalent within local prisons that it can be difficult to know which prisoners to prioritise. As such, they can be of limited practical use in guiding the management of risk, and their identification within individuals is often supplemented by organisational or establishment-wide interventions as part of a whole population approach (Blaaw & Kerkhof, 2006; Hawton et al., 2014; Lohner & Konrad, 2007). These approaches are influenced by prevention strategies which are used for the general population (Department of Health, 2012; 2015), while also recognising the specific needs of prisoners (Hawton et al., 2013). They also recognise the need for partnership working across agencies and the role of organisational culture in change (Thomas & Hardy, 2011).

In England and Wales, HM Prison Service has promoted a multi-disciplinary approach to suicide prevention for over two decades, following an earlier period in which there had been heavier reliance upon health staff to manage suicide risks (Senior, 2007). Responsibility now sits jointly with prison managers and healthcare services, with the aim of providing mutually supportive services. Partnership working and prison culture are included as key concepts in approaches suggested for prisons (Hayes, 2012; World Health Organisation, 2007) and their principles have been integrated into prison policy in England and Wales (Prison Service Order 2700: Ministry of Justice, 2005; Prison Service Instruction 64/2011: Ministry of Justice, 2013). However, there are local variations in the interpretation and implementation of these principles, and it is important to understand which local practices work best, in order to enable learning between establishments and to further policy development. To date, however, there is a scarcity of work evaluating the impact of organisational factors on suicidal behaviour, and in considering the effect of novel regime models.

This paper seeks to fill gaps in the existing literature by evaluating how one urban local prison in London managed to prevent self-inflicted deaths for over three years. It uses a retrospective evaluation to draw upon the experience of staff and managers to capture critical elements and consider the human aspect of effective suicide prevention in a large organisation. It also recognises that every suicide in custody is a terrible personal event which has a wide impact, including an emotional impact on family, staff and other prisoners.

Objectives

- To identify whether organisational changes contributed to suicide reduction

- To establish which features of organisational changes contributed to suicide prevention, as perceived by staff
- To compare identified organisational change factors with best practice guidance (World Health Organisation, 2007; outlined table 2).

Method

This case study evaluation was undertaken in an urban local medium secure prison[3] and covers the period April 2008 – December 2011 (as well as making comparisons with earlier points in the prison's history). During the period examined, the prison held up to 792 prisoners and received approximately 90 new prisoners every week. Up to 63 prisoners were managed daily under ACCT procedures (Her Majesty's Inspectorate of Prisons[4], 2011).

We used a revelatory case study methodology: widely used for business evaluations to examine outcomes that are rarely achieved and therefore relatively inaccessible for evaluation, this method utilises a broad approach, with both quantitative and qualitative components (Konig et al., 2012; Yin, 2009). Case study methods are often used in social research, and they are usually applied when research topics are broadly defined, cover contextual or complex multi-variate conditions, and when they rely on multiple sources of evidence (Yin, 2003). The broad, complex, multi-variate nature of this particular case study fits this method better than purer quantitative or qualitative approaches.

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[3] A local medium secure prison is one which serves local courts and receives all prisoners remanded or sentenced to prison, except those who are considered to present the highest risk to the public

[4] Her Majesty's Inspectorate of Prisons (HMIP) is an independent body which is responsible for reporting directly to the UK Government on the treatment and conditions of prisoners in England and Wales

Due to the complex and inter-disciplinary nature of the variables, a data triangulation approach was used. The exploratory nature of the study meant that multiple and independent measures of a point provided a more useful portrayal of the phenomena being studied (Jick, 1979). The triangulation of quantitative data with multi-disciplinary interviews allowed for richer detail regarding the perceived contribution of key aspects of organisational changes, and its effect on suicide prevention practice.

Study approval was obtained from the prison Governor and ethical approval was granted by an appropriate body.

Staff Perception of Key Changes Questionnaire

A questionnaire was developed based on key changes that occurred in the prison during the three years from 2008. Initially, a list of all organisational changes between 2008 and 2011 was developed from multiple sources of information, including local policy documents and HMIP reports. Then, six staff from health, prison and psychology departments who were employed during the relevant period but were not actively involved in suicide prevention, provided information regarding additional changes that had not already been identified. In total, 41 changes were recorded and all were included in the final questionnaire (examples in table 3). Each aspect was scored on a continuum of its perceived importance regarding suicide reduction (1= Important negative effect; 2 = somewhat negative effect; 3 = no effect, 4 = somewhat positive effect; 5 = Important positive effect).

Participants were identified from staff who were employed in the prison and had knowledge of its suicide prevention practices (including staff who had been members of the safer custody team, or who had attended safer custody meetings throughout the time), while staff who had been involved in developing the questionnaire were excluded to prevent bias.

Quantitative data were received from 17 of 32 (53%) identified multi-disciplinary staff[5] and were representative of departments involved in suicide prevention management.

Interviews

Seven staff members[6] undertook semi-structured interviews to expand upon the context and implementation of changes identified as most relevant in the questionnaire. All participants in the interview stage had completed the questionnaire and volunteered to be interviewed, and all interviews were recorded.

Within the interviews, participants were initially asked a number of open questions to establish which organisational changes they perceived to have had an impact on suicide prevention. Once a change had been identified, they were then asked to expand on the content of that change and its perceived impact. Finally, they were prompted to expand on their perceptions of the changes identified as most relevant through the questionnaire.

Thematic analysis was used as a method for 'identifying, analysing and reporting patterns within data' (Braun & Clarke, 2006, p. 79). It involved transcription, thorough reading to increase familiarisation, and data reduction (through coding). Given that the focus of this research was on understanding the mechanisms of organisational change, analysis was informed by the World Health Organisation guidance (2007) and quantitative themes that had been identified.

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[5] 17 participants included prison governor grades, prison officers, nurses and psychologists (male 64%; age range 24-59).

[6] 7 participants were two prison governors during 2008-2011, current suicide prevention co-ordinator, regional suicide prevention co-ordinator during 2008-2011, psychologist and two prison officers (male 57%; age range 24-55).

After these joint themes had been identified, the process of triangulation allowed information from this wide range of sources to be reviewed together, to facilitate a multi-source approach to the analysis of themes.

Results

Self-inflicted deaths at study prison

The prison's self-inflicted death[7] rate was analysed across the three stages of strategic suicide prevention strategies outlined in table 2 (stage 1, 1978-1990: no strategy; stage 2, 1991-2008: F2052SH and ACCT (from 2006); stage 3, 2009-2011: local multi-agency and change).

Insert table 2 here

This was done to establish whether the introduction of the National Suicide Prevention Strategy at the study prison (stage 2: described in Shaw and Turnbull, 2006), or the subsequent local strategy from late 2008 (stage 3) were associated with statistically significant changes in the rate of self-inflicted death in the prison (see figure 1).

Analysis 1. Self-inflicted death rates at the prison during the period 1978-1990 were modelled and compared with deaths during the period 1991-2008. Assuming a constant rate, an over-dispersion Poisson Regression was performed (95% CI = 2.06 – 3.39), and Chi-Square indicated a significant difference between the pattern of self-inflicted death rates between the periods 1979-1990 and 1991-2008: X^2 (1, 29) = 14.393, p= <0.0001. Analysis

[7] When a self-inflicted prison death takes place, HM Prison Service of England and Wales formally records 'self-inflicted' death. However, most of these cases have a verdict of suicide returned at subsequent Inquest (Forrester, 2009). Due to extensive delays of up to five years between death and inquest, all figures provided here reflect the broader term 'self-inflicted death (SID)', rather than the term 'suicide'.

indicated that the likelihood of this level of reduction in self-inflicted deaths having occurred by chance was 2:100,000, and supported the view that the implementation of a national strategy and process had a significant role in reducing suicide rates.

Analysis 2. The self-inflicted death rate during the period 1991-2008 was modelled and compared with that during the period 2009-2011. Assuming a constant rate, an over-dispersion Poisson Regression was performed (95% CI = 1.04 – 2.01), with Chi-Square indicating a significant difference between the pattern of self-inflicted deaths between the periods 1991-2008 and 2009-2011: X^2 (1, 19) = 9.5573, p= <0.0001. Analysis indicated that the likelihood of this further reduction in the rate of self-inflicted death occurring by chance was 2.5:100,000, thereby supporting the relevance of stage 3 local changes.

Insert Figure 1 here

Staff questionnaire of Perception of Key Factors

Scores ranged from 3.3 to 4.5 across items (Mean = 3.86, SD=2.67). Using a one-sample t-test all changes were significantly in a positive direction from the midpoint (p <.05 for all variables) demonstrating that all changes identified were considered positive and supportive of change. A one-sample t-test was therefore performed to identify those factors considered to be most or least relevant to suicide prevention. This t-test compared each item Mean with the Mean for the full sample. Items found to be significant at the p<.05 level are outlined in Table 3.

Place Table 3 here

Triangulation

The final stage of analysis triangulated the significant themes from the staff questionnaire and interview data. Table 4 outlines the results of the triangulation, reporting Factor, Questionnaire item, Interview-derived Mechanism and Perceived outcome as defined by participants. All factors were considered to be relevant and supportive of suicide reduction, with further analysis supporting the presence of some factors as more prominent and as key drivers in that reduction. The most prominent WHO factors identified were: Training; Prison Climate; Screening; Communication Regarding High-Risk Prisoners; Debriefing staff and learning from incidents; and Mental health treatment. Two WHO factors were not identified as prominent: Post-Intake Screening; and Written Procedures. Two additional themes were identified as important for effective organisational suicide prevention: Management and Leadership Approach; and Specialist Knowledge.

***Insert Table 4 here**

Discussion

In the study prison, there were significant reductions in the rate of self-inflicted death (SID) between each of the three phases of organisational change (1978-1990; 1991-2008; 2009-2011). This provides support for the view that national strategic changes can have local impact, and that the changes which were introduced locally, from 2009, enhanced the effectiveness of this earlier national impact. The sustained reduction in the annual SID rate was significant and highly unusual, with a likelihood of only 2:100,000 of this occurring by chance.

This study also provides supportive evidence for a range of factors which are already meant to underpin organisational best practice in prisons (WHO, 2007), and it suggests that some crucial local factors can have a useful additive effect. These factors include p*rison climate*

and culture, *communication* & *active collaboration regarding high-risk prisoners*, *mental health treatment (and integration), debriefing staff* and *learning from incidents*. In addition to these factors, two further key themes were identified – *Management and Leadership Approach*, and *Specialist Knowledge*. All of these factors demonstrate the importance of combining national and local approaches, and they also reinforce the pivotal roles of active partnership working, positive organisational culture (Hayes, 2012; Thomas & Hardy, 2011) and staff support (Marzano et al., 2012). Each of these factors are considered in further detail below:

Prison Climate and Culture

The idea that organisational culture can play a prominent role in promoting safer and more integrated systems approaches is gaining momentum across health and social care (Thomas & Hardy, 2011; Till et al., 2014). Within that context, this study suggests that changes in prison culture can have an impact upon safety and outcomes, and study participants linked these change with positive developments in staff attitudes and behaviour.

"I think, [the prison]'s got one unique thing, and it's with staff and prisoner relationships, I think that's made a huge impact" (Participant F)

High quality listening skills and compassion are known to be vital qualities in supporting the wellbeing of prisoners (HMIP, 2011; Marzano, Ciclitira and Adler, 2012), and in the study prison the underlying culture of integration was identified as provided an important context for these qualities. This integrated approach influenced the suicide prevention approach, and it supports wider calls, made elsewhere, that suicide precautions should not be punitive (Hayes, 2013). As an example of this approach, segregation was infrequently used as a method of establishment control in the study prison (HMCIP reports 2008, 2011).

In the study prison, the senior management team had identified suicide prevention as a key priority, and it factored centrally in strategic decisions. This indicates that the prioritisation of suicide prevention, through management support for staff and prisoners and its integration within wider decision-making, can assist in improving staff clarity regarding their work priorities in a complex environment (Towl & Forbes, 2002).

> *"I think that's what spurred it on is people being more aware of it and being more comfortable with it and also becoming more of a priority, top down, from sort of management" (Participant B)*

Communication Regarding High-Risk Prisoners (and active partnership working)

Effective systems for communication between diverse disciplines inside and outside the prison (including, for example, prison officers, governors, clinicians, psychologists and probation staff) were perceived as a critical component of suicide prevention (Daniel, 2006; Hayes, 2012). This is consistent with what is already known: incompatible systems and tensions between disciplines can create barriers to joint care (Marzano, Adler and Ciclitira, 2012). However, two key local initiatives which supported communication and multi-agency working were highlighted, above those outlined in national procedures: *Complex cases meeting* and *healthcare wing partnership working*.

Complex cases. The establishment of an active and discrete multi-agency approach was considered crucial to effective communication and outcome. The prison managed up to 63 prisoners under the ACCT process on any given day, across five separate wings. In order to manage these cases across disciplines and wings, a complex cases approach provided a regular multi-agency forum to discuss issues of concern and coordinate the management of individuals who presented the highest levels of risk.

"because rather than ten departments trying to deal with that person individually, they're all coming together and talking about it as a group or, you know, as a whole" (Governor A)

The complex case meeting was a fortnightly meeting, at which prisoners considered to be at high risk of suicide, self-harm or violence, were discussed. All departments were represented at a senior level, and management plans were agreed holistically. These plans provided well-considered, evidence-based and procedurally sound decisions and interventions. The complex cases meeting also laid a framework for effective communication throughout the prison, supporting those at highest risk, while also encouraging wider proactive collaboration.

Healthcare wing partnership. The movement of prisoners with mental health issues between healthcare and prison wings (PPO, 2008), for whom a heightened risk of suicide was established (Webb et al., 2013), represented one area of risk. Incompatible recording systems, and changes in case responsibility, introduced a potential information "black hole" as prisoners moved between services. To remedy this, a single care-planning process was introduced across the healthcare and prison wings using the existing suicide prevention care plan (ACCT) process, allowing for effective partnership working and communication using shared language. This approach was not without criticism: it was considered "heavy-handed", and it was thought that it could undermine existing systems by over-using the ACCT process (HMCIP, 2011). However, this joint care-planning did allow for unprecedented joint responsibility sharing between health and prison managers.

" I think that, … you can only judge it by the results to be honest, and we've had HMCIP reports which criticise that strategy because it undermines the importance of ACCT, but I will

just point to the results, nobody has come out of healthcare and been lost in the system and committed suicide, you just can't argue with it" (Senior Officer B)

Mental Health Treatment and communication with external agencies

Within England and Wales, there have been considerable developments in mental health services provided to prisoners over the last two decades. These changes have largely been policy derived (Department of Health, 2001), and the study prison was one of the first sites for the newly introduced mental health in-reach teams, from 2001. Within the study prison, the mental health service developed further during the period described (Forrester et al., 2010; Forrester et al, 2014), and it took determined steps towards multi-agency integration and pathways working from 2008.

"certainly my experience of inviting outreach or primary mental health team, you know you get that other input, which is something that didn't happen before," (Senior Officer B)

In collaboration with the prison, greater emphasis was given to multi-agency meetings, and attendance at complex case meetings was prioritised[8]. Mental health staff also attended primary care and substance misuse meetings regularly, and were central participants in the ACCT process. Overall, this approach ensured that mental health services were an integral partner, and it represented a considerable shift from the historic norm in which services had tended to sit separately.

[8] As was attendance at other multi-agency meetings, including Care Programme Approach meetings (before transfer to other prisons or release to the community) and Multi-Agency Protection Panel Arrangements (MAPPA) meetings

Debriefing staff and learning from incidents (including ongoing staff support)

The use of swift, in-depth, internal reviews of a serious self-harm incident with immediate changes to practice reduces existing risk for other prisoners (WHO, 2007). This study evidenced the perceived importance of swift and detailed investigations, when linked to active reviews of policy and practice amongst multi-disciplinary managers in managing on-going risk.

"All death in custody reports received from the Prisons and Probation Ombudsman (PPO) had resulted in an action plan that was completed and regularly reviewed. Local investigations into serious attempts at suicide or self-harm were completed to a very high standard (HMIP report, 2011).

The importance of staff support following traumatic incidents, and supervision in clinical practice, is well documented (Tehrani, 2004; Cutcliffe, Hyrkas and Fowler, 2011), but the specific working ingredients of such support are less well understood. This study, however, indicates that prison staff consider the provision of constructive advice and feedback to be vital in improving competencies and supporting training needs (Marzano and Adler, 2007).

"I think sort of little by little as people have got more confident with the process, sort of the smaller things then get picked up on as not being done 'cause you've tackled the big problems". (Prison Officer C)

Across professions, staff highlighted the importance of emotional and practical support during and after incidents (and, in particular, during inquiry processes). Although prison staff have access to local and national support systems, these are optional, and they are not profession-specific. Unlike many health professionals, prison officers do not have a system

for supervision available to them: yet this study indicates that professional and emotional support is required (Forrester & Slade, 2013).

Management and Leadership Approach (including staff accountability)

The specific management approach used in the study prison was identified as an additional important factor across all groups of staff. It was referred to as a positive attitude, and it incorporated a clear prioritisation of suicide prevention by senior management.

"..there was a different emphasis, … it was much more high profile".. (Prison Officer C)

The identified ingredients of this factor included: clear messages that suicide was not inevitable; physical presence on the wings; encouraging personal communication; offering hope and support to front-line staff; supporting innovative approaches with clear expectations; and holding staff to account. Of these ingredients, staff reported that support for innovative approaches and individualised risk management (e.g. complex cases meeting; joint care-planning system across healthcare wing; daily bite-sized policy directions; feedback on ACCT assessments) led to improved staff confidence and belief. In addition, holding staff accountable was identified as leading to improved service quality and a more consistent approach.

Crucially, staff reported that the development of an optimistic approach towards suicide prevention was central to this renewed emphasis and its associated outcomes. This sense of hope and optimism amongst staff is in contrast to literature which has described negative and pessimistic attitudes amongst prison staff (Marzano et al., 2012; Hawton et al., 2013), but it supports findings that individual and organisational optimism regarding suicide

prevention is associated with reduced suicide risks (Department of Health, 2015; Slade & Lopresti, 2013). As reported by one senior manager,

"Previously it had felt inevitable ….but [we] gave this prison hope that we could stop it" (Governor H)

Specialist Knowledge for strategic management

A final additional factor is the role of *Specialist Knowledge* and experience to guide and advise on major organisational change, training provision and support services; with a level of seniority suitable for the development of policies across agencies.

"I think a wider understanding of all the contributing factors that lead to self-harm and different ways of managing that …and also an understanding of the different ways that staff can manage it. I'm not saying that officers don't have that, but I think having a psychology background helped place a number of different behaviours and management strategies into context" (Psychologist G)

In this case study, the utilisation of a senior-level forensic psychologist to project lead, with experience of working across disciplines, knowledge of prisons, risk management and prison suicide, was considered to provide an effective mix to develop practical and effective strategies. It indicates that Project Leads within high-risk prisons should be equipped with the skills to manage complex inter-disciplinary negotiations, along with sufficient professional knowledge to guide services.

Limitations

The absence of a developed literature in this area is consequent upon difficulties in evaluating a rare event in an applied setting, especially one in which suicide prevention is not the main focus of business. The i*n-vivo* nature of this research means that there are inherent evaluation difficulties, with an abundance of potential confounding variables, and these represent study limitations. For instance, new developments within prison occur with fluidity, which taken alongside the time required for full implementation of complex change, results in less distinct start points for evaluation. However, the study includes discrete years reflective of the national and local changes.

Although it is possible that the staff employed in the study prison's suicide prevention processes had an overly positive view of the work that had been implemented, the study does demonstrate a significantly reduced suicide rate over a sustained period of time. A prospective study could allow for further testing of these staff perceptions of effective organisational factors as regards their causal effect on suicide, but would be virtually impossible to set up given the operational priorities of the prison service.

The evaluation may be difficult to interpret and generalise from a small sample and a single prison, and the casual mechanisms cannot be inferred from the staff perceptions. However, the main identified themes were consistent with those documented in international guidance (WHO, 2007), and they find support in the wider literature.

The study was retrospective in nature because the unique success of the organisational change was only fully understood after the event, after it was identified by staff and external bodies (e.g. HMCIP). It was not set up as a research project, but rather as a service change, across agencies, with an intended effect (suicide reduction).

Conclusion

This study explored the mechanism of a suicide prevention process which introduced an extraordinary reduction in suicide rates at a high-turnover early-stage prison in London, UK. It provides support for two pivotal factors in the promotion of prison suicide prevention: *senior management supported cultural change* (Thomas & Hardy, 2011) and *cross-professional collaborative working* (Daniel, 2006; HMCIP, 1999). By working across agencies and disciplines in a collaborative manner, drawing upon different the expertise of different professional groups, it is possible to assist in supporting the experience of staff and prisoners. This supports a move away from 'silo' working (Department of Health, 2009) and assumptions that any one profession is best placed to prevent suicide. It also supports the key role of senior management in embarking upon and driving change through generating optimism that suicide is preventable, and by encouraging expertise, confidence and integration amongst staff (Coyle, 2013). By demonstrating the defining role of energetic, active, collaborative, innovative and supportive approaches, it may be possible to make a real difference in suicide rates in prison. However, the study also describes a need to address issues of information sharing and single joint management processes at a national level. It also describes the benefit of local engagement with specialists in prison suicide prevention to guide initial implementation to ensure strategy, innovations, staff training and prisoner care meet the highest possible standards. Staff support also plays an important role - it encourages the provision of individualised and effective support to large numbers of at-risk prisoners. By providing support, while also holding staff responsible for their decisions, a functioning and less risk-averse staff group can become possible. Finally, the use of innovative approaches in the management of local risks is also highlighted. In this case,

although innovation was not without criticism, it was seen as crucial in overcoming entrenched issues within the prison.

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