Prisoners' mental state: A psychosocial perspective. A multi-method study focusing upon prisoner vulnerability, socialization and identity - highlighting implications for policy, research and practice.

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PRISONERS' MENTAL STATE: A PSYCHOSOCIAL PERSPECTIVE

A MULTI- METHOD STUDY

FOCUSSING UPON PRISONER VULNERABILITY, SOCIALIZATION AND IDENTITY –

HIGHLIGHTING IMPLICATIONS FOR POLICY, RESEARCH AND PRACTICE

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Preface

The author of this PhD was responsible for developing and framing the research question, and finalising the aims and objectives of the study. He worked with his supervisor, Professor Ceri Phillips, as co-principal researcher on the funded parts of the study and under his supervision throughout. The author asserts his role as project manager, and was responsible for obtaining ethical approval, development of methodology and identification of outcome measures. He had help and support in collecting and entering data. He was solely responsible for data analysis and development of theory.

Abstract

Many prisoners share socially excluded backgrounds and experience poor mental health in prison. The sometimes fatal experience of prison increases the risk of self-harm and continuing exclusion and mental health problems for many. Furthermore, constructive prison outcomes are unlikely without good mental health. Despite this background, few prison research studies have attempted to capture the dynamic effect upon the individual of both pre-prison and prison experience. This thesis, therefore, aims to identify correlates of prisoners' mental state within both an epidemiological and qualitative-psychosocial perspective.

The literature, health and social background data (n = 409), and GHQ-12 mental state data within a case-control study (n = 861), show that prisoners experience a nexus of interconnected problems. Consistent with the literature, being on remand and being in prison for the first time were associated with poor mental state. Remorse and variables related to personality type, specific offence and regime characteristics also had significant associations with poor mental state. Conversely, a beneficial association was found from having had a previous sentence, and also from two counter-intuitive and previously unreported 'typical' social exclusion-related prisoner characteristics, viz. being unemployed prior to prison and having a 'history of drug use'. Professionals (n = 60), however, use alternative constructs for interpreting the mental state of prisoners, and as a consequence, 'atypical' and remorseful prisoners may possess hidden morbidity and need.

From these findings and a narrative of the 'lived' prison experience, entry-into, or exclusion-from a socialised prison identity is proposed as a critical mediating factor for prisoners' mental state. This 'adaptation' hypothesis suggests that for many prisoners, prison may paradoxically create, maintain and reinforce an 'invulnerable' shared identity. This identity is based upon offending and common pre-prison social experience, and adaptive prison socialisation and solidarity is predicated upon it. These identity socialisation factors appear to be protective of mental state. However the institutionally specific qualities of this shared 'prisonized' identity will work against preparation for life outside prison, given that successful integration within society requires different identity attributes. The prison identity dynamic may be further reinforced upon release by public opinion (n = *306*), which is intolerant of prisoners, presents an obstacle to their reintegration into society, and potentially strengthens offending identities and behaviours. Whilst prisons are now mandated to address prisoners' needs, their institutional constraints may ultimately make them both pathogenic for those excluded from the shared prison identity, and unfit for the purpose of rehabilitation for those included within it.

Declaration

This work has not previously been accepted in substance for any degree and is not being concurrently submitted in candidature for any degree.

Signed . .... (candidate)

Date ..... 25/6/10 .....

STATEMENT 1

This thesis is the result of my own investigations, except where otherwise stated. Where correction services have been used, the extent and nature of the correction is clearly marked in a footnote(s).

Other sources are acknowledged by footnotes giving explicit references. A bibliography is appended.

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CHAPTER 1

INTRODUCTION

1. INTRODUCTION

This chapter states the research question, viz. 'which factors influence prisoners' mental state?'; outlines the significance of prisoners' mental state; identifies the main subject foci, themes and topics which permeate the study; details the background, aims, and objectives; presents the rationale for selected literature; identifies the distinct datasets which contributed to the study; and provides an overview of the thesis structure and chapter content. In so doing, this chapter summarises the current state of knowledge and practice in relation to prisoners' mental state, places this study within context, maps out the main study features, and gives direction through the thesis. The study is proposed as a timely, ethical and considered psychosocial contribution to the contemporary research literature on prisoners' mental state.

1.1. WHERE ARE WE NOW?

Recent years have seen unprecedented growth in mental health care research in prisons (Mills et al. 2006), following greater National Health Service (NHS) funding for prison research and the research involvement of general health-oriented university departments in addition to the long-standing specialised interests of criminological or prison-practitioner researchers. Recognition of the importance of mental health in prison is evolving as the prison service works to reduce the levels of self-harming and suicide (HM Prison Service 2007); modernise their health care services (De Viggiani et al. 2005); look to develop evidence based corrections practice (Cullen and Gendreau 2001); and manage the scale of mental disorder amongst the prison population (Dyer 2008).

The notion of prisoners benefitting from their custodial sentences whilst having opportunities to address their training, educational, social and health needs, known as a constructive regime (Prison Reform Trust 1995), is dependent upon the presence of mental well-being amongst prisoners. However there is a wealth of evidence to indicate considerable mental health morbidity amongst prisoners (Shaw 2002), which would undermine the opportunity for a constructive regime experience for many prisoners. Furthermore much morbidity has previously gone undetected due to inadequate screening and assessment procedures in prison and more widely (Shaw, Tomenson, and Creed 2003).

1.1.1. Prison overview

UK prisons constitute part of the Criminal Justice System overseen by the Ministry of Justice, and provide a public service keeping in custody those committed by the courts, either for remand (pre-trial) or as part of a custodial sentence following conviction. The level of risk posed by each individual prisoner is assessed and they are allocated to one of four prison categories (A – D) with A representing the most violent, dangerous and difficult prisoners, and conversely D representing those deemed to be lowest risk

due to the nature of offence or their proximity to release within their sentence. Prisons themselves are defined by the category of prisoners which they hold (HM Prison Service 2009). The mission statement for prisons commits them to look after prisoners 'with humanity and help them lead law-abiding and useful lives in custody and after release' (HM Prison Service 2009). In order to achieve this, prisons are expected and required primarily to be secure, in order to prevent prisoners from escaping. Furthermore prisons are charged with creating a rehabilitative environment so that prisoners can lead fulfilling lives in prison and be better equipped for life outside once they are released. In order to foster support for prisoners post-release, prisons work in close partnership with commissioners, police, probation, health and social services to achieve effective supervision and resettlement. The offender management functions of these agencies is coordinated by the National Offender Management Service whose role it is to ensure that individual needs are met whilst at the same time ensuring public safety. Both of the prisons in this study were category B prisons, and one also held young offenders and juveniles.

1.1.2. Mental health research and prison

Prisoners experience many social and health related problems (World Health Organisation 2005), whilst prisons display inherently pathogenic (Smith 2000) and institutional qualities (Goffman 1961), which themselves need to be taken into account within prison research. Prisons have been unable to deliver services to meet the scale and diversity of need (Arboleda-Flórez 1999), and pose many challenges to prisoners' mental state (James 2003b). Research has to date failed to actively engage prisoners within health research (Caraher 2002). These issues are now further discussed in order to establish a rationale for undertaking the study.

1.1.3. Prisoners as a special population

Prisoners have long been recognised as a special population by virtue of their often troubled social backgrounds, sporadic utilisation of health services, criminality, behaviour, incarceration, and levels of substance misuse and trauma (Novick et al. 1977). Prosecuted crime is generally committed by young people often with special needs, and prisoners tend to be young, come from socially excluded backgrounds and experience multiple problems (Farrant 2005). Imprisonment itself is likely to compound many of these disadvantages (The Howard League for Penal Reform 1995).

Prison itself is likely to exert a demeaning influence (Haney et al. 1973) and an institutional effect, eroding the daily skills necessary for societal adaptation and reintegration (Goffman 1969), whilst also marking the individual with a stigma. Around the mentally disordered prisoner a number of stigmatising experiences coalesce. Contact with the Criminal Justice System often for relatively minor drug-related offences (Buchanan and Young 2000), the experience of prison (Haney 2008), and having mental health

problems (Brunton 1997, Carvel 2004) all serve to stigmatize the individual. The effect of stigma is that the individual is marked as unacceptably different from the rest of society and elicits the sanctions of further exclusion and denial of opportunity (Scambler 1998). Such stigma serves to reinforce already negative attitudes towards offenders. UK public opinion, whilst ill-informed of the reality of sentencing practice, is critical of court sentences as being too lenient (Hough and Roberts 1999). Internationally, opinion polls have reflected similar perceptions of court leniency (Stalans and Diamond 1990, Stalans and Lurigio 1996).

Consequently, prisoners have great difficulty re-entering society as constructive and law-abiding citizens, often because legitimate means to support a socially inclusive existence are denied them through lack of education, lack of skills, dependency, illness or continued exclusion (The Aldridge Foundation 2008). Such limited life chances are likely to lead to continued circular patterns of exclusion, offending, and imprisonment with associated risks to mental health (Social Exclusion Unit 2002).

1.1.4. Social exclusion and health status

Many offenders display evidence of social exclusion (Seddon 2006). Accompanying social exclusion are trauma (Novick et al. 1977), poor health (Watson et al. 2004), and especially poor mental health (Shaw 2002). These factors are inextricably linked to offending (Social Exclusion Unit 2002), along with poor parenting, and personality traits related to impulsivity which are problems poorly provided for in childhood and adolescence (Farrington 1995). Public health problems such as substance misuse, and communicable disease (e.g. tuberculosis, sexually transmitted disease and hepatitis C) have further harmful health, economic and social effects (World Health Organisation 2005). Cumulatively these experiences are likely to render individuals vulnerable to further poor health and social outcomes, negative life trajectories and damage self-identity and self-esteem.

1.1.5. Psychiatric morbidity

Pre-prison stress associated with the Criminal Justice System and court process has been linked to psychiatric symptomatology amongst prisoners during the early stage of imprisonment (Harding 1989). Although prison itself can be a constructive experience (Bonta and Gendreau 1990), many individuals experience prison as offering a poor quality of life, deleterious to mental state, where they cannot cope and are vulnerable to assault, self-harm and suicide (Liebling 1995, Birmingham 2003). Prison is not equipped to deal with mental distress (Gannon 2000) and does not adequately prepare prisoners for life outside (Prison Reform Trust 1995). The combined problems associated with imprisonment and mental disorder impede reintegration into mainstream community life, thus contributing to the likelihood of recidivism, continued exclusion and the absence of mental health care (Fryers et al. 1998). The Chief

Inspector of Prisons identified that prison often exacerbated mental health problems therefore impacting on both the individual prisoner and the community into which they are released (HM Chief Inspector of Prisons 2007). For this reason the Welsh Assembly Government have issued guidance that community mental health teams should link to prisoners with mental health problems upon release from prison (Welsh Assembly Government 2005).

1.1.6. Prisons as service providers

A number of developing themes arise within the health and social care literature regarding mentally disordered offender-prisoners. The term offender-prisoners is used within the thesis to widen the perspective upon an individual's offending career, making a link to their background and allowing consideration of offenders who are managed outside of the prison system. One theme has been the necessity for flexible and well resourced multi-agency working and case management approaches to respond to the totality and complexity of need (Ventura et al. 1998). There is evidence in relation to prisons, to suggest that the scale and complexities of the prison population are intractable and near overwhelming (Narey 2002), and that services encounter a level of need which had not been anticipated or resourced (HM Inspectorate of Prisons 2007). It has been concluded that:

> Those who end up in our prisons have complex and long-standing mental health needs, often linked to substance misuse, and ranging from acute psychosis, through personality disorder, to high levels of anxiety and depression...these needs are themselves only part of a more complex picture of multiple disadvantage and social exclusion, which may fall through the net of community health, social care, housing and drugs agencies.
>
> HM Inspectorate of Prisons 2007 p.5

Prisoners' mental health problems therefore constitute part of a range of difficulties involving a nexus of interconnected health, psychosocial, substance misuse and offending problems (Foster 2000). Prisons, meanwhile, pose both opportunities and threats to prisoners' mental state (Smith 2000). Furthermore prison has become a default setting for many individuals with a range of mental health problems (HM Inspectorate of Prisons 2007), whilst prison mental health care services are dysfunctional (Kmietowicz 2006), and receive only a third of the funding they require, to meet government standards to match community mental health services (Dyer 2008, Sainsbury Centre for Mental Health 2008). Moreover the impoverished regimes of many prisons (Newell 2001, Farrant 2005), combined with a record prison population of over 80,000 (Guardian 2008), are factors likely to worsen mental state (Simpson 2003). Upon release prisoners are poorly regarded by society (Zimring and Johnson 2006) with the effect of further marginalising an already disadvantaged group.

1.1.7. Motivation for undertaking study

Subsequent to Home Office circular 66/90 (Home Office 1990) which directed district-based services to provide for mentally disordered offenders, the author was involved in developing services for mentally disordered offenders, nursing offender-prisoners and managing services which had contact with offender-prisoners in a variety of settings. From this standpoint the author developed an interest in the plight of offender-prisoners. Subsequently, the specific issues of personality disorders amongst offenders formed the basis of a publication (Bowler 1999), whilst the interface between mental health and the police services formed the basis of two additional papers (Bowler and Tredget 2000a, Bowler and Tredget 2000b). Social exclusion and its relationship to suicide formed the basis of a further paper (Bowler 2001). More recently, the author's responsibilities as a lecturer in mental health nursing have included a focus upon psychosocial care for individuals with serious mental illness, developing educational links with HMP Swansea, other local secure services for mentally disordered offenders, and involvement in research into prisoners' health and social needs (Bowler et al. 2008a, Bowler et al. 2008b).

The opportunity to undertake this PhD thesis accompanied involvement with prison health needs assessment research in four prisons (Davies et al. 2001). An invitation by the Local Health Board, to conduct further mental health specific needs assessment in two of these prisons, provided the impetus for the PhD proposal and an opportunity to draw together many of the professional interests of the author within a study which met the challenges of contemporary prison research. The potential for the comparison of prisoner groups' mental state (Gordis 2005) was built into the mental health needs assessment research via the survey, but only fully developed (appendix A) and undertaken within this PhD study.

1.2. WHERE ARE WE AT?

There is consensus that poor mental state in prison links to multiple markers of distress such as continuing exclusion and ill health (Department of Health. 2001), suicide and self-harm (Cooper 2001), reduced life chances (The Howard League for Penal Reform 1999) and increased risk of reoffending (James 1996). These markers are all indicative of a negative life trajectory for prisoners experiencing poor mental state in prison, and warrant enquiry into firstly causation of poor prison mental state, and secondly therapeutic intervention and prevention. Research into prisoners' mental health is therefore ripe for development (Shaw 2002) yet continues to be under-researched (University of Oxford - Department of Psychiatry 2008), whilst much of the research which has been conducted, has failed to engage prisoners (Caraher 2002) by sitting within a descriptive epidemiological tradition such as that espoused by Marshall et al. (2001), rather than a paradigm embraced by the best prison research which is prisoner-centred,

reflective of the lived experience and problem focussed, for example Lart (1997). This study therefore aims to contribute to the available cannon of contemporary prison mental health research, reflecting prisoner experience and mental state.

1.3. WHAT THIS STUDY ADDS

This study attempts to identify psychosocial factors which dynamically interact, impact upon prisoners' mental health, and mediate mental state in prison. Within the context of this study mental state is utilised as a term to encapsulate current mental health, consistent with Goldberg (1992). The mental state concept is effectively one of a snapshot of mental health as it is experienced at a point in time; it comprises a distillation of biological, psychological and social status thus making it sensitive to the dynamic background of negative societal and prison specific influences (Department of Health. 2001).

Few studies have attempted to capture the interaction of experiential and psychosocial factors as they impact upon the experience of prison and specifically prisoners' mental state. The effects of negative factors upon the lived experience of the individual prisoner are routinely overlooked within prison mental health research, and contemporary research into prisoners' mental state must therefore develop methodologies capable of capturing the effect of these lived influences upon mental state of both individuals and groups (Liebling 1999a). From the amalgam of problems faced by prisoners and posed by prisons, this study attempts to identify variables of special significance to prisoners' mental state. The methodology of this study aspired to involve prisoners and staff more actively (giving them a voice through the focus groups) than in purely epidemiological surveys, whilst integrating quantitative and qualitative data. It sought also to capture a sense of public perception towards prisoners. This study, therefore, sought to consider the dynamic interaction between combined multiple factors which potentially influence prisoners' mental state and identify those which exert a mediating influence. Finally, the study attempted to outline theory which might assist understanding of the factors and processes influencing mental state in prison.

1.4. AIMS OF THE STUDY

The aim of this study was to identify factors influencing mental state in prison by considering circumstantial, social and experiential variables and their dynamic interaction. A secondary aim was to consider the necessary service provision for promoting a positive mental state amongst prisoners.

1.4.1. Objectives

The specific objectives of the study were to consider the nature of imprisonment; to identify determinants of mental state in prison; to consider consequences of poor mental state; to set mental state within an extended pre and post-release timeline; to consider necessary service provision; to explore relevant concepts which arose from the literature and data; and to construct theory consistent with the data. The aims may be summarised by the rephrased question: 'How do prisoners' circumstances and experiences affect their mental state in prison and beyond?'

The objectives could be broken down into the following goals:

- Present imprisonment within an historical, social and experiential context
- Identify the current social status of imprisonment
- Examine the psychological, health and social status variables of prisoners before and during prison
- Identify variables associated with mental state
- Contextualise mental state within the lived experience
- Consider the necessary provision of services to meet prisoners' mental health needs
- Explore the public dimension of imprisonment and its impact upon mental state
- Generate theory which helps explain the data

1.5. ETHICAL CONSIDERATIONS

Pursuant to the task of collecting, storing and analysing data and consistent with the *Code of Professional Conduct* (Nursing and Midwifery Council 2008), the author sought to manage the study within the parameters of best research practice. The 2002 data collection (see data source no. 2 in Table 1) resulted from the researcher seeking, securing funding and leading as co-principal a mental health needs assessment research project. At this juncture the researcher was an enrolled PhD candidate. Ethical approval was granted by the local research ethics committee only following lengthy consultation and action to safeguard prisoners' wellbeing and interests.

A further application was made to the local research ethics committee specific to the PhD study. Approval was given in February 2004. This gave permission for the inclusion of the 2002 needs assessment data within the study and collection of additional staff data. The data (itemised under no. 5 in Table 1) from HMP Swansea in 2005 was collected as part of an audit to inform service redesign, and the prison and

local health board decided ethical approval was not needed. This data was made available to the researcher specifically for use within the PhD study. All other data was already in the public domain.

1.6. STUDY DESIGN

The study constituted a triangulated (Bowling 1997), multi-method enquiry into factors affecting the mental state of prisoners. It followed the usual research conventions consisting of reviewing the literature, formalising a research question, collecting and analysing data and then writing-up. As with much applied research (Bickman and Rog 1998) there was some iterative development of theory as the study developed.

1.6.1. Study precis

Literature was reviewed relating to prisoners' mental state and a wide range of psychosocial variables linked to pre-prison and prison experiences. Themes (life outside prison, life inside prison, mental state in prison), and topics (social exclusion, socialization, experience, regime, vulnerability, identity, health), were utilised in order to organise literature and data. Tools were developed (questionnaires and a semi-structured interview schedule), and utilised General Health Questionnaire (GHQ-12) to collect quantitative and qualitative data sets from six sources, on these variables. Data collected consisted of a range of psychosocial variables representative of the multiple potential influences upon mental state. Data were reported descriptively and inferentially tested for association with mental state and contextualised within emerging qualitative data themes. Poor prisoner mental state was considered in terms of causation, service responses, prisoner and staff perceptions, and public hostility to prisoners. Theory was developed to explain the study findings. Socialization and identity were proposed as critical factors mediating mental state and comprise part of an 'adaptive-socialization' hypothesis.

1.7. THEMATIC LINKS

In order to establish clear logical links through the study, the thesis attempts to refer subject matter at each stage of the thesis back to the research question. Data collected and variables analysed reflect the themes and topics; the theme life outside prison and the topic social exclusion are represented in a number of variables such as unemployed and history of drug use. Life inside, socialization and regime, are represented in the variables time in cell, constructive daily regime and feel safe sharing cell. Therefore the topics and themes covered within the literature review, the data collection, analysis and ensuing discussion and recommendations, all establish relevance to the research. In this way the study logically links its themes, topics, literature and data, and exploits these to address the research question.

1.8. REVIEW OF LITERATURE

Literature was selected from a broad range of multi-professional and media sources on the basis that it linked to the study's topics and themes, helped illuminate the nature of prisoners' mental state and addressed the research question. Each chapter within the literature review therefore discusses aspects of psychosocial experience and links to prisoners' mental state. The process of acquiring necessary literature to support the research has taken place throughout the study. For example the needs assessment aspect of the study required specific attention on needs assessment, whilst the use of the BBC data required some search for literature discussing using the Internet within research studies. Over 400 documents and 50 books were collated within a personal library, whilst around 1,000 references were collected on an endnote bibliographic database. Search terms used included 'prisons', 'prison health', 'prisoner mental health', 'social exclusion', and 'offender health'. A further literature review was conducted in July 2006. This search was intended to follow up data obtained within the 2005 health needs assessment at HMP Swansea and HMP & YOI Parc. This search focussed upon literature relating to prisoners' health and social exclusion. The following databases were utilised: Medline, Embase, Cumulative Index to Nursing & Allied Health Literature (CINAHL), the Cochrane Database of Systematic Reviews, and the Applied Social Sciences Index and Abstracts.Specialised collections published by the Department of Health (England), Welsh Assembly Government and UK prison services, systematic reviews, guidelines, press releases, conference proceedings and statistics published in the UK and in English were also considered. In addition, throughout the study, the author monitored news stories appearing in the media and where relevant tried to make use of them. The BBC news website was the primary source for this literature, whilst other websites were also accessed.

In addition papers identified within a systematic review by Watson et al. (2004), were obtained via personal correspondence. Initially an annotated bibliography was obtained. Following cross-referencing against the existing documents held, further correspondence led to an exchange of those articles not already held. This systematic review was commissioned by an English NHS regional executive in order to inform them of prison health care issues. The search strategy encompassed all aspects of prison health, including health promotion, mental health, communicable diseases, and palliative care. This review obtained 90 papers and 21 reports or policy documents: 13 from the UK, five from North America and three from Europe.

1.9. DATA SOURCES

The various datasets contributing towards the study are identified in Table 1. The year of the dataset, as shown in Table 1, is used within the results section to identify specific datasets being referred to. Links between the data and themed chapters within the thesis are shown within the links column.

Table 1: Outline of Data Sources

Data Source	Purpose	Tools	Links
1. Woolf Report into UK prison riots of 1990 (Woolf, 1991)	Establish context on nature and experience of imprisonment	Analysis of report	Chapter 3 Literature Review: Life on the 'In' (i) Regime Chapter 10 Results: Life on the 'In'
2. Prisoners at HMP & YOI Parc (and the Juvenile Unit) and HMP Swansea (2002)	Establish prisoners' psychosocial, personality, offending, regime and mental status Elicit perceptions re. how prison impacts upon individual prisoners	i) Purpose designed questionnaire including GHQ-12 (*n = 861)* ii) Semi-structured schedule of questions used with seven focus groups	Chapter 2 Literature Review: Life on the 'Out' Chapter 3 Literature Review: Life on the 'In' (i) Regime Chapter 4 Literature Review: Life on the 'In' (ii) Experiential Factors Chapter 5 Literature Review: Life on the 'In' (iii) Health and Mental State Chapter 6 Literature Review: Life on the 'In' 'My Head's Gone!' Chapter 9 Results (i): Life on the 'Out' Chapter 10 Results (ii): Life on the 'In' Chapter 11 Results (iii): 'My head's gone!'
3. Audit of medical records from HMP Swansea and HMP & YOI Parc (2002)	Establish extent to which 'problems' figure within official medical records	Purpose designed audit tool (*n = 270*)	Chapter 5 Literature Review: Life on the 'In' (iii) Health and Mental State Chapter 6 Literature Review: Life on the 'In' 'My Head's Gone!' Chapter 10 Results (ii): Life on the 'In' Chapter 11 Results (iii): 'My head's gone!'
4. Staff working in prison or community locations (2004)	Establish staff perceptions of: i) factors impacting prisoners' mental state ii) service priorities	Purpose designed staff questionnaire (*n = 60)*	Chapter 5 Literature Review: Life on the 'In' (iii) Health and Mental State Chapter 6 Literature Review: Life on the 'In' 'My Head's Gone!' Chapter 10 Results (ii): Life on the 'In' Chapter 11 Results (iii): 'My head's gone!'
5. HMP Swansea (2005)	Establish general health and social status of prisoners	Prison first reception health screen - revised F2169 (*n = 409)*	Chapter 5 Literature Review: Life on the 'In' (iii) Health and Mental State Chapter 6 Literature Review: Life on the 'In' 'My Head's Gone!' Chapter 10 Results (ii): Life on the 'In' Chapter 11 Results (iii): 'My head's gone!'
6. BBC *Discussion Board* (2006)	Establish public perspective of prisoners and their problems	Data collected directly from BBC website *(n = 327)* and selected data used verbatim	Chapter 2 Literature Review: Life on the 'Out' Chapter 9 Results (i): Life on the 'Out'

1.10. THESIS STRUCTURE

The thesis is designed to answer the question 'which factors influence prisoners' mental state' and in so doing has to marshal a wealth of literature and data and funnel it toward the research answer. Key to the thesis structure is the linkage between literature review chapters and results chapters. Each of the chapters within the literature review is linked to a results chapter where data illustrative of the themes and topics identified within the literature review, are presented. This serves to link general topic areas concerning prisoners' circumstances raised within the literature review (social exclusion, socialization, regime, experience, vulnerability, identity, health) more immediately to the prison mental state question. It also serves to anticipate the rationale for data analysis whereby variables embodying the themes and topics are tested for association with mental state.

- Chapter 2 reviews literature relevant to life outside prison
    - links to results in Chapter 9
- Chapters 3, 4 and 5 review literature relating to an element of life inside prison (regime, experience and health respectively) and relate to mental state
    - links to results in Chapter 10
- Chapter 6 summarises the literature review themes and topics and acts as a lens to focus the subject matter upon the prison mental state question
    - Links to results in Chapter 11
- Chapter 7 outlines the study design
- Chapter 8 details the methods
- Chapter 9 presents descriptive data which is illustrative of prisoners' experience of life outside prison
    - links to Chapter 2
- Chapter 10 presents data which describes health status and experiences of life inside prison
    - links to Chapters 3, 4 and 5
- Chapter 11 presents the GHQ data identifying which variables are associated with mental state; and qualitative data which establishes context
    - links to Chapter 6
- Chapter 12 discusses the results, and proposes an adaptive-socialization theory predicated upon identity, to explain the findings
- Chapter 13 makes recommendations for policy, practice and research

The schema of the study showing linkages between data, themes and chapters was shown in Table 1 at 1.9.

1.11. SUMMARY

This chapter has stated the research question namely which factors influence prisoners' mental state?; summarised the current state of research knowledge regarding prisoners' mental status (epidemiologically developed but lacking in participative, prison and pre-prison lived experience research); and established a prospectus as to why prisoners' mental state matters (it links to distress, self-harm, suicide and negative life trajectories). Prisoners have been presented as a special population, (experiencing routinely excluded backgrounds and multiple disadvantages) and presenting with special needs. Formative experiences, as well as experiences in prison, have been proposed as being likely to influence prisoners' mental state. Research to date has largely avoided the complexity of the real life, dynamic interaction between life experiences especially outside prison, and mental state in prison. The case for research capturing the dynamic interaction between these factors has been made, the means by which this was undertaken was described, and the linked structure of the thesis outlined. The following chapter presents a review of the social background literature for prisoners and considers its significance to mental state.

CHAPTER 2

LITERATURE REVIEW: LIFE ON THE 'OUT'

2. LIFE ON THE 'OUT'

2.1. INTRODUCTION

Central to this thesis is the question: how do prisoners' circumstances and experiences affect their mental state in prison and beyond? Prisoners' circumstances comprise their pre-prison experience, social background, education, training and work, relationships, health, drug use, and offending. Each chapter within the literature review defines and discusses aspects of psychosocial experience from which the study data was drawn. This chapter offers a review of the literature describing the pre-prison psychosocial experience of prisoners and links to data presented in Chapter 9, which is further analysed in Chapter 11. The effect of adverse formative developmental, social, cultural, and offending factors upon the identity of the individual is discussed. The notion that common pre-prison factors draw together individuals within a shared experience identity is proposed and explored with reference to mental state.

2.2. RATIONALE

Could the pre-prison social experiences of prisoners be relevant to mental state in prison? Pre-existing mental health problems clearly impact upon suicide in prison (Howard League for Penal Reform 1999), but what of less recent, formative or more subtle cultural experiences? Might these too exert an influence within the prison environment, and if so how? In order to start addressing these questions it is necessary to examine the backgrounds of prisoners.

2.3. SHARED CHARACTERISTICS

Many offenders appear to share a number of social characteristics (Foster 2000, De Viggiani et al. 2005). They tend to be young, repeat offenders with lengthy histories of criminal behaviour often of an acquisitive nature, frequently accompanied by violence, with poor levels of educational attainment, poor employment history and prospects (Ashby et al. 2005, Carrabine et al. 2002, Carr and Vandiver 2001). Prisoners often also present with substance misuse problems and mental illness (Ramsbotham 2003). Prisoners are therefore likely to be drawn from a geographical and social pool where a nexus of interconnected factors characterised by childhood disadvantage, low educational attainment, poverty, unemployment, drug use, ill health, victimisation, and family and social fracture coexist (Foster 2000).
The following table (Table 2) highlights the disadvantage experienced by many prisoners in comparison to the general population.

Table 2: Social Characteristics of Prisoners (Social Exclusion Unit, 2002)

Characteristic	General Population	Prison population
Ran away from home as a child	11%	47% of male and 50% of female sentenced prisoners
Taken into care as a child	2%	27%
Regularly truanted from school	3%	30%
Excluded from school	2%	49% of male and 33% of female sentenced prisoners
No qualifications	15%	52% of male and 71% of female sentenced prisoners
Numeracy at or below Level 1	23%	65% (level expected of 11-year-olds)
Reading ability at or below Level 1	21-23%	48% (level expected of 11-year-olds)
Unemployed before imprisonment	5%	67%
Homeless	0.9%	32%
Suffer from two or more mental disorders	5% men and 2% women	72% of male and 70% of female sentenced prisoners
Psychotic disorder	0.5% men and 0.6% women	7% of male and 14% of female sentenced prisoners
Drug use in previous year	13% men and 8% women	66% of male and 55% of female sentenced prisoners
Hazardous drinking	38% men and 15% women	63% of male and 39% of female sentenced prisoners

Table 2 shows the extent to which prisoners are disadvantaged across a broad range of educational and social indicators. For example half (50%) of prisoners ran away from home as a child - compared to 11 per cent of the general population. About one third of male prisoners were excluded from school and over half have no qualifications. Less than 5 per cent of the general population have two or more mental disorders, compared to 72 per cent of male sentenced prisoners. This data portrays a population at a considerable disadvantage to their peers and amongst the most disadvantaged within the UK. Prisoners are therefore often individuals adversely affected by their social situation (The Howard League for Penal Reform 2000) who present with multiple and complex needs. As Corner notes:

> the bulk of prisoners are drawn from the most socially excluded sections of society. A high proportion of the prison population, particularly those on remand or short sentences, have a range of complex needs, including mental health problems, severe debt, homelessness and drug and alcohol issues.
>
> Corner 2004 p.6

This has led to a formulation by Juliet Lyon of The Prison Reform Trust, that prison is fulfilling the function of a 'capacious social service' (BBC News 2007), a role it is not designed, or adequately resourced for.

2.3.1. The social exclusion concept

The portrayal of the default social care function of prison highlights the extent to which prisoners come from the socially problematic backgrounds captured by the term social exclusion described by Bradshaw and Finch (2003) as combining multiple processes from which situations of social disadvantage can arise (Whelan and Whelan 1995). Social exclusion has further been defined as 'being shut out of the economic, political and cultural systems which make up social life' (Moore 2002 p.83).

According to the Social Exclusion Unit (2005), social exclusion occurs when people or places suffer from this nexus of problems creating a culture of continuing exclusion. Social exclusion starts at birth or arises from problematic situations faced by individuals throughout life, resulting in a life spent on the fringes or outside the normal boundaries of civilised society (Foster 2000). The creation of points of re-entry into society is the goal of much government policy (Watt 2001), although sentencing an increasingly large number results in a tangible form of exclusion from society. Central to the experience of social exclusion is unemployment (Byrne 1999). According to Moore (2002), other constituent factors of social exclusion are school exclusion, restricted access to General Practitioners, ill health, relationship and family breakdown, self-harm, and social injustice (Garland and Sparks 2000).

In the US a common public attitude towards offenders is one of hostility and a desire for an increase in the number of offenders imprisoned (Zimring and Johnson 2006). Public opinion in the UK is also generally hostile to offenders. The link between media portrayals of youth crime and punitive public attitudes towards young offenders has also been demonstrated (Haines et al. 2007). This study comprised a public survey of 496 people in Swansea and was predicated upon testing local opinion in an area adopting an inclusive approach to young people. The authors concluded that at a local level, opinion is formed by national media and fuelled by rhetoric such as prison works (Howard 1996), rather than a mature understanding and recognition of the needs of offenders. Such hostility forms the background to the environment into which prisoners are released and is likely to affect their post-release experience and further reinforce social exclusion.

2.3.2. Social exclusion, mental state and prison

Social alienation and exclusion have been linked to suicide (Catanese and Tice 2005, Kushner and Sterk 2005), whilst a report by the Department of Health (1999) highlights that:

- unemployed people are twice as likely to have depression as people in work
- children in the poorest households are three times more likely to have mental health problems than children in well off households
- people who have been abused or been victims of domestic violence have higher rates of mental health problems
- people with drug and alcohol problems have higher rates of mental health problems
- between a quarter and a half of people using night shelters or sleeping rough may have a serious mental disorder, and up to half may be alcohol dependent
- some black and minority ethnic communities are diagnosed as having higher rates of mental health problems than the general population - refugees are especially vulnerable
- there is a high rate of mental health problems in the prison population
- people with physical illnesses have twice the rate of mental health problems compared to the general population

Individuals whose backgrounds include being homeless, poorly educated, drug or alcohol dependent, having mental health problems or have experienced family trauma can find these issues aggravated by the experience of prison (The Howard League for Penal Reform 2000). These problems can be exacerbated in prison through mechanisms of loss of employment and general dislocation from supportive familial and social networks, leading to further problems following release. This further exacerbation of problems post-prison, results in high levels of reoffending (Social Exclusion Unit 2005). Reoffending rates among offenders are high:

- 67% are reconvicted within two years of release
- among men aged 18-21 the rate is 78%
- nearly one in three will be of 'no fixed abode' upon release
- the majority of prisoners will have no job to go to
- 60% of employers automatically exclude those with a criminal record making employment difficult even for those with skills or experience

BBC News 2006d

2.3.3. Re-entry into society following release from prison

The mental health status of an individual may be inextricably linked with social exclusion, their offending behaviour and their future chances of staying clear of the Criminal Justice System. As Travis and Petersillia (2001) note of the US experience, based upon an analysis of government agency data and focussing upon the prospect of the current cohort of prisoners re-entering society:

> the consequences [of imprisonment] for a prisoner's mental health may be adverse, and for substance abusers the effects of incarceration depend heavily on the management of the risk of relapse.
>
> Travis and Petersillia 2001 p.302

Whilst there are significant differences between the US and UK criminal justice and social systems, notably the availability of universal welfare and health provision in the UK, the issues discussed and the problems identified as facing prisoners upon release in this paper have a resonance with the UK experience:

> prisoners are less prepared for reintegration and less connected to community based structures. Linkages between prisoner re-entry and the related social policy domains of health policy, family and child welfare policy, workforce participation, civic participation and racial disparities...show the potential for more systematic reintegration policies.
>
> Travis and Petersillia 2001 p.291

Although some of the challenges faced by UK prisoners are comparable with their US counterparts, the provision of universal statutory services in the UK facilitates strategic planning to provide regional frameworks for re-entry as this quotation from a West Midlands regional planning document shows:

> The individual needs of each ex-prisoner cannot be overemphasised. The resettlement components that are relevant will vary according to those needs.
>
> Engage 2004 p.9)

In the findings of one UK study comprising eighty qualitative interviews, additional telephone interviews and seminars with prisoners, staff and other stakeholders, key to successful re-entry was the provision of affordable quality accommodation which enabled other needs to be organised and addressed within a stable social environment (Allender et al. 2005).

Lart (1997) reported that prisoners' continuing mental health needs were often not addressed at the point of discharge, and that upon release, prisoners presenting with a range of needs arising from mental illness were referred between agencies unable or unwilling to deal with them. These findings arose from an action research project undertaken at HMP Winchester with the Wessex consortium of five local health authorities and a social services department serving a catchment area with a population of 2.5 million in southern England. The project team surveyed 937 prisoners to identify those who required access to mental health services and then attempted to bridge the gap between prison and community services upon release by facilitating referral and information exchange between agencies in order that prisoners' needs could be met. A further needs assessment commissioned by the same consortium (Badger et al. 1999) identified a lack of specialist secure psychiatric provision, resulting in many seriously mentally disturbed prisoners continuing to be held within the prison system.

2.4. DRUG USE AND CRIME

Drug use and crime ameliorate the deadening experience of social exclusion (Foster 2000), whilst 87 per cent of prisoners have a mental health or drug problem (Higginson 2003). In a UK study of substance use, health and social problems of 1,075 service users assessed at referral by 54 agencies chosen to be representative of the main national drug treatment modalities, poly drug use and heavy drinking were found to be significantly correlated with offending behaviours (Gossop et al. 1998). In a study comprising interviews with 136 defendants who had been detained by the police prior to their first appearance in Liverpool Magistrates' Court for their current alleged offence (Brabbins and Travers 1994), lack of diversion for drug users was found to be problematic and prison was considered likely to make their drug problems worse.

Often presenting with complex needs compounded by money problems and drug habits, individual offenders can become dependent upon acquisitive crime to fund their drug use. Drug use may also in turn lead to socialization within an offending and criminalised subculture (Moore 2002), and is also linked to the transmission of communicable disease and poor mental health (RCN 2001; Watson, Stimpson et al. 2004; World Health Organisation 2005). Drug misuse is an important problem spanning community and prisons because apart from the direct effect on health (intoxication, overdose), it also causes problems through dependency relating to social, health and offending domains. For example injecting, needle sharing and intravenous drug abuse is a particular concern because of the risk of spread of HIV (Hart et al. 1989). Dependency on heroin use highlights a shift in the availability, affordability and popularity of heroin as a street drug now, compared with 10 years ago when it was less widely available and used. There is some evidence to suggest that maintaining offenders using heroin in community treatment programmes has a positive effect in reducing further offending, although the benefit is marginal (Healey et al. 2003). New patterns of working between prison and community drug teams (Hucklesby and Wilkinson 2001) need to be developed to maintain mental health and safe drug use post-release. Most substance misusing prisoners will return to their previous home address or area, resulting in any progress towards drug abstinence in a carefully managed prison environment, being severely tested and often lost once the individual re-engages with their previous peer group.

2.5. MENTAL ILLNESS AND CRIME

Mentally disordered offenders generally appear to pose a relatively low risk to the public as it is only a small sub-group of mentally ill persons that represent a risk to others (Bonta et al. 1998). More often issues relating to drug and alcohol abuse in particular are related to offending behaviour (Gossop et al. 1998). Personality disordered individuals who feature heavily within the prison population will now be

better accommodated within mental health legislation. The more open definition of 'mental disorder' in the new Mental Health Act (2007), along with detention being permitted where appropriate treatment and/or management is possible, will enable detention of individuals with dangerous and severe personality disorder. Similarly the new community treatment orders are intended to enable closer supervision, monitoring and recall of individuals with serious mental illness deemed a risk to the public although evidence for the effectiveness of such measures is lacking at this juncture. Two contemporary epidemiological trials in Australia (n>118,000), combined with a systematic review of similar studies in the literature (n = 1108), found community treatment orders are ineffective at preventing cyclical repeat admissions to mental health services (Kisely and Campbell 2007).

However, there is a clear relationship between some specific mental health issues and offending. Personality disorder is associated with recidivism, repeated crime and violent offending; serious mental illnesses when accompanied by paranoia and assaultative command hallucinations are associated with violent crime; delusional disorders are associated with arson and stalking (Powis 2002). There is also a theory that some minor repeat offences are being committed by individuals who would have been given asylum within the old mental hospital system (Catcheside 2000, Gilligan 2001). Taylor and Gunn (1984) found that 30 per cent of men remanded to prison in the Oxfordshire region, who had a mental illness, were refused psychiatric care, whilst 9 per cent of the sample had a psychotic illness and 45 per cent of those with schizophrenia were charged with a violent offence. In their findings they concluded that the prosecution of minor offences amongst individuals with mental illness and who required care was inflating the prison population. Coid (1988) in a study based upon Winchester prison, focussed on the processes by which a decision to offer treatment was made and the willingness of NHS psychiatrists to offer treatment. The findings of this study were that 16 per cent of remanded men with mental illness were refused treatment and these were generally the men with the most severe levels of impairment often exhibiting learning disabilities. Subsequent work summarised by Shaw (2002) appears less concerned with whether transcarceration has occurred and more concerned with the scale of mentally disordered persons in prison. The consensus being that the number of mentally disordered persons in prison has increased significantly in the interim, is problematic, and is worse amongst the female and remand population.

2.6. YOUTH AND CRIME

> Prosecuted crime is committed overwhelmingly by young people.
>
> Carrabine et al. 2002 p.38

There appears to be an association between social exclusion, youth and offending. Establishing the exact nature of that association is complex although research has identified the following factors as being linked with youth offending:

- being male
- being brought up by a criminal parent or parents
- living in a family with multiple problems
- experiencing poor parenting and lack of supervision
- poor discipline in the family and at school
- playing truant or being excluded from school
- associating with delinquent friends
- having siblings who offend

Home Office 1997 p.15

These findings clearly show the extent to which early antecedents such as poor parenting, educational problems and socialization within offending cultures predispose individuals towards criminal life trajectories. Theoretical perspectives generated by psychologist Albert Bandura (Bandura 1973, 1976, 1977) relating to social learning theory, and criminologists Robert Burgess and Robert Akers who studied the empirical evidence regarding operant conditioning and socialization process within offending (Burgess and Akers 1966), also suggest that there is a strong socialization and learnt behaviour element to criminality, aggression and violence. (See also Siegel 1992, Conger 1976).

However there is little that is clearly or absolutely causal regarding criminal behaviour, even taking into account social learning. Recent research involving three related studies of socially excluded youth in some of Britain's poorest neighbourhoods in Teesside, utilising a critical case study methodology of participant observation and tape-recorded biographical interviews, stresses the importance of a qualitative, biographical and long-term perspective in attempting to understand drug using and criminal careers and wider youth transitions (MacDonald 2006). Against a background of collective exclusion amongst the young people interviewed (*n = 186;* 82 female and 104 male), most subjects shared many of the risk factors associated with offending. However only a minority went on to pursue full-blown criminal or drug using careers. Causal factors in defining delinquent transitions from more conventional ones were impossible to identify without reference to specific experiences and interpretations of those experiences. Critical moments such as parental separation or bereavement turned transitions in unpredictable directions; sometimes towards crime, sometimes away from crime. Another key finding was that whilst belonging to the local neighbourhood network engendered security and a sense of safety, the social capital of these networks restricted effective participation outside of this limited social arena.

2.6.1. Youth justice and welfare

There is evidence to show that young people are particularly poorly served by imprisonment. Young people who have committed relatively minor offences and who have complex issues are serving custodial sentences in environments which are overcrowded, and unsuited to addressing the social focus of individuals' problems (BBC News 2007a). Since the 1960s, measures to address youth offending and its causes have been dispersed across the social welfare and criminal justice agencies. Carrabine et al. (2002) identify that modern government policy has added welfare principles and disposals to the more punitive measures already available to the courts:

> The point is that welfare (meeting needs) or justice (punishing deeds) do not exist in pure forms...the policies and practices of youth justice continue to be characterized by compromises and contradictions between care and control.
>
> Carrabine et al. 2002 p.42

This theme of justice as an extension of welfare is reflected by Young (1999) who states that:

> this repositions the Criminal Justice System from the agency that is there to control crime to a bit player in the social agenda playing second bill to the family and employment, and dependent itself on public cooperation and support.
>
> Young 1999 p.31

This quotation develops the notion that prison has become a default social care agency – a role it is not resourced or prepared for and which does nothing to counter the long-term debilitating effects of exclusion.

In the long-term exclusion amongst the young may engender a sense of hopelessness, apathy and fatalism. This deadening experience is often relieved through drug use and crime or what may be described as a drugs-crime nexus. Whilst clearly being a factor implicated within youth crime, the relationship with drug use is not entirely clear cut or causal. Although far more common amongst young people now than in previous generations a survey conducted in London combining both qualitative and quantitative approaches reported that although drug use has increased, the view that drug use is now culturally mainstream, the so called'normalisation hypothesis is problematic as it exaggerates the extent and manner of use of drugs by young people (Shiner and Newburn 1997). This research which was an adjunct to a peer education project, was based around Manchester, comprised 52 interviews, and was contextualised by international statistical data which had led to a theory of normalisation (Parker et al. 1995). They found that young people were found to discriminate between what they saw as more acceptable softer and recreational drugs such as cannabis and ecstasy and harder drugs such as crack

cocaine and heroin. Furthermore many young people remained disapproving and punitive in their attitude towards drug users. From this they concluded that whilst drug use was as frequent as the international data suggested, they were able to distinguish between frequency and normality.

Rejection of the normalisation hypothesis as a satisfactory explanation for the drugs-crime link, has led other commentators to suggest that it is precisely the combination of social exclusion *and* drug use, which better explains the role of drug use within offending behaviour (Seddon 2000, Seddon 2006). Thus individuals can become trapped within parallel drug and criminal careers in as much as

> Those who have been forced out to the social margins live a precarious existence with no sense that their futures will be any improvement on the present. This is a deadening experience.
>
> Foster 2000 p.322

Such socially blighted environments are loaded with traumatic and oppressive antecedents which inevitably shape an individual's aspirations, identity, coping style and ability to function as a constructive member of society. Many of the behaviours evidenced prior to prison, such as substance use, or association with other individuals engaged in criminal activity, might be seen as a response to the stresses of disorganised and chaotic backgrounds, or as a way of seeking status or supportive interpersonal relationships within that environment. One individual involved in a conference for offenders and ex-offenders put it like this:

> it's just natural. When you are a boy in a deprived area you want to be the big man. You want respect and power, you want to fit in. You look around you and the only way respect is coming is from the crimes people commit.
>
> The Aldridge Foundation 2008 p.4

The issues of identity and meaning being derived from offending also came from another comment at the same conference:

> Sure I was 'attention seeking', but I only knew who I was when I was committing crimes. I had an identity. Otherwise I was no one, invisible and worthless, just like they said.
>
> The Aldridge Foundation 2008 p.9

These parallel drug and criminal careers further perpetuate a:

> superfluous class of unskilled, 'inadequate consumers' which are to a large degree created by... [this] vicious circle of penal and social exclusion.
>
> Van Swaaningen 1999 p.24

Whereas crime has long been a problem especially associated with misspent youth, there is now evidence that the disenfranchisement that results from social exclusion is lengthening the period of criminality well into adulthood (Home Office 1997).

2.6.2. Youth offending policy

During the 1960s, an increase in juvenile delinquency led to a large prison building programme for young offenders (Wildbore 2004). However incarceration is likely to be prejudicial in terms of life outcomes for young people. James (2003) from first-hand experience reports that:

> Young offender institutions ... are often little more than proving grounds for immature and maladjusted young men; gladiator schools rife with gangsterism, intimidation and fear.
>
> James 2003b p.149

For many young people imprisonment exacerbates their problems.

> the process of imprisonment and incarceration is a traumatic one that can shift individuals who were coping with the stress and trauma of life to a situation where mental illness is one consequence.
>
> Caraher et al. 2000 p.8

Suicide and self-harm are particular problems amongst young prisoners (HAFAL 2005) and are very much a feature of the culture of YOIs. Both the scale and the complexities of problems implicated within youth offending are significant. Travis states that more than one in four of all teenagers have committed a criminal offence in the last 12 months (Travis 2004). Mental health and other health and social care professionals are now involved in Young Offender Teams making it possible to offer health and social services to this group of mainly male, vulnerable people (Wildbore 2004). There is a high prevalence of mental health and learning disability problems amongst young offenders (Kroll 2002) but only 23 per cent of offenders diagnosed with psychiatric problems receive treatment, with ethnic minorities being particularly disadvantaged (Shelton 2005), and appropriate secure provision for mentally disordered adolescents being scarce (Vaughan 2004). There is a paucity of research into care of juveniles in secure settings and community alternatives (Kessler 2002). The discordance between policy rhetoric, which proposes alternatives to prison for younger offenders, and legislation and sentencing practice which increases the likelihood of their imprisonment, has been highlighted by Professor Rod Morgan, former head of the Youth Justice Board (BBC News 2007).

2.7. EXCLUSION AND HEALTH

Exclusion has consequences for health, demonstrated across a range of indicators such as increased morbidity, long-term limiting illness and early mortality (Joseph Rowntree Foundation 2000), whilst social isolation is similarly implicated to a broad range of morbidity (Lynch 1979). Furthermore, primary care engagement with excluded individuals is poor (Williamson 2007), resulting in individuals not receiving care and services they need. The Black Report (Department of Health and Social Security 1980) was the report of the expert committee into health inequality commissioned by the Labour government of the mid 1970s. It reported that since the creation of the welfare state in 1945 there had been an overall improvement in health, but that there were significant variations linked to social status and poverty. Subsequent reports have made similar findings, as for example in the Acheson Report (Acheson 1998, Joseph Rowntree Foundation 2000). Early life exposure to exclusion is particularly deleterious, resulting in:

> adverse trends in reading skills, unmanageable and aggressive behaviour at school, drug misuse, unemployment, teenage pregnancy, homelessness, crime and suicide.
>
> Watt 2001 p.175

Whilst exclusion and many areas of illness are linked via poverty, self-neglect, chaotic lifestyle and problems accessing services, there appears to be an interconnectedness of three main problem areas: mental health, substance misuse and communicable diseases. Homeless individuals are also over represented within the prison system and homelessness is linked to morbidity and exclusion from services. Homeless individuals are unlikely to be registered with a GP, making access to primary and secondary health care provision difficult, and limiting their ability to receive benefits. Homeless individuals are likely to present with multiple physical mental health and social problems (Wright and Tompkins 2006, Martens 2001). Homelessness is also implicated within the continuing cycle of offending, imprisonment, and reoffending. As one individual recalls:

> No fixed abode is the start of it all, it's the biggest punch to the stomach when you realise you've got nowhere to go but back to where you started.
>
> The Aldridge Foundation 2008 p.4

2.8. SOCIAL EXCLUSION, CRIMINALITY AND IDENTITY

Aspects of social exclusion have been directly linked with offending. Most offenders coming into contact with social work agencies will be poor, with poverty being central to their experience and almost their defining characteristic (Smith 1995). Crime is linked with unemployment, socio-economic deprivation, poor parenting, family deviance, school problems, hyperactivity and anti-social behaviour (Farrington et

al. 1990), these being the constituent prerequisites, antecedents and constituent factors of exclusion. The coexistence of social exclusion and criminality is seen as a feature of 'late modernity' by Young, who describes

> a movement from an *inclusive* to an *exclusive* society ... from a society whose accent was on assimilation and incorporation to one that separates and excludes.
>
> Young 1999 p.7

The weight of penal discipline falls disproportionately on the poorest and most excluded, further compounding their exclusion experience (Sparks 1996). This situation has been exacerbated by new statutes which criminalise certain anti-social behaviours and result in custodial sentences for offences, again particularly for the young (BBC News 2007). Offenders are also often victims of child abuse and other early trauma which have long-term psychological effects and require services designed specifically for them (Williamson 2007). These formative and social antecedents are likely to impact upon identity and social functioning. For excluded individuals, drugs and offending offer both some release and a medium for a shared social identity. This social identity may promote a code of behaviour which further embraces poly-drug use and acquisitive crime. As Moore (2002) notes of groups characterised by exclusion and drug use: 'Offending behaviour is more likely to occur as the group will provide mutual support in offending' (Moore 2002 p.272).

2.9. SUMMARY

The literature relating to the concept of social exclusion (Bradshaw and Finch 2003, Whelan and Whelan 1995) reviewed in this chapter establishes a high degree of consensus regarding the interlinkage between social conditions, mental health problems, substance misuse and offending (Social Exclusion Unit 2002, The Howard League for Penal Reform 2000). Furthermore the literature links social exclusion to the backgrounds of many offenders (Seddon 2006) and leads to the conclusion that these experiences are a common factor in many prisoners' backgrounds. Prisoners are most often young, habitual often acquisitive offenders, with problems relating to employment, substance misuse, mental health problems and violence (Ashby et al. 2005, Carrabine et al. 2002, Carr and Vandiver 2001). These experiences, in addition to difficult family environments and key relationships (Bandura 1977), exert a powerful modelling influence upon identity and attitudinal, behavioural and cognitive processes, and influence social function. Whilst common (and influential within behavioural and lifestyle patterns), social exclusion experiences cannot claim to be causal in terms of criminality. MacDonald (2006) identifies the importance of looking at critical life junctures within the individual's life story, in order to understand progression into criminality or abstinence from offending. The commonality of social exclusion experiences, suggests that before prison, prisoners share aspects of experience, culture and identity. It is possible that the social world of prison will reflect norms and values rooted in these factors.

CHAPTER 3

LITERATURE REVIEW: LIFE ON THE 'IN'

(i) REGIME

3. REGIME

3.1. INTRODUCTION

Whilst the background factors described in Chapter 2 establish a context for understanding pre-prison socialization and identity; experiences in prison are more immediate antecedents to prison mental state. This chapter tries to answer the questions 'what is it like in prison?' and 'how might the experience of prison relate to mental state?' In order to describe prison life, the chapter reviews literature relevant to the lived experience of prison. Special consideration is given to the Woolf Report into the 1990 prison riots (Woolf 1991). A more contemporary perspective is also provided, to identify cultural features, values and attitudes which are central to the experience of imprisonment. Policy and practice are described in order to outline the nature of prison regimes, from which the immediate experience of prison is derived. It is proposed that this subjective, immediate lived experience of the prison world is likely to be a critical influence upon prisoners' mental state.

3.2. RATIONALE

Much of the mental distress in prison appears to be situation specific: it is peculiar to the experience of being processed through the Criminal Justice System and being removed from familiar family and social contacts (Harding 1989). This chapter reviews the research evidence and other literature pertinent to the nature of mental distress in prison.

3.3. THE ROLE AND FUNCTION OF PRISON

Prisons are secure institutions housing (usually) men convicted, or remanded for trial (BBC 2006c). Their intended role is threefold. Firstly to house prisoners following arrest and throughout the judicial process, secondly to house prisoners with short sentences and thirdly to receive longer-term prisoners during the final part of their sentence in order to facilitate their return home (Ramsbotham 2003). Prisoners have committed offences serious enough to warrant custodial sentences (Criminal Justice Act 2003), such as those involving violence and where the individual is perceived as being a threat to society, although repeated minor offences or non-compliance with other non-custodial disposals may also result in imprisonment. For prisoners being held on remand other possible outcomes are acquittal, fines, being bound-over (where a magistrate exercises a power to instruct law abiding behaviour upon threat of imprisonment), a suspended sentence or community order. Where mental disorder is present, disposals available to the court include bail or remand for psychiatric assessment, and assessment or treatment under the Mental Health Act (1983) depending upon the court's view of public protection and risk (Woods 2005).

Prisons aim to protect the public by holding prisoners securely; reducing the risk of prisoners reoffending; and providing safe and well-ordered establishments in which prisoners are treated humanely, decently and lawfully. In working towards these objectives prisons have to work in close partnership with their commissioners and others in the Criminal Justice System to obtain best value from the resources available using research to ensure effective correctional practice. Prisons are also required to promote diversity, equality of opportunity and combat unlawful discrimination, and ensure staff have the right support and training to undertake their work effectively (HM Prison Service 2010).

3.3.1. Modern imprisonment in an historical context

The modern concept of imprisonment (Foucault 1979) is based upon the principles of visibility (the population can see the prison), observation (by the custodians of the prison) and control (through the regulation of space and time via the regime). Enforced supervision, control and order replaced brutality as the defining characteristics of modern disciplinary punishment, although some aspects of brutality remain within the current system (Black et al. 2006). However the ability of the prison to transform itself from an environment primarily of punishment, to one concerned with rehabilitation and reform of the individual, appears both to be a point relevant to the consideration of prisoners' mental state and also a current policy and practice dilemma. Meanwhile, recent new build prisons with their larger capacities tend to reflect an attitude of warehousing of prisoners (Kitchiner 2000). This attitude appears consistent with the modern ideas of control and order, but is contained within a culture of 'correction', privatisation and a free market of prison providers which is now becoming established in the UK following import from the US (Coyle 2005). Prisons, therefore, continue to exist within an historical narrative, a physical environment and a philosophical discourse centred upon punishment, whereas increasingly the needs of mentally disordered prisoners, and prisoners more generally (Wilson 2005), are being recognised within an alternative discourse on treatment, care, and support.

Alternatives to prison

State surveillance of felons has developed along a parallel course post-war, into new forms of regulating offenders. A modern justice professionalism has emerged, most clearly reflected within the ethos and practice of the probation services but also within elements of social work, mental health nursing, and other community based disciplines. This new professionalism, although commissioned within a statutory framework, principally operates upon constructs of supervision, pastoral care, support and guidance rather than incarceration. Within this model sanctions tend to be more subtly coercive initially (Kallert 2008, Szmukler and Appelbaum 2008), although detention or imprisonment exists as an ultimate fallback, pending serious non-engagement or non-cooperation (Kallert 2008).

Alternatives to prison have been developed in the form of community orders, a range of fines, community sentences and probation orders (Criminal Justice Act 2001). These alternatives share some common characteristics. Offenders subject to them reside in the community rather than in custody but are required to comply with various specified requirements as to their behaviour. Adherences to the requirements of the order are monitored by the probation service, and prosecution results from any serious breach of conditions. Many community alternatives are covered by the term probation orders, which allow the offender to retain his or her liberty by complying with the requirements of a court order and being supervised by an appropriately authorised official employed by, or acting on behalf of, a probation service. Community service orders are similar to other alternatives in so far as they involve supervision and compliance, but involve a higher level of direct reparation. Other forms of supervisory penalty include electronically monitored curfew orders, which are not necessarily supervised by probation services. Definitions of community penalties often exclude a large proportion of the offenders actually supervised by probation services where probation is used as a monitoring and rehabilitative means post-prison (Raynor and Vanstone 2002). For mentally disordered individuals, courts are able to consider remands on bail before sentence and wider use of treatment and non-custodial community disposals such as psychiatric probation orders and guardianship orders after conviction.

A prejudicial doctrine of less eligibility has historically condemned prisoners to a lower standard of living than that which is generally available to his or her peers (Sparks 1996). A public wish for punishment and hardship (just deserts) for prisoners would seem to be a necessary feature of penal policy (Potter 1990). The prevailing belief was that a person without means, whilst receiving some level of state aid, should not do better than the most poorly paid worker (Sim 1999). Attitudes towards prison in the nineteenth century can be summarised by a belief in 'hard fare, hard labour, hard bed' (Harding 1988 p.592).

Austerity

The late twentieth century form of the less eligibility doctrine found expression within an ethos of austerity (Garland and Sparks 2000). Consequently many professionals within the Criminal Justice System came to view those confined as

> different, abnormal and ...incarceration is therefore justified not only **as** punishment, but also **for** punishment.
>
> Sim 1999 p.30

In addition, within the prison system local prisons have maintained the most severe regimes. Local prison regimes are historically 'short and sharp' whilst longer sentences would be more 'prolonged and reformative' (McConville 1996). Sparks (1996) comments further upon the culture of penal austerity, noting how it has gained widespread political support. The notion of austere and Spartan regimes has developed the idea of the less deserving prisoner, in a more modern and acceptable guise. Although less

severe now than previously, particularly with the introduction of improved sanitation, the ending of slopping out and the introduction of television in cells, prisons are not cosy places, and the theme of austerity is reflected in the amount spent on food. Breakfast, lunch and an evening meal cost an average of £1.68 per prisoner per day (BBC News 2006f). Whilst notions of austerity have purposely been incorporated within modern regime design, frank injustices and routine pettiness have also existed well into recent times.

3.4. THE PRISON DISTURBANCES OF 1990

During April 1990, HMP Strangeways (now HMP Manchester) experienced the worst riot in UK prison history (Woolf 1991). Five further copycat disturbances followed (Cavadino and Dignan 2002). Although several inmates were charged with offences, the resulting inquiry found that the riots had some causes in unjust prison practices and repressive regimes. Systemic failures were identified within the Prison Service, which were felt to be contributory factors towards creating an environment within which the serious disturbances that took place in these six prisons could take hold and escalate (Woolf 1991). Woolf noted that the 1990 disturbances were themselves the latest in a recent line of such events, stating that:

> The events of April 1990 were only the last in a litany of serious disturbances which differed from the earlier disturbances only in their gravity and longevity.
>
> Woolf 1991 p.224

The riots of 1990 were seminal in shaping subsequent penal policy. The report into the disturbances by Lord Justice Woolf establishes a clear portrayal of modern policy and practice within UK prisons, but also an impression of the life and times of those incarcerated. Furthermore the report enables a deeper understanding as to how the culture and workings of a prison might influence the experience and inner or mental life of the prisoners themselves. In so doing, it provides a convenient resource from which to study prisons, their cultures and subsequent effects upon prisoners. For these reasons the Woolf Report was studied in some depth and handled somewhat differently from the rest of the literature reviewed. In effect it was handled as a 'primary' historical source (Kelleher-Storey 2004).

3.5. THE WOOLF REPORT

In its description of the events leading up to the outbreak of the disturbances, the Woolf Report identifies a systematic failure of the Prison Service to live up to its aspirational statements and rules. In effect, this resulted in an over emphasis upon security and control at the expense of humanity and justice. In this context injustice is deemed to be placing the prisoner within conditions which are 'inhumane and degrading' (p.241). This theme of injustice is a thread which runs throughout the Woolf Report,

manifesting in the conditions which many prisoners in many prisons face, especially if they are remand prisoners (p.241) or prisoners who are in some respect 'vulnerable' due to mental state or perhaps the nature of their crime and particularly individuals who have committed sexual offences. This injustice manifested itself through a lack of recourse to due process for resolution of grievances and complaints, due to a rigid interpretation of Prison Rules. Lord Woolf concluded that petty authoritarianism, overcrowding and the consequent degredation of prison regimes and conditions 'debilitated' (Jameson and Allison 2005) the whole prison system.

3.5.1. Significance of Woolf to thesis

Lord Woolf's report was published in February 1991. It was widely viewed as both liberal and radical, and the most fundamental appraisal of UK prisons during the twentieth century; as the Guardian Newspaper put it at the time, it was a plan for the restoration of decency and justice into jails where conditions had become intolerable (Jameson and Allison 2005). The prison experience in 1990 appeared, rather than to rehabilitate, to dislocate the prisoner from society and impede their chances and opportunities of leading a lawful life. Furthermore the harshness of prison existence is portrayed in the Woolf Report as petty, unnecessarily punitive and lacking in constructive opportunity. Paul Taylor who led the riots responded to a sermon by the prison chaplain immediately prior to the start of the riot, by saying:

> I would just like to say, right, that this man has just talked about the blessing of the heart and how a hardened heart can be delivered. No it cannot, not with resentment, anger and bitterness and hatred being instilled in people.
>
> Jameson and Allison 2005

Taylor's comment summarised the resentment and bitterness which was poisoning the UK prison system, and described the harsh environment which prisoners lived. It gives a powerful insight into the experience of imprisonment. The experience of hard and unjust fare was unlikely to be consistent with mentally healthy regimes, although it clearly produced a sense of solidarity on the part of prisoners united by defiance against the system. However not all prisoners were admitted to the collective solidarity. Woolf reports the terrible punishments meted out to segregated prisoners which led to mock executions, serious injuries and one death. Unjust and Spartan regimes, it appears, perpetuate stratified abusive social structures within the body of prisoners. Within this dynamic it is likely that the oppressed will fare worse, both generally in terms of their prison experience and specifically in relation to mental state, than those admitted to the collective.

3.6. PENAL POLICY SINCE WOOLF

Post Woolf, penal policy has consistently referred to, but varied from the proposals outlined within the report (Coyle 2005). The theme of missed opportunity as a result of not implementing the recommendations of the report more fully, find expression in the literature. For example, although the development of a coherent sentencing framework, consistent with Woolf, was an adopted principle of the 1997 government (Coyle 2005), the subsequent political pressures have mitigated against the kind of reforms and regime in prison that Woolf was recommending. The consequent tensions in prison have led once more to the kinds of tensions which preceded the 1990 disturbances (BBC News 2002a).

3.6.1. Recent policy and guidance

Government policy in the early to mid 1990s responded to the popular perception of lax regimes by increasing the numbers of offenders going to prison, curtailing more liberal regimes and generally reversing the recommendations of the Woolf Report (Sparks 1996). 'Tough on crime' was a mantra of the newly elected New Labour government of 1997 (Bennett 2006). Such rhetoric appears to have continued to impact upon prisons through decent but austere regimes (Bryans 2000), with an emphasis upon the removal of offenders from society and other situational responses rather than upon rehabilitative measures (Coyle 2005).

This shift away from Woolf marked a return to seeing the primary function of prison as being to punish the offender and protect society rather than to rehabilitate or care for the prisoner. Custodial regimes were the sequel to the policy goal of'public protection. Prison works became a political catchphrase justifying the sending of increasingly large numbers of offenders to prison (Baker 1996). However, harsh public policy often meant that training, preparation for release, and health care subsequently became expendable and cut back due to financial limits.

A significant critique of conventional penal policy in the shape of Restorative Justice is emerging, which favours alternatives to custody where practicable. Restorative Justice is a model of correctional thought, borne out of the perceived failure of retributive models of justice. Restorative Justice is reparative in nature. It proposes that rehabilitation can best be achieved through allowing offenders access to the consequences of their actions, and thus learning the effect of their actions upon others, often their immediate victims (Gurney and Watson 2005). It involves a high level of therapeutic risk-taking on the part of offenders and those affected by their actions (Small and Kimbrough-Melton 2002). The proposed benefit is that primarily offenders but also those offended against learn about the human cost of offending and share a therapeutic and healing experience which can be rehabilitative and socially inclusive for

offenders. Also for victims, the direct contact with offenders can give a sense of justice being served and an opportunity to raise directly with offenders the extent of any trauma which they have experienced (Herman 2005).

Community based restorative programmes in the US and Canada have found particular application with sexual offenders, through Circles of Support, which are groups of interested lay people who work with the offenders to help them maintain a lawful existence (Armstrong et al. 2008). Such programmes have been initiated in the UK, but they remain in their infancy, and remain controversial because of the sensitive nature of the work required. Restorative Justice as an alternative to retributive models of justice does appear to be gaining a foothold, particularly where community sentences are being considered as an alternative to custody (Lo and Harris 2004), but also increasingly within prison settings as an integral part of the sentence structure (Ministry of Justice 2007a).

More recently different government ministers have shown preferences for contrasting approaches to criminal justice. As Home Secretary, Charles Clarke was sympathetic to the needs of offenders. He called for a stronger focus upon meeting their wider health, social and rehabilitation needs (Clarke 2005). Whilst Jack Straw, as Minister for Justice, struck a far more conservative and familiar tone, in calling for prioritisation within the Criminal Justice System upon the needs of victims, and the primacy of prison punishment when dealing with offenders (Guardian 2008).

Lord Carter's review of prisons (Ministry of Justice 2007b) recognised the extreme pressure on prison places and recommended a management strategy based upon moderating sentence demand through structured sentencing, rationalising the operation of the prison system through an estate management strategy and the development of super-scale Titan prisons. The Justice Select Committee's report of 2008 outlined difficulties with the current sentencing framework, particularly a failure to target the most difficult and violent offenders which was the intention of the 2003 Criminal Justice Act; poor resourcing of the new indeterminate sentences; and increased pressure from new criminal statute.

A number of current reports have focussed upon the inadequate arrangements and resources for diverting mentally disordered persons from prison. Lord Bradley's review of people with mental health problems or learning disabilities in the Criminal Justice System (Department of Health 2009) recognised the increasing number of people with such problems within the prison system and advocated both more effective diversion at the point of arrest and better support in prison. A report by the Prison Reform Trust (2009) revealed that many people who should have been diverted into mental health or social care from police stations or courts are entering prisons, which are inappropriate to their needs, and are then being released back into the community without sufficient support. The Department of Health (2009b) published plans to respond to the issues identified in the Bradley Report. These included key government initiatives

around protecting the public, reducing health inequalities, reducing reoffending, and health improvement and protection. Older prisoners also face the risk of their needs not being recognised or met. 'Doing Time', a further report from the Prison Reform Trust (2008) provides evidence that older prisoners face isolation and discrimination, with prisons being unable to meet their specialist health needs, often related to chronic disease, with social and resettlement issues, whilst prisoners who use wheelchairs are often unable to join in day-to-day prison activities. Older prisoners can also face difficulties continuing prescribed medication regimes when in prison and often do not receive preventative and screening services. In addition few social services departments provide services for older people in prison. Provision for terminally ill prisoners is also problematic at a time when the number of older prisoners is increasing Prison Reform Trust (2008).

3.7. QUALITY OF PRISON LIFE

The type and age of prisons are material factors in considering the quality of life whilst inside. Many local prisons are old Victorian buildings usually lacking in classroom and workshop facilities and falling into serious and hazardous states of disrepair due to lack of maintenance. There appears to be a direct link between the policy framework with its emphasis upon just deserts and punishment and the impoverishment of both regimes and the experience of the prisoner. The plight of mentally ill prisoners is more shocking, for as Ramsbotham (2003) notes:

> All day long they lay down or sat beside their beds with nothing to do ... Other than medication, however, they received no day-care or any other kind of treatment programme.
>
> Ramsbotham 2003 p.10-11

The nature of the regime, as we have seen from the Woolf Report, is a significant determinant of quality of life in prison, as it affects all areas of experience. The pressure on places results in some local prisons housing prisoners a long way from their homes (Liberty 2006), as Newell (2001) observes:

> There are still inadequate opportunities for people to be held in prisons close to their homes, with 26,000 people held over 50 miles from their homes, 11,000 of whom are held over 100 miles away. As a result, the task of resettlement and safe return is made more difficult.
>
> Newell 2001 p.1

Reception into prison can be particularly traumatic for first time prisoners as this quotation illustrates:

> They [prison authorities] didn't tell me anything. I was terrified, they didn't even help me call my parents. By the second time though, you get used to it and you know what to do.
>
> The Aldridge Foundation 2008 p.10

Local prisons bear the brunt of problems associated with managing high turnover and capacity prison population. Endemic overcrowding and rising prison numbers have increased pressure on regimes, facilities and prison capacity generally. During June 2008 (BBC News 2008), the prison population stood at a then record of 83,245, right at the operational limit of the Prison Service, but it continued to rise. By October the figure stood at 83,383 (Guardian 2008). The lack of spaces to accommodate new prisoners from the courts has led to a national concern about the placement of prisoners (BBC News 2006a, BBC News 2006e), with the government promising to make emergency places available (BBC News 2006d), whilst prison reformers have called for an end to the use of prison as a dumping ground for social problems or as a 'social dustbin' (Higham 2006).

3.7.1. Prisonization

Notions of prison determining and shaping individual's responses to prison life, and life beyond prison, have featured within the literature throughout the latter part of the twentieth century. The prisonization theory was first developed in the 1940s by Donald Clemmer and held that prisoners would come to adopt the culture, mores and ways of the prison in terms of both their thinking and behaviour, resulting in individuals coming to identify themselves as criminals (Walters 2003). According to Walters, Wheeler (1961) used an inverted 'U' image to describe the prisonization process, being weakest and less pernicious immediately after reception into prison and prior to release. Prisonization supposes a change process within the individual prisoner, where the identity of the prisoner is reflexively shaped by contact with other prisoners and starts to reflect their values and patterns of behaviour. The theory proposes that the longer an individual is in prison, the more they will become prisonized or changed from their former values and distanced from the mainstream values of society. Thus longer sentences make rehabilitation more difficult. Prisonization therefore predisposes the individual, upon release, to recidivistic behaviour, criminality and thereby to further incarceration (Fry 1976).

Subsequently two variants of prisonization theory were developed (Walters 2003). The deprivation model proposed that prisonization arose as a result of the hardships and privations of prison, resulting in prisoners forming close bonds to help them through the prison experience. This model suggested that it was factors within prison such as length of sentence, expectations about role and function post-release, closeness of ties with others outside prison and conversely those within prison, social role adaptation, and the extent of alienation, which determined the extent of prisonization. The importation variant proposed that prisoners brought exposure to criminalised value systems and subcultures with them into prison which then became hybridised into the pervading milieu.

Recent criticisms of the prisonization theory highlight that the prisonization model focuses on explaining homogeny within the prison population rather than subjective differences (The John Howard Society

2010). Prisonization overlooks the fact that responses to the prison experience differ amongst individuals. While some inmates may display elements of prisonized behaviour, in other respects their values and conduct may differ significantly. Fowles (1977) presents two critiques of the theory suggesting that the process of prisonization is explainable by other factors related to social class or the individual prisoner's problems.

The John Howard Society (2010) report that recent studies into prisonization have suggested that in order to understand individual responses to imprisonment, 'a much finer analysis' is required than is forwarded by the generalisations of prisonization theory. They cite Zamble and Porporino (1988) stating that some researchers maintain it may be more useful to view prisonization as primarily an attitudinal factor. It is in combination with other experiential factors that the attitudinal prisonization factor then combines to influence adaptation to prison, rather than as an exclusive mediating process which can be accurately predicted (Zamble and Porporino 1988).

3.8. SUMMARY

Within the broader literature, prisonization (Clemner 1940) proposed that prison exerts a pervasive influence which shapes the individual's response to incarceration, but whilst depicting a realistic generalization of process within the prison population, it fails to account for differences between individual responses to imprisonment. The Woolf Report (Woolf 1991) found evidence of degrading conditions, pettiness and frank injustice with a lack of recourse to remedies available to prisoners. Prisons had the effect of brutally de-humanising their inmates and dislocating them from the social worlds from which they came and would return to, thereby compromising future life chances. Although policy post-Woolf has looked to incorporate the report's liberal and enabling findings, a lack of political will combined with hostile public opinion and pressure on prison places has constrained the introduction of rehabilitative regimes. Paucity of regime continues to the present, with many prisoners lacking meaningful elements to their prison day, and being poorly linked to external agencies. Prison environments are likely to create an adversarial social dynamic (us and them), rigid hierarchies, and have a potentially deleterious effect upon the mental state of many, particularly the most vulnerable individuals, exposed to them.

CHAPTER 4

LITERATURE REVIEW: LIFE ON THE 'IN'

(ii) EXPERIENTIAL FACTORS

4. EXPERIENTIAL FACTORS

4.1. INTRODUCTION

This chapter links to topics identified within Chapters 2 and 3 relating to common social experience and regime, and reviews the literature relevant to how the specific experiential factors linked to vulnerability, identity, and socialization may influence mental state in prison. These ideas are developed as constructs which may help us to understand the nature of being a prisoner, and how the process of imprisonment may act upon the individual and potentially influence mental state. A typology of prisoner vulnerability is presented. The links between vulnerability, identity, socialization and prisoners' mental state are discussed.

4.2. RATIONALE

Insight into the prison experience is necessary in order to understand the particular facets of prison life that impact upon the vulnerabilities which some prisoners have. Individuals differ in their ability to cope with prison, and adopt coping styles with varying degrees of associated psychopathological risk (Mohino et al. 2008).

Individual coping styles

An individual's level of coping can be influenced by internal cognitive responses to external factors and life experiences. According to the cognitive school of psychology, cognitive styles, that is an individual's tendency to think about their situation in a particular way, may directly influence mental state (Beck 1995). Individuals may evidence widely differing responses to seemingly similar events, according to their cognitions (thoughts) and core beliefs held concerning themselves and the perceived world, and the influence that these exert upon their emotional response to a given situation. Difficult emotions are likely to be regulated in some form by the individual in order to minimise distress. For example, individuals may often use substances in the belief that these will modify their mood and cognitive state within a particular situation, in effect constituting self-medicating (Graham 1998). However such behaviour can further destabilise individuals with poor mental state leading to drug induced psychosis. Whilst some or many life experiences may be common to many prisoners, such as a low level of educational attainment, varying degrees of social exclusion, and unemployment, their cognitive styles, adaptation to specific situations, and general ability to cope may differ markedly.

Features of prison life

There are also some common features of prison life, encapsulated in the regime, the experience of incarceration, detachment from friends and family, the necessity of coping with a sentence, and the nature of the interpersonal demands of fellow prisoners and prison officers, which may be thought of as material to prison experience and quality of life. Quality of life is likely to at least partly regulate mental state in prison. Alienation, illness or poor coping may render a prisoner vulnerable to the rigours of the prison system, the malice of other prisoners and to poor mental health. There may also be a cumulative effect of stressors, vulnerabilities and predisposing factors experienced outside prison combining with those experienced inside. The axes upon which individual well-being and mental state can be measured, therefore include functional, occupational, interpersonal, experiential, psychological and health related domains (Skodol 1991). Multi-axial assessment of mental state, incorporating such domains, has become routinely incorporated within diagnostic schema and clinical practice (Michels et al. 1996). The subjective experience and response of the individual prisoner to these multi-axial elements during imprisonment, will determine mental state.

This chapter examines the potentially mediating constructs of abuse, vulnerability, and identity. These constructs span a number of the axes identified as impacting upon mental state and summarise negative life events, a state in which future negative events are more likely to occur (vulnerability), and the self state which may do much to determine the cognitive and coping style of the individual (identity). Themes in this chapter link to the data presented in Chapter 11, where GHQ-12 data is tested against vulnerability and abuse variables for association with poor mental state. Qualitative data is also used to illustrate some of the themes arising from this chapter in Chapters 9 and 10.

4.3. THE PRISON EXPERIENCE

For those being received into prison reception the impact of prison can be traumatic, especially for first time prisoners. Stress can be increased by late arrival at the prison and delays in completing reception processes. Some prisons have earmarked special first night accommodation in order to smooth the transition into prison life (Mills 2005b). Issues linked to difficult experiences in prison include overcrowding (Black et al. 2006), frequent movement of prisoners, endemic drug use (Grounds 2000), a culture of bullying (Biggam and Power 1999), racial abuse (Shaw, Tomenson, and Creed 2003) and intimidation. Prisoners also have to contend with a range of related health problems in prison, and therefore face many challenges arising from their backgrounds and the custodial environments within which they reside, all of which may impact upon mental state.

4.4. ABUSE

Ever since revelations concerning neglect and abuse within mental health and learning disability hospitals entered the public domain throughout the 1970s, the profile of service user abuse across a range of care settings has risen dramatically. This profile was raised further by fresh scandals concerning neglectful, profit driven practice in the elderly care sector during the 1980s (Eastman 1994) and subsequently (Ward 2000), and the well publicised 'pin down' scandals within Leicestershire children's homes during the early 1990s (Levy and Kahan. 1991). Public concern at these scandals has driven the introduction of several pieces of government legislation designed to prevent the abuse of people who receive services, such as The Children Act (1990) (White et al. 1991), and 'No Secrets - Protection of Vulnerable Adults' (McCreadie 2000). These acts serve a twofold purpose - to deter potential abusers from actually abusing vulnerable individuals, and to effectively debar people who carry out abuse from working with vulnerable people in the future.

A large of body of literature has steadily emerged alongside this profile, the bulk of which includes sections about the psychological effects of being abused or exploited. These effects are uniformly viewed as negative and undesirable, such as symptoms of post traumatic stress disorder, re-victimisation, depression, anger, amnesia, anxiety, and substance misuse (Marsland et al. 2005). While much of this literature has focussed upon staff members' propensity to abuse, the problem of abuse inflicted by one service-user upon another is beginning to gain attention. Within the prison environment this would relate to prisoner-prisoner abuse. However, the potential for staff-prisoner abuse also remains real.

4.5. VULNERABILITY

Vulnerability has a number of specific meanings relevant to the experience of imprisonment. In Chapter 11, vulnerability will be examined against GHQ data to ascertain whether there are specific characteristics of the prison population which signal or appear to be correlates of poor mental state in the prison environment specifically. The identification of individuals with the propensity or predisposition to develop illness is the common use of the term vulnerable in the health related literature. The concept of the vulnerable adult has also recently become central to policy and practice in the field of social care. For example the propensity for some individuals to be predisposed or vulnerable towards schizophrenia is currently favoured in contemporary literature discussing the possible causation mechanism or aetiology of this serious mental illness. The 'stress-vulnerability model' (Zubin and Spring 1977) suggests that the pathology of schizophrenia exists within an interaction of social, psychological and physiological determinants (Freeman 2002). Vulnerability is here identified as a factor likely to lead to a particular

outcome, the development of a schizophrenic illness, and as part of the dynamic interaction of other variables such as stress, coping ability, extent of supportive friendships, and so on.

4.5.1. Vulnerable: a concept analysis

If we see the prisoner as vulnerable to negative life influences and outcomes, including continuing offending, exclusion and poor mental health, this recasts the prisoner from being a perpetrator to being a powerless player in the social hierarchy. Whilst being too simplistic an analysis to be any kind of objective truth, the use of the term vulnerable may open up new insights into the world of the prisoner.

Spiers (2000) proposes that the concept of vulnerability whilst used as an objective or epidemiological concept has omitted reference to the personal experience of the individual. This is an important consideration if health care is to respond to and accommodate individuals' own understanding of their health status and needs rather than organising care around the epidemiological interpretation of risk, one based upon comparative norms:

> Risk is usually equated with vulnerability. Population groups defined as vulnerable include the elderly, children, the poor, people with chronic illnesses, and people from minority cultures...members of captive populations, such as prisoners and refugees are also included.
>
> Saunders and Valente 1992 p.716

Within the epidemiological construct, vulnerability is seen as a predictive phenomenon, quantifiable and directly related to characteristics such as poverty or overall health status and determining the level of risk of a further event usually health related, such as myocardial infarction, onset of diabetes or sometimes related to personal abuse or other interpersonal situations. According to Spiers a personalised concept of vulnerability is dependent upon an individual's perception that the threat which they face is a real and meaningful one. In this way a person misusing substances recreationally may be happy with their drug use and therefore would not perceive a risk emanating from this aspect of their behaviour (Morse 1997).

Following Parse (1996), Spiers states that individuals have the capacity to determine what constitutes risk to them, and therefore vulnerability, like quality of life, is a subjective phenomenon for which a subjective account is required. Within Spiers' conceptual analysis, challenge is central to vulnerability, although challenge need not always be a negative experience and may present, citing Phillips (Phillips 1992), as an opportunity for personal development or growth.

Motivational interviewing (Rollnick et al. 1992) recognises the individuals' perception of their situation as key to developing a response to it. Cognitive behavioural approaches and, to a lesser extent, more traditional counselling approaches to therapy are also centred upon the individuals' subjective

experience, desire for change and ensuing action (Egan and Schroeder 2002). Spiers sees risk as an essential motivational factor for change:

> risk may still be part of this experience, but so is the individual's way of living with the risk and transforming it into positive growth.
>
> Spiers 2000 p. 717

Within a prison setting it is this positive growth or positive engagement with change which may be life changing and life enhancing. Such change may afford the individual prisoner an opportunity to attain skills and attitudes, which can admit them upon release, to a socially inclusive environment. Creating the necessary pre-conditions for such change to occur particularly in a custodial environment is skilled work not made easier by the prison emphasis upon security and custody rather than therapy (Norman and Parrish 2002).

A further concept analysis (Purdy 2004) identified three major categories of meaning associated with vulnerability within a systematic analysis of health and social care related literature. Firstly a risk based meaning, indicating a heightened chance or risk of acquiring an illness (incorporated within the first category of Table 3); secondly, a social dimension, arising from poverty and other adverse social circumstances (incorporated within the second category of Table 3); and thirdly vulnerability as openness to new possibilities, changes in personal recognition of situations and their possibilities (incorporated within the third category of Table 3).

Social exclusion as a form of vulnerability

The concept of social exclusion appears to comprise many of the same constituent concepts as epidemiological vulnerability as used in this discussion, but appears focussed upon the experiences of communities outside prison. Social exclusion predicates vulnerability to future negative events as being implicit within the definition of social exclusion. The following table (Table 3) attempts to summarise different dimensions of vulnerability as they apply to the prison setting and experience of prisoners. Table 3 follows:

Table 3: A Typology of Prisoner Vulnerability

Type	Discussion
. Epidemiological ulnerability quates to eightened risk of orbidity and ortality	Prisoners exhibit raised morbidity across a broad range of health indicators (Harty et al. 2003, Butler et al. 2005, Fazel and Benning 2006, Foster 2000). The prison population is therefore a vulnerable one (Condon et al. 2006) and especially vulnerable to poor mental health (Department of Health 1999). Arguably Zubin and Spring's (1977) stress-vulnerability model, which is often used to link life stressors with psychotic symptomatology, is a specific development of, but is also consistent with, this more general usage.
. Vulnerability rough social xclusion	In a social domain, prisoners tend to belong to socially excluded communities. These communities will often display cultures of poor educational levels of attainment, unemployment, substance misusing behaviours, crime, and poor prospects (Foster 2000, Farrant 2005). Prisoners therefore are likely to have complex needs, including mental health problems, severe debt, and homelessness (Corner 2004, Harman 2004). They are therefore vulnerable to the consequences of continuing social exclusion.
. Vulnerability as ersonal cognition of need	In one usage (Spiers 2000, Purdy 2004) vulnerability implies a personal level of understanding and recognition of the individual's own subjective propensity to illness and a concomitant response on the part of the individual. Vulnerability here is defined by the individual's perception and understanding, rather than any external or objective assessment.
. The vulnerable dult	The term vulnerable adult is a term used in social care services to describe a wide range of vulnerabilities, in particular to forms of abuse at the hands of others. In this context vulnerability is defined in relation to other people's actions (Bonds 2005, Cambridge and Parkes 2006, Griffith and Tengnah 2006, Gudjonsson et al. 2003, Thompson 1998). Protection Of Vulnerable Adult, or POVA, policies and procedures are now a statutory requirement of social service departments and other public agencies.
. Vulnerability to ressors within the rison environment	Some prisoners display a vulnerability specific to the stressors of the prison environment (Heritage 1994, Mills 2005a, Palmer and Connelly 2005, Hanson 2003, Hay and Sparks 1992, McGurk et al. 1996, Bonds et al. 2005). This may be an extension of the vulnerable adult concept discussed in no. 4, however appears to merit a separate type, as some individuals who might function well enough on the outside may display vulnerability in prison due to age, personality or offence type (Fry and Howe 2005, Garrard 1993).
. Vulnerability to icide	Of prisoners vulnerable to the specific stressors of the prison environment a subgroup will commit or attempt suicide, or have suicidal ideation (Liebling 1995) and evidence self-harm and suicide (Department of Health and HM Prison Service 2001). Young men, who make up the bulk of the prison population, are especially vulnerable to suicide, especially if they have a serious mental illness (Gasson 1995).
. Vulnerability to rvice neglect	Those prisoners with mental health problems are said to be especially vulnerable to statutory and professional neglect and being disowned by services (Watson 1993, Hore 2004). Individuals with serious mental illness are more likely to be arrested (Robertson, 1988). Prisoners with mental health problems discharged from prison are likely to be poorly served by community services (Lart 1997, Vaughan et al. 2000). These are often contributory factors towards reoffending.
. Vulnerability to stitutional abuse	Vulnerability to the power and abuse of prison authority, manifest through unjust, degrading, demeaning or assaultative treatment from prison officers (James 2003a, Wilson 2005).
. Vulnerability to led reintegration, gmatisation and offending	Upon release prisoners find reintegration into society difficult. On re-entry into society prisoners face a number of stigmatising factors such as a lack of qualifications, historical abuse, the status of offender-prisoner, mental health problems, and drug use. Stigmas may act through a hidden distress mechanism to limit life choice and opportunity (Scambler 1998, Scambler 2004). All of these stigmas may make resettlement more difficult and increase the likelihood of reoffending, relapse and continued exclusion. Failure to reintegrate is linked to high rates of reoffending (HM Inspectorate of Prisons 2007).
0. Vulnerability to dicalization	Placing people in a prison environment may compound their vulnerability to radicalization (Hannah et al. 2008).

4.6. DISCUSSION

As Table 3 shows, prisoners appear to be potentially vulnerable in a manner spanning ten distinct, but sometimes overlapping dimensions. Whilst the typology reflects distinctions in the use of the term, these categorisations cannot be thought of as watertight or absolute, but rather as variations upon a theme. The typology is not exhaustive. The different usages suggest care should be used in being precise about exactly what is meant when prisoners (or others) are described as being vulnerable.

4.7. IDENTITY IN PRISON

Competing narratives seek to explain the nature of relationships, and by extension identity, in prison. On the one hand, an American tradition of prison study presents the critique that prisons exist to forcibly contain and that prisoners are necessarily subjugated and oppressed within prison. This critique reflects a dichotomous analysis of power relationships in prison. In this analysis prison becomes an extension of the adversarial system of law, casting staff as authority enforcer figures, and prisoners as powerless. Powerlessness might reasonably be expected to lead to negative self-image and identity and poor mental state outcomes. A competing European tradition suggests more subtle social processes are at work.

Within the US tradition, the Stanford Experiment (Haney et al. 1973) assumes central significance. In this study a group of students were allocated roles within an environment designed to replicate the living conditions of prison. The students allocated to be guards quickly became authoritarian, repressive, aggressive and coercive towards their captives. Ideas generated from this key finding lead to the 'Lucifer Effect' theory, that 'good' people become 'bad' when presented with power and status within regimes designed to control others. This theory, according to Zimbardo (2007), is supported by historical evidence of abuses of power by political elites such as happened in Nazi Germany. More recent supportive evidence comes in the form of reports of prisoner abuse such as at the US military prison at Abu Ghraib following the Iraq war (Shanker 2004). In this instance, Iraqi prisoners were subjected to humiliating and sadistic practices by their US military captors. Both Zimbardo and Haney argue that the abuse and misuse of power is a logical and inevitable situational outcome arising out of deindividualisation within power-based prison environments.

Closer to home, the systematic abuse at HMP Wormwood Scrubs (James 2003a), might be thought to provide further evidence that prisons are a fertile ground for systematic abuse, in support of Zimbardo's position. Wilson's thesis (Wilson 2005), proposes that prisons are unsuitable and sometimes lethal environments for the rehabilitation of offenders, and is also predicated upon a notion that prisons perpetuate injustice, violence and abuse. Furthermore he argues that attempts to reform will be

ineffective in changing the prevailing culture, and hegemony of prisons, and consequently that the dismantling of the prison system is called for.

A European sociological-psychological perspective suggests a more sophisticated and shifting set of staff-prisoner relationships arising from the power dynamic of the prison environment. Piacentini (2006) whilst recognising the adversarial and skewed power dynamic which shapes much of the appearance of staff-prisoner relationships, also suggests a more subtle process is at work:

> a negotiated order of accommodation and compromise...Prisoners and guards isolated collectively from the outside world can share 'solidarities' and identities...The prison, its mode of rules and its flow control of physical and social interaction demands compliance from both the guard and the prisoner while the masculinist, hierarchical and austere environment must be shared by all.
>
> Piacentini 2006 p.10

A number of researchers have noted the extent to which a reactionary masculine identity based upon toughness exerts a controlling influence over prison culture (De Viggiani 2003, Mills 2003, Mills et al. 2006). Mills also describes the importance of prison authorities managing the prevailing masculine and closed staff and prisoner culture, in order to enable vulnerable prisoners especially, to cope with the pains of prison life. According to Mills, where special units exist to support vulnerable prisoners, staff very often evidence a more developed sense of empathy with the prisoners. It is this degree of empathy and emotional support, which enables a greater psychological intimacy to develop than is possible within a more adversarial environment, such as routine 'locations' [the average residential wing) within prisons.

Haslam and Reicher (2003), through replication of Zimbardo's Stanford Experiment, come to challenge its key finding that social and power roles within prison polarise and are pre-determined by the attribution of 'prisoner' or 'guard' status. Haslam and Reicher also report a more complex and shifting set of relationships, influenced by other variables and in particular the phenomenon of leadership. In their simulated experiment the 'prisoners' formed a cohesive social group with strong leadership structures, which was able to compete with the 'guards' for power. The prisoners were able to actively confront and resist the instructions of the guards. This scenario caused decreasing physiological symptoms of stress in the prisoners and increasing symptoms of stress in the guards over the course of the experiment.

4.8. IDENTITY AND MENTAL STATE

The significance of the prison power literature may lie in the development of prisoners' self-identity. The dominant narrative within sociology and psychology argues that identity is defined within a social context. Identity in prison is therefore likely to be shaped by the social world of the prison. Following Simnell (Wolff 1950), Goffman (Goffman 1969) in his 'interactionist' consideration of the presentation of self, developed

the 'dramaturgical-analogy', namely that humans adapt themselves to fit in with their surroundings, where the rules are unwritten but learnt by each of the 'performers'. Similarly, according to Anthony Giddens (Giddens 1984) culture and identity are inseparable, whereby individuals necessarily define themselves within their cultural experience. Close relationships are central to the socialization process and both create and maintain identities (Berger and Kellner 1977). Notwithstanding differences in interpretation of the power dynamics of prison relationships, some elements of analysis appear common. Prisons exert a rigid masculine hierarchy (Butler 2006, Mills 2003) within which prisoners must define themselves (Goffman 1969, Haney and Zimbardo 1998, Haslam and Reicher 2003). The resulting identities may do much to dictate the experience of imprisonment and the mental state of each individual prisoner.

4.9. SUMMARY

Following a brief exploration of the significance of abuse, the concept of vulnerability was analysed and proposed as a means of combining axes which negatively impact upon prisoners, and offering a fresh perspective upon the situation of the prisoner. In this context vulnerability plays out against another conceptual construct, that of power as it impacts upon relationship dynamics. The typology of prisoner vulnerability presented in Table 3, proposes ten discrete ways in which prisoners are vulnerable, and considers how these relate to the prison environment. Identity is likely to be influenced by elements of common social experience but redefined and re-allocated within the social world of the prison. Identity may define the individual's role within the prison's hierarchies and social networks and thereby influence socialization within the prison environment. Mental state seems likely to be a logical outcome of the lived experience of prison life and appears particularly susceptible to the pains and privations of prison. Poor mental state appears to combine issues of self-identity, vulnerability and prison socialization although the mechanism for the dynamic interaction can only be speculated upon and may differ between individuals. This chapter therefore served to identify a number of drivers likely to affect mental state: abuse, vulnerability, and identity.

CHAPTER 5

LITERATURE REVIEW: LIFE ON THE 'IN'

(iii) HEALTH AND MENTAL STATE

5. HEALTH AND MENTAL STATE

5.1. INTRODUCTION

Previous chapters have established links between social exclusion and morbidity, related to communicable disease, substance misuse and mental health problems. Given the extent of socially excluded individuals in prison, this nexus of problems is also evident amongst the prison population. Poor health in prison will be another impediment to serving a constructive period of custody; a constraint upon life quality in prison; and further shape the lived experience of the individual prisoner thereby influencing mental state. This chapter looks at the literature relating to prisoner health and explores links with mental state.

5.2. RATIONALE

Current conceptualisations of health have embraced biological, psychological and social (bio-psychosocial) dimensions. Thus, the most commonly used definition emphasises health as being more than the absence of illness, and including a state of 'complete physical, mental and social well-being' (World Health Organisation 1992, World Health Organization 1948). This definition shifted a previously illness-centred paradigm towards a more proactive, health promotion focussed construct. It also established a strategic direction for subsequent work in measuring and defining health status, within both population based research, and individual clinical assessment. Within the total health paradigm the importance of the subjective perception of health is also accorded significance. Quality of life (Ormel et al. 1997), although a broader construct, also impacts upon perception of health. Poor health, particularly chronic forms of illness (Pollock and Duffy 1990) are likely to be perceived as stressful and potentially compromise mental state through acting as stressors within a dynamic model of mental state, where stressors impact upon the individual's innate coping ability, which is proposed as being to some extent pre-determined by their genetic vulnerability (Zubin and Spring 1977). The availability of psychological support is likely to mitigate against the effects of stress, conversely its non availability may contribute toward a further deterioration in health status (Ben-Sira 1984).

5.2.1. Measuring health and mental health status

Within health assessment protocols the bio-psychosocial notion of health has also required elucidation of the subjective perception of health. For example a widely used baseline assessment of health status, The Nottingham Health Profile (McEwen 1993), intended for primary health care to provide a brief indication of health status, scores a patient's perceived (emotional, social and physical health) problems. The bio-

psychosocial nature of the Nottingham Health Profile is reflected in the six assessment sub-areas energy level: pain, emotional reaction, sleep, social isolation and physical abilities.

First Reception Health Screen

The First Reception Health Screen is routinely used throughout the prison service to assess prisoner health on entry to prison (HM Prison Service 2004). It also encompasses a multi-axial rationale. The data elicited by the First Reception Health Screen can be broken down into factors covering: medical and social status; physical health status; alcohol and drug use; mental health status; self-harm; and assessment outcomes. It has been criticised for failing to detect significant areas of morbidity and work has been undertaken to modify it (Birmingham et al. 1997).

Multi-axial assessment of mental state

Similarly mental health status has increasingly been measured across multiple-axes encompassing the bio-psychosocial domains (Jenkins and Shepherd 1996). The Camberwell Assessment of Need (CAN), commonly used to measure health and social care needs of individuals with serious mental health problems, is a 22 item rating scale incorporating physical, occupational, social and psychological items (Phelan 1995). CAN measures functional disability, social loneliness and emotional loneliness factors. Another common assessment format for mental health assessment, The Health of the Nation Outcome Scales (HoNOS) (Royal College of Psychiatry Research Unit 1995, Wing et al. 1998) measures 12 bio-psychosocial problem related items:

> overactive, aggressive, disruptive or agitated behaviour; non-accidental self-injury; drinking or drug taking; cognitive problems; physical illness or disability; hallucinations and delusions; depressed mood; other mental and behavioural problems; relationships; activities of daily living; living conditions; occupation and activities.
>
> (Royal College of Psychiatry Research Unit 1995)

5.3. PRISONER HEALTH OVERVIEW

The problem nexus related to social exclusion, communicable disease, substance misuse and mental health problems has found a particular focus within prison settings. In a systematic review of literature prisoners were found to have greater levels of illness than the community and exhibit greater health promotion needs and chronic disease management needs (Condon et al. 2006, Prison Reform Trust 2005) and raised morbidity across a broad range of health indicators (Harty et al. 2003, Butler et al. 2005, Fazel and Benning 2006, Foster 2000). In another systematic review of prison related health care literature three main, and often interrelated, health themes are identified, viz. mental health, substance misuse and communicable diseases - whilst also recognising that women and older prisoners have needs distinctive from the rest of the prison population (Watson et al. 2004). According to the Royal College of

Nursing (RCN 2001) the pressing health care problems in prison are self-harm, diabetes, asthma, communicable diseases, mental health problems and drug addiction.

Interaction of problems

The interaction of health and social problems can be seen through the fact that the prevalence of communicable diseases amongst prisoners can be 20 times greater than in the general population because of the concurrence of substance abuse and mental health problems (Potts 2000).

> The presence of illicit drugs and the associated harm from their problematic use has changed considerably the reality of prisons throughout Europe and the rest of the world. In the past two decades or so, the linked resurgence of communicable diseases such as tuberculosis and sexually transmitted diseases and the arrival of the new life-threatening epidemic of HIV/AIDS as well as the increasing attention being paid to the prevalence of hepatitis C has led all countries to seek the best ways of reducing their harmful health, economic and social effects.
>
> World Health Organisation 2005 p.1

Due to the favourable environment which overcrowded prisons offer to the transmission of infectious disease such as tuberculosis (Carbonara et al. 2005), hepatitis B and C and HIV (Allwright et al. 2000), prisons can facilitate the spread of these diseases. Young male injecting drug users are at particular risk (Crofts et al. 1995). Prison is therefore an important location for addressing major public health risks associated with infectious disease, whilst capability for dealing with chronic disease needs development. The leading cause of natural death amongst male prisoners in England and Wales are circulatory disease, followed by respiratory diseases (Fazel and Benning 2006). Smoking which is linked to the aetiology of these conditions is endemic amongst prisoners at around 80 per cent (Davies et al. 2001) and is a behaviour associated with lower socio-economic groups (Aitken et al. 1982), youth (Charlton 2001), worse health status (Gulliford et al. 2003) and longer term smoking related illness (Haustein 2006). Smoking therefore constitutes a major health challenge in prisons (Awofeso 2002).

5.3.1. Substance misuse

Within a US study, histories of substance misuse increased the risk of significant unmet physical and mental health needs (Narevic et al. 2006), whilst alcohol misuse is an extremely common but preventable major cause of ill health (Marmot 1997) which goes poorly treated in prison (Allison 2004). Alcohol is implicated within a crime-alcohol nexus whereby half of all homicides and serious assaults are related to alcohol use (Martin 2001); alcohol is often a significant contributory factor within criminal behaviour, causes significant harm to health and is responsible for considerable accidental injury (Bonds 2005). Poly drug use (Gossop et al. 1998, Gossop et al 2000, Farrell et al. 2000) and heavy drinking (McMurran and Baldwin 1989) feature prominently amongst the prison population, and are significantly correlated with offending behaviours (Gossop et al. 1998, Foster 2000), and poor health and social problems (Brooke et

al. 2000, Kraus et al. 2001). Conversely, coming off and remaining clean of illicit substances, is associated with cessation of criminal behaviour (Crossen-White and Galvin 2002).

Incidence

Measures of the level of substance use and dependence amongst the prison population vary according to the method of calculation (Fazel and Benning 2006). For example the determining criteria for inclusion can vary from any lifetime-use, to the much higher clinical dependence. The Fazel et al. study (2006) was a review of thirteen international studies (prisoner n = 7563) which met their standard for the use of standardised diagnostic criteria (placing the threshold towards the top of the acuity scale). They found that the threshold for alcohol abuse or dependence was met by between 18 per cent and 30 per cent of male prisoners. Drug abuse or dependence was found to vary from 10 per cent to 48 per cent of male prisoners. In a UK study (Mason et al. 1997) substance misuse is evident in 57 per cent of prisoners before remand to prison, constitutes a treatable condition within one-third of the remand population and is a significant marker for vulnerability within an already disadvantaged population (Brooke et al. 2000). Lifetime-use is likely to be considerably higher, with 85 per cent of prisoners admitting to illicit drug use within one self-reported, UK prison health needs assessment (Bowler et al. 2003a); this finding is consistent with a study from the United States which reported that:

> 80% of the state prison population report a history of drug and/or alcohol use, including 74% of the 'soon-to-be-released'.
>
> Travis and Petersillia 2001 p.302

These findings suggest that within many offending populations drug and alcohol use are cultural norms which often compound tendencies towards offending behaviour.

Prison fails substance users

Prison can be counter-productive for those with a substance misuse problem. Custody often worsens associated mental health problems and can provide opportunities to establish networks for future drug dealing. Traditional custodial sentences do little to help offenders with substance misuse problems to break out of their revolving criminal and drug use behaviours (Baron and Kennedy 1998, Buchanan and Young 2000). The fundamental problem of prison drug treatment-based programmes is that they may be reasonably effective at detoxifying motivated individuals within prison, but are likely to be of minimal efficacy once the individual is released back into the same drug-using social milieu, within which their earlier drug use took place and within which their crimes were committed. This problem was addressed within a study by Inciardia et al. (1997). This study evaluated a scheme which introduced follow-up care into the prisoner's release programme. Treatment was initiated within a therapeutic community prison environment in a three-stage system, with each phase corresponding to the individual's pathway through the prison system. The main stages being incarceration, work release within the community, and parole.

A comparison was made of 18 month follow-up data for those receiving no treatment, treatment in a prison-based therapeutic community only, a work-release therapeutic community followed by aftercare, and the prison-based therapeutic community followed by the work release therapeutic community and aftercare. Those who received receiving care during the parole stage had lower rates of drug use and reoffending, even when adjusted for other risk factors. The results provide evidence to support treatment models which extend beyond the confines of the prison.

5.4. MENTALLY DISORDERED PERSONS IN PRISON

Within the prison population, mental disorder has long been recognised as an issue of concern, and the subject of epidemiological research (Gunn et al. 1978). Prison mental health studies repeatedly show illness prevalence rates above community comparators, and highest rates amongst the remand and female prison population (Shaw 2002, Meltzer et al. 2002).

The nature of mental distress in prison

The nature of mental disorder amongst prisoners is often of a relatively transitory and reactive (but often severe) nature, arising from difficult life events, relationship problems, passage through the criminal justice process and reception into prison (Ramsbotham 2003). Conversely, problems may relate to long-standing forms of complex and serious (often psychotic) mental illness, suicidality and personality disorder (Shaw 2002). Prisoners appear especially vulnerable to poor mental health (Department of Health 1999), self-harm and suicide (Department of Health et al. 2001). Social exclusion experiences can contribute to these mental states, either as specific stressors, or in contributing towards the overall and general levels of stress experienced by prisoners, thereby heightening the likelihood of mental health problems. The prevalence of substance misuse, co-occurring within a mentally disordered prisoner, is a further complicating factor in terms of aetiology, presentation and management (Phillips 2000).

Mentally disordered prisoners have problems often stemming from adolescence, through management whilst in prison (Nicol et al. 2000), to inadequate follow-up, support and care upon release (Vaughan et al. 2000, Lart and Swyer 1997). Consequently mentally disordered prisoners constitute a vulnerable and difficult to manage group both inside and outside prison (Department of Health 1999). Inside prison, morbidity levels are raised in comparison to non-prison populations, appropriate therapeutic provision is scarce, whilst the incidence of self-harm (RCN 2001) and suicide is high (Howard League for Penal Reform 1999). Young men, who make up the bulk of the prison population, are especially vulnerable to suicide, especially if they have a serious mental illness (Gasson 1995). Mental disorder (MIND 2006) and disturbing levels of self-harm and suicide (Owers 2005) are routine in prison, whilst mental disorder links to the raised incidence of communicable, and non-communicable diseases, and heightens risk of both unintentional and intentional injury (Prince et al. 2007).

Research evidence

The evidence for factors linked to stress reactions upon reception into prison is conflicting. In a French study (Blanc et al. 2001) quality of life among prisoners was assessed using the French version of the Nottingham Health Profile tool. This study investigated the influence of incarceration on emotional reaction. This was undertaken through self-administration of the Nottingham Health Profile by prisoners, prior to their formal medical examination upon reception into prison. Two prison populations in Toulouse were studied (n = 199). The score of each dimension on the French version of the Nottingham Health Profile questionnaire, the responses to questions on socio-demographic and penal characteristics, and results of the medical survey were analysed. The response rate and rate of completion for each dimension are excellent (100%). Considerable evidence is found for the reliability of the Nottingham Health Profile (Cronbach a >0.72 for all dimensions except energy 0.64 and physical mobility 0.64) and for construct validity in terms of distinguishing between groups with expected health differences.

Emotional reaction was found to be above community comparators, a difference suggested by the researchers as resulting from the experience of incarceration. Prisoners on remand were found to score higher on the emotional reaction dimension, whilst three variables concerning aspects of life in prison are correlated with variation of the emotional reaction dimension. These variables were prisoners who had multiple previous sentences; inmate numbers per cell – with sharing being linked to stress reactions; and duration of remaining sentence – with a heightened stress reaction being linked to closeness of release. The researchers discuss the accuracy of the finding pertaining to multiplicity of sentences served and add that experienced prisoners may be trying to manipulate the system by exaggerating their level of distress.

A number of other studies have elicited signs of adaptation as prisoners became habituated within the prison environment. Gunn et al. (1978) undertook a study of longer term prisoners. This study was conducted at Grendon Underwood Prison between June 1971 and May 1972. It also covered some prisoners treated by the psychiatric service in Wormwood Scrubs and a postal survey to 811 offenders in the south-east of England. The object of the study was to examine the extent and efficacy of psychotherapeutic provision within prison. A battery of tests were administered via questionnaires and semi-structured interviews including the GHQ. Prisoners were re-interviewed on a schedule of three months, nine months and prior to discharge to measure change longitudinally. GHQ results showed that over time, the 27 men who completed the GHQ both initially and at three months, as a whole began to feel much better.

> It is likely that...the decrease in symptomatology simply reflected the men's increasing habituation to prison life. Distress and anxiety will, especially for the first timer, be at their height at the start of the sentence, and with time the prisoner will begin to adjust himself to his new setting.
>
> Gunn et al. 1978 p.147

The authors conclude that:

> a large amount of psychological disturbance exists in the prison population. Although we could not distinguish between the abnormality inherent in the population and the specific contribution made to manifest pathology by imprisonment itself, we believe that the latter factor certainly contributed to the anxiety and depression which existed.
>
> Gunn et al. 1978 p.232

Harding and Zimmerman (1989) interviewed 208 male prisoners on the tenth day of incarceration (T1), and they found high levels of psychiatric symptomatology as measured by the GHQ were recorded. These GHQ scores were strongly correlated with perceived worries and concerns of the prisoners (cognitive stress). After 60 days of detention (T2), a significant fall in GHQ scores was observed, and they were still correlated with cognitive stress. A significant negative correlation between cognitive stress at T1 and GHQ scores at T2 was observed. The relationship between potential vulnerability factors (life experiences, social network, personality factors) and GHQ scores was not strong at either T1 or T2. The authors conclude that whilst psychiatric symptoms are common during the early phase of imprisonment they are relatively transitory and are not durable.

Nurse et al. (2003) undertook a qualitative study with seven focus groups, consisting of four homogenous prisoner groups comprising remand, sentenced, female and segregated prisoners, and three staff groups involving uniformed, non-uniformed and health care staff. Each focus group lasted for one and a half hours and was recorded, and then transcribed by NHS staff. Prisoners articulated experiences of boredom and long periods of isolation with little constructive activity or opportunities for association. They felt that this contributed to poor mental health and led to strong feelings of anger, frustration, and anxiety. Illicit drugs were identified as a release from the boredom of the environment. Some of the focus groups identified a lack of constructive relationships between staff and prisoners as contributing towards the stress of both groups. Staff described a 'circle of stress', whereby the constraints of the prison regime including staff shortages caused stress which led to staff sickness and further demands upon remaining staff. Staff shortages led to prisoners being locked up for longer periods of time, resulting in greater tension and conflict between prisoners and staff and compounding the situation further. The lack of constructive regime also proved a breeding ground for bullying and reduced the amount of time available to maintain contact with their families. The authors conclude that greater consideration should be given to understanding the wider regime factors that contribute to poor mental health in prisons. These factors need to be taken into account when designing prisons and regimes by policy makers, managers and health care providers to prisoners.

Furthermore prison imposes its own social world upon the individual, governed by both official and unofficial rules (James 2003b). Given its remoteness from everyday life, the difficulty of gaining access to

prison and the unique nature of its social world, prisons have been referred to as 'special places' (Bottoms and Sparks 1997), whilst prisoners refer to a 'secret world' in their autobiographical accounts (Morgan 1999). Having an insight into this secret world seems like an essential prerequisite in understanding factors likely to affect prisoners' mental state.

Summary of evidence relating to the prison effect

Stress appears to be a specific effect of the prison experience which impacts upon mental state. Particular stressors are associated with remand (Birmingham et al. 2000, Blanc et al. 2001), or early adaptation to the prison environment (Gunn, Robertson et al. 1978, Harding and Zimmerman 1989). These stressors may manifest within neurotic psychiatric symptoms or self-harming behaviours, although some prisoners appear to develop coping mechanisms (Harding and Zimmerman 1989). The research reviewed within this chapter produced a consensus upon the issue that incarceration produces heightened levels of symptomatology related to the stress of imprisonment (Blanc et al. 2001, Harding 1989, Gunn et al. 1978, Harding and Zimmerman 1979, Nurse et al. 2003). However at issue between some of the studies, is whether first time reception into prison is particularly difficult (Gunn et al. 1978, Harding and Zimmerman 1979), with a concomitant reduction in symptomatology over time and the emergence of a protective factor through habituation. Conversely, Blanc et al. (2001) found heightened stress responses amongst prisoners with a history of serving multiple sentences, although they tempered this finding in their discussion. The notion of habituation (Harding and Zimmerman 1979) recognises that *something* happens over time to effect a reduction in symptoms; the study does little to identify the exact mechanism by which this occurs.

5.4.1. Mental illness evidence

The scale of mental health morbidity found in prison differs between studies although all the reviewed studies found levels above community comparators. Research based on semi-structured interviews found that 7 per cent of male prisoners suffered psychosis (10% of remand prisoners); 14 per cent of female prisoners suffered psychosis; 75 per cent of female prisoners suffered neurosis; and 20 per cent of men and 40 per cent of women have attempted suicide. Psychopathic personality disorder featured in 63 per cent of remanded men and 49 per cent of sentenced men (Fryers et al. 1998). In an international review of 62 prison studies it was reported that 3.7 per cent of men had psychotic illnesses, 10 per cent major depression, and 65 per cent a personality disorder, including 47 per cent with an antisocial personality disorder (Fazel 2002). In another study it was found that 37 per cent of prisoners have a psychiatric disorder, 15 per cent requiring on-going treatment either in prison or in a therapeutic community and 3 per cent requiring transfer to a psychiatric hospital (Gunn et al. 1991). A higher incidence amongst remand prisoners, with 55 per cent having a need for immediate treatment (Brooke et al. 1996).

Evidence from the Prison Reform Trust and MIND (2006), in relation to prisoners' mental state inside prison, is summarised in Table 4:

Table 4: Prisoners' Mental Health Status (MIND 2006)

Prisoners' mental health status	Comment
Three quarters of men in prison are affected by two or more mental health problems.	
Two thirds of men in prison are diagnosed with a personality disorder and two fifths show symptoms of at least one neurotic disorder such as depression, anxiety and phobias.	Among the general population less than a fifth of men are affected by these disorders.
Men in prison have a high rate of severe mental health problems such as schizophrenia or delusional disorders – nearly 10%.	This compares to less than 1% of the general population.
One in five men in prison are on prescribed medication such as anti-depressants or anti-psychotic medicine.	There is evidence that the use of medication increases whilst in custody. Many prisoners self-medicate with illicit drugs in prison.
One in five male prisoners have attempted suicide at some stage in their life.	The same number has previously been admitted for in-patient psychiatric care.
Prisoners are twice as likely to be refused treatment for mental health problems inside prison than outside.	The government's Social Exclusion Unit concluded that the mental health care in prisons is in need of significant improvement.
Prison regimes do little to address the mental health needs of prisoners.	Research has found that 28% of male sentenced prisoners with evidence of psychosis reported spending 23 or more hours a day in their cells – over twice the proportion of those without mental health problems.
Prisoners with severe mental health problems are often not diverted to more appropriate secure provision.	The Chief Inspector of Prisons has estimated, based on visits to local prisons, that 41% of prisoners being held in health care centres should have been in secure NHS accommodation (HM Chief Inspector of Prisons' Annual Report 2002/3). Research has found that there are up to 500 patients in prison health care centres with mental health problems sufficiently ill to require immediate NHS admission.

In Tables 5 and 6, there is a summary of the expert evidence relating to mental illness in UK prisons amongst sentenced and remand prisoners respectively (Shaw 2002). All of the published studies relating to mental illness and mental health problems in prison show a higher incidence than in the community and highest rates amongst the remand population.

Table 5: Prevalence of Psychiatric Disorder in Sentenced Prisoners (Shaw 2002 p.8)

Author	Population	Method	Prevalence
Gunn, Maden and Swinton (1991)	1,365 males, at 5 local, 10 training, and 2 open prisons	Semi-structured interview	• Psychosis – 2.4% (including schizophrenia – 1.5%) • Affective psychosis – 0.5% • Neurotic disorder – 5.2% • Alcohol dependence – 8.6% • Drug dependence – 10.1% • Personality disorder – 7.3%
Neighbors (1978)	1,070 males, at all prisons in Michigan	National Institute of Mental Health Diagnostic Interview Schedule (NIMH-DIS)	• Schizophrenia – 2.8% • Major depression – 5.1% • Bipolar disorder or mania – 3.8% • Personality disorder – 50% • Alcohol abuse / dependence – 47%
Singleton et al. (1997, 1998)	584 females and 1,121 males, national random sample	Alcohol Use Disorders Identification Test (AUDIT), drug misuse questions, self-harm questions, sample – Schedule for Clinical Assessment in Neuropsychiatry (SCAN) interview	• Probable psychosis – 10% (females) and 4% (males) • Neurotic disorders – 63% (females) and 40% (males) • Alcohol dependence – 39% (females) and 63% (males)

Table 6: Prevalence of Psychiatric Disorder in Remand Prisoners (Shaw 2002 p.9)

Author	Population	Method	Prevalence
Taylor and Gunn (1984)	2,743 men and 1,241 women, consecutive sample at Brixton	Case note diagnosis	• Schizophrenia – 6% • Affective disorder – 1.2% • Neurotic disorders – 3.3%
Davidson et al. (1995)	371 men and 18 women, 50% random sample at Scottish prisons	CIS	• Schizophrenia – 2.3% • Depression – 14.1% • Anxiety – 10.8%
Birmingham, Mason and Grubin (1996)	569 men, at Durham Prison	Semi-structured interview and Schedule for Attachment Disorder and Schizophrenia (SADS)	• Mental disorder – 26% • Schizophrenia or affective psychosis – 4.5%
Brooke et al. (1996)	544 males, 206 young offenders, and 245 women, national random sample	Semi-structured clinical interview	• Schizophrenia, psychosis or delusional disorder – 5.5% • Neurotic disorder – 19.1% • Personality disorder – 11% • Substance misuse – 39%
Singleton et al. (1998)	187 females and 1,250 males, national random sample	CIS+ sample, SCAN, AUDIT, drug misuse questions, self-harm questions	• Probable psychosis – 21% (females) and 9% (males) • Neurotic disorders – 76% (females) and 59% (males)
Teplin (1990)	728 males, at Chicago	NIMH-DIS	• Schizophrenia – 2.74% • Any other Diagnostic Interview Schedule (DIS) disorder – 62.4% • Drug dependence – 15.3% • Alcohol dependence – 19.1%

5.4.2. Psychosis

Meltzer et al. (2002) commented upon high levels of psychotic mental illnesses. In 1997, the Office for National Statistics' survey of psychiatric morbidity of all prisons in England and Wales (Singleton et al. 1999) reported that 7 per cent of sentenced men, 10 per cent of remanded men, and 14 per cent of women had psychotic mental illness in clinical interviews. They also questioned the arrangements for follow-up care for psychotic prisoners upon release from prison. They conducted a large scale survey of 3,142 prisoners to identify how many were followed up, and to identify both mental health outcomes and service provision outcomes. According to Meltzer:

> A substantial proportion of prisoners with psychosis are untraceable after release from prisons...rates of engagement in psychiatric care were low and few of those released were in supported accommodation.
>
> Meltzer et al. 2002 p.11

Mentally disordered prisoners failing to receive care is also described by a New Zealand study:

> Many of those inmates suffering from a major mental disorder within the prison system are not receiving treatment. This is particularly noticeable for inmates with major depression (46.4% in treatment) and schizophrenic disorders (37.0% in treatment).
>
> Brinded et al. 2001 p.172

Shaw in an 'expert review' of studies found that:

> the prevalence of severe and enduring mental illness in prisoners on both sides of the Atlantic is higher than equivalent community rates...Many of the large population-based studies of prevalence of mental disorder in prisons have reported high rates of alcohol and drug dependence...personality disorder identified in prison has varied enormously.
>
> Shaw 2002 p.3-4

In a further study Shaw, Tomenson, and Creed (2003) developed a screening questionnaire specific for the detection of serious mental illness within the Criminal Justice System. This involved the development of a seven item screening questionnaire developed from 2,920 attendees at magistrates courts following initial screening using the General Health Questionnaire and the Psychosis Screening Questionnaire. Logistic regression was undertaken using components of the two initial screening tools to identify the optimal profile of the new, shorter seven item scale and to ensure construct validity. The prevalence of psychosis poses a major health management problem for the prison authorities, and identifies the importance of a wide range of psychiatric service facilities to manage mentally ill prisoners who are currently poorly provided for in prison:

> the House of Commons Health Select Committee has recently drawn attention to a range of unresolved issues, including the future level of high and medium secure psychiatric provision, and the standard of psychiatric care in prisons.
>
> Meltzer et al. 2002 p.9

Commissioning on this scale though, requires strategic planning, as Diamond et al. (2001) comment:

> Criminal justice and public mental health policy makers should think at least 10 years ahead in their planning for mentally disordered offenders.
>
> Diamond et al. 2001 p.38

5.4.3. Prison mental health services and in-reach

The past decade has seen a significant shift in government policy towards the provision of prison health care as a function of local NHS health districts, rather than as an in-house prison service department (Grounds 2000, De Viggiani et al. 2005). Consequently, systematic assessment of prisoners' health needs have taken place to facilitate transfer of responsibility and service delivery, giving clearer insights into prisoners' health status than previously available (Condon et al. 2006). Contemporary thinking in sentence management places emphasis upon management of prisoners from arrest via prison back to the community. This necessitates consideration of psychosocial domains of care, and afford opportunities to see prisoners' well-being as both a worthwhile end in itself, and also as part of the wider rehabilitative and restorative purpose of prison (Hedderman 2005). Attempts at formalising the joint working necessary for such constructive regimes have seen the creation of a new government agency, the National Offender Management Service, to coordinate the necessary inputs (Clarke 2005).

Despite the raft of policy measures to divert mentally disordered offenders (Department of Health and Home Office 1992, Home Office 1995), there is little evidence that government policy has resulted in a reduction of mental health problems present in prisons (Fryers et al. 1998).The growth of the mentally ill prison population has led some observers to link the growth of the mentally disordered prison population with the reduction of mental hospital beds and the failure to develop facilities into which offenders can be diverted (Gunn et al. 1978, Catcheside 2000, Gilligan 2001, Polczyk-Przybyla 1999). This 'transcarceration' hypothesis, proposes the substitution of one institutional environment for another.

The prison mental health service model of choice over the past decade (Welsh Assembly Government 2001, Daly 2002, Tarleton 2003, Steel et al. 2007), is the mental health in-reach team. Such teams mirror the role of community mental health teams, to prioritise serious mental illness, assess and case manage, and ensure continuity of care upon discharge. Within this remit they offer structured psychosocial interventions for psychotic illness, relapse prevention work, and specialist assessment to identify the prevalence of mental disorder within the prison population (Salathial 2003). Prison mental health services

are also attending to another perennial issue of concern, within the management of serious mental illness individuals, that of medication adherence. A study by Gray et al. (2008) concluded that adherence interventions for prisoners taking antipsychotic medication would be more effective if they focussed on increasing personal benefit from medication and on enhancing motivation to stick with treatment. However, in-reach teams have faced difficulty in establishing their remit within prisons, targeting their work, and have often been unable to successfully engage with community based services to share the workload (Brooker 2009). Furthermore, in-reach teams have been inadequately funded, under-resourced with an average size of 3 whole time equivalent staff, and consequently have been swamped with work given the levels of morbidity in prison (Vere-Jones 2006). Arguably they have failed to respond adequately to prison specific forms of mental distress which fall outside community norms for serious mental illness. Furthermore some commentators have argued that like community based teams they need to develop specialist functions such as crisis intervention and assertive outreach if they are to become a truly effective and equitable component of forensic mental health services (Steel et al. 2007).

5.5. SUMMARY

Prisoners' health might be characterised as a concomitant of the vulnerabilities which they face inside and outside prison (Novick et al. 1977). Prisons pose both opportunities to health, through bringing prisoners into a managed health care environment, but also risks to public health through failure to detect and properly treat communicable disease (Jacobi and Center 2005). The nexus of problems which prisoners experience travel chaotically with the individual between both sides of the prison wall (Levy 1997). Despite attempts to divert mentally disordered individuals away from prison and into the health and social care system, there is evidence from a raft of high quality clinical studies over the past two decades that mental illness generally is far higher amongst the prison population than compared to the general population (Singleton et al. 1999). The prevalence of all forms of mental illness and personality disorder are linked to suicide (Bebbington et al. 2005). The availability of psychological support is likely to mediate the effects of stress (Ben-Sira 1984). The levels of mental health problems in prison and the scale of self-harming behaviours suggest that prisons may themselves be iatrogenic environments (Clements et al. 2007), which are deleterious to mental state. Whilst mental distress is often transitory in prison, its' relationship to the power-dynamic of prison and its' correlation with self-harm and suicidal behaviours gives the appearance of a form of mental distress specific to the prison environment. The trilogy of substance misuse, psychosis and self-harm/suicide pose considerable management problems and significant risks to vulnerable prisoners. Prisons face considerable difficulty in relation to regime, resources and environment in offering high quality care for mentally disordered individuals. Screening of prisoners to detect serious mental illness is under developed as are services to provide psychosocial interventions which continue, or link to community based agencies following release. Places within secure mental health facilities, which could offer an alternative to care in prison, are at a premium.

CHAPTER 6

APPLYING THE LITERATURE REVIEW THEMES: 'MY HEAD'S GONE!'

MENTAL STATE IN PRISON

6. MENTAL STATE IN PRISON

6.1. INTRODUCTION

This chapter summarises themes identified in Chapters 2, 3, 4 and 5 and applies them specifically to the mental state in prison question. In so doing, this chapter acts as a lens to focus the more general discussion from the literature review, within the aims and objectives of the study. The multiple factors explored within the literature review are sometimes distant geographically, isolated experientially, or remote chronologically from the measured mental state event within the data collected. This chapter speculates as to how these multiple and diverse factors may operate within the prison environment and thereby influence mental state. It further develops the significance of the vulnerability, socialization and identity constructs referred to in Chapter 4. It is tentatively proposed that these constructs describe the means by which the multiple factors may operate, through socialization and identity processes, compounded by prisoner vulnerability. The nature of interpersonal relationships in prison and their influence upon the immediate social and psychological environment are considered.

6.2. RATIONALE

This chapter formally posits the potentially mediating effects of socialization and identity within a vulnerability context, and links to inferential data and aspects of the prison narrative presented in Chapter 11. A summary of prisoner experience might be: disadvantage, dysfunction, disorder, distress, discontinuity, and displacement. It is against this nexus of problems which much offending behaviour arises and mental state can be set:

- Prisoners reflect the health and social problems of the *disadvantaged* communities from which they are drawn (Watson et al. 2004, Foster 2000, De Viggiani et al. 2005)
- Services in prison risk continued *disadvantage* through an inability to cope with the scale and type of presenting problems (HM Inspectorate of Prisons 2007)
- The majority of prisoners are young and many have *dysfunctional* family backgrounds (Farrington 2003, Hawkins et al 2000, Smith 1995) with clear antecedents to mental health, behavioural and offending problems
- Mentally *disordered* persons are over represented within the prison population (Shaw 2000)
- Psychological *distress* is inextricably linked to social situation, and is an intensely personal experience, see for example Kai and Hedges (1999)
- Prison mental health research has tended to ignore the subjective nature of mental *distress* and fallen within a purely epidemiological paradigm (Butler et al. 2005, Brooke et al. 1996)
- *Discontinuity* of service provision especially upon release (Lart 1997, Swyer and Lart 1996)

- Prisoners are socially *displaced* upon release, often leading to reoffending (Home Office 2004)

Table 7 proposes the significance of factors identified within the literature review, and identifies links to the results chapters. Table 7 is followed by a discussion, organised by chapter theme, of the relevance of these factors to the prison mental state question 'how do prisoners' circumstances and experiences affect their mental state in prison and beyond?' The discussion is organised by applying the chapter themes to the mental state in prison question: 'life on the "out"'; 'life on the "in" – regime'; 'life on the "in" – experience'; 'life on the "in" – health'; and 'mental state in prison'. Table 7 follows:

Table 7: Proposed Significance of Factors Arising from Literature Review

Chapter	Factors identified	Proposed significance to mental state in prison	Link to results chapter
2. Life on the 'Out'	Social exclusion; social experience; youth; habitual offending; substance misuse; hostile public opinion; problem crime nexus; mental health problems; offending subculture; family background; identity; attitudinal, behavioural, cognitive and social functioning; shared aspects of experience, culture and identity; vulnerability	The social and psychological world of prison may reflect norms and values rooted in a shared background and offending identity. In the community, social exclusion is linked to mental health problems, and, given the extent of exclusion evident in the pre-prison status of most prisoners, this may impact upon mental state in prison	Chapter 9
3. Life on the 'In' – Regime	Lived experience; prison regime; degrading conditions; injustice; dehumanising effects of prison; dislocating prisoners from their social worlds; compromised future life chances; public policy; hostile public opinion; pressure on prison places; paucity of regime; poor links to external agencies; adversarial social dynamic; rigid hierarchies; prison deleterious to mental state of many, particularly the most vulnerable individuals	Harsh regimes and the macho world of the prison are likely to be deleterious to mental state of vulnerable individuals; public hostility makes constructive re-entry into society difficult, increases risk of reoffending and creates a circular reoffending re-imprisonment dynamic to which some may be immune and others continually fail to cope; prisons are remote from society creating an institutional social environment	Chapter 10
4. Life on the 'In' – Experiential Factors	Abuse; prisoner vulnerability; prison environment; identity; common social experience; social world of the prison; individual roles; prisons hierarchies; stigma; social networks; socialization within the prison environment; mental state as outcome of the lived experience of prison life; pains and privations of prison	Identity in prison is tarnished by stigma, abuse and vulnerability; mental state is likely to be impacted by these factors	Chapter 10
5. Life on the 'In' – Health and Mental State	Prisoners' health; threats to health; failure to detect and treat communicable diseases; nexus of problems travel both sides of the prison wall; stress of prison impacts upon well-being; stressors associated with remand or early adaptation to prison; neurotic psychiatric symptoms or self-harming behaviours; coping; serious mental illness; mental illness and personality disorder linked to suicide; psychological support mediates stress; prisons as iatrogenic environments	Physical and mental health affect well-being and mental state whilst the stress of prison also impacts; the early period of prison is stressful; some individuals cope, others less so and the level of support available may influence coping	Chapter 10

6.3. APPLIED THEME: LIFE ON THE 'OUT' AND MENTAL STATE IN PRISON

This section considers the psychosocial factors discussed in Chapter 2 and attempts to summarise and establish links between pre-prison experience and prison mental state. Chapter 2 focussed upon the pre-prison (life on the 'out') experience. The factors were summarised in Chapter 2 as a nexus. The factors were: social exclusion; youth; youth delinquency; habitual offending; hostile public opinion; problem crime nexus; substance misuse; mental health problems; offending subculture; family background; identity; attitudinal, behavioural, cognitive and social functioning; shared aspects of experience, culture and identity.

Characteristics linking development, mental health and offending

From a review of the literature there appears to be some consensus upon characteristics linking childhood development and offending. These include low intelligence, impulsivity, poor conceptual thinking, low school attainment, hyperactivity, and antisocial behaviour (Farrington 2003, Hawkins et al. 2000). Formative to these traits are thought to be socio-economic factors linked to social exclusion, interpersonal and peer factors. However, MacDonald (2006) identifies the importance of understanding the individual's narrative through critical life events and transitions to understand why some develop criminal careers, whilst others do not. The socio-economic factors linking children and adolescents with offending are much the same as the circumstances faced by prisoners generally pre-prison. In brief they comprise, school exclusion, poor educational attainment, poverty (Social Exclusion Unit 2002), drug use (Foster 2000), and socialization within a criminal subculture (Moore 2002). The pains of childhood within damaged families are also identified as being formative to criminal behaviour. Typically these experiences may include:

> poor parental supervision, harsh discipline and child physical abuse...a cold parental attitude and child neglect, low involvement of parents with children, parental conflict, broken families, criminal parents, delinquent siblings.
>
> Farrington, 2003 p. 221

These interpersonal factors, which might in effect be thought of as an impoverishment of the parent child relationship and a diminution of the supportive and caring role of the family, are also cited within the mental illness literature as being implicated within the development of mental illness (Rutter 2002, Beck 1979). Loss, neglect or trauma experienced during childhood can undermine the social, emotional and interpersonal attachment necessary for later healthy adjustment to relationships, social roles and consequential mental well-being (Gumley and Schwannauer 2006). This identification of an impoverished childhood contributing to delinquency in adolescence and criminality in later life was also a theme within the work of Carl Rogers (Mecca and Smelser 1989). Rogers proposed that an impoverished upbringing

deprived the developing individual of the core conditions necessary for social and emotional maturation. In later life this could lead to either emotional and psychological problems or social deviance.

A formulation linking traumatic antecedents to later outcomes

According to Gumley and Schwannauer (2006) traumatic experiences in childhood impact upon individual's schemata or core beliefs and are likely to compromise future chances of developing healthy and trusting relationships. Consequently individuals who have experienced these negative core conditions in infancy or youth are more likely to experience problems of affect (mood), interpersonal and social adjustment, and difficulty in dealing with unpleasant and negative emotional states. Core beliefs can be linked to over-developed or habitual interpersonal strategies, for example the belief that 'I am bad', arising from emotional, physical or sexual abuse may be observed through self-harming, punitive attitudes towards self, a lack of assertiveness, self-neglect and avoidance of others. Similarly the belief that others are untrustworthy may result in hostile and suspicious behaviours.

Hostile and suspicious behaviours may later manifest as constituent components of personality disordered individuals, or as symptoms of a frank psychotic presentation. Such traits are also linked to violent and serious criminal behaviours (Johnson et al. 2000). Furthermore, the range of childhood characteristics and formative factors identified by Farrington (2003) as linking childhood experience to criminal behaviour (see Section 4.5), are also identified within a cluster of traits associated with psychopathic tendencies in early adult life (Soderstrom et al. 2004). Soderstrom concludes that childhood-onset social, behavioural and psychiatric disorders constitute the most relevant psychiatric symptom cluster linked to persistent adult violent behaviour, in contrast to later-onset mental disorders which are correlated with single acts of violent or sexual aggression.

6.3.1. Youth service provision

Whilst the psychosocial and developmental factors predicating both offending and the development of mental health problems are well established in the literature, epidemiological and needs assessment research identify a paucity of appropriate services to meet the needs of young people at the interface of mental health and the Criminal Justice System (Bailey 2003). The Welsh Assembly Government is developing services through strategic guidelines, to meet the needs of:

> a small...group of children and adolescents who are regarded as 'disruptive' or 'difficult to place'. They are among children with the greatest unmet needs and this group may partially overlap with the group of 'looked after' children and those who require forensic mental health services. They may show very low levels of educational attainment, unmet needs for both physical and mental healthcare and high levels of substance misuse.
>
> Welsh Assembly Government 2001 p.51

Other specific client groups requiring statutory services include:

children who are mentally ill and either:
-severely suicidal and self-harming; or
-in need of a secure setting in which to undergo treatment or begin psychiatric rehabilitation:

- brain injured with severely challenging behaviour
- sex offenders and abusers
- mentally disordered serious offenders; and
- learning disabled in connection with one of the above problems

Welsh Assembly Government 2001 p.52

6.3.2. Youth vulnerability in the Criminal Justice System

Young people are recognised as being vulnerable within the Criminal Justice System. This is recognised in law by the necessity for the provision of an appropriate adult throughout the period of police detention (Littlechild and Fearns 2005). This inherent level of vulnerability is further complicated if the young person has mental health problems or learning difficulties. The extent to which psychiatric morbidity and mental health issues often form part of a constellation or nexus of problems amongst young offenders, requires that professional mental health support is essential within specialist Youth Offending Teams (Callaghan and Owen 2005). For young offenders facing a complex combination of issues, Young Offender Institutions may live up to their billing as universities of crime (James 2003b) and otherwise further complicate the route towards psychological maturation and social integration and increase the chances of continued social exclusion, further offending and continuing mental health problems.

6.3.3. Life on the 'Out': concluding discussion

The cumulative effect of a prisoner's background experiences often characterised by social exclusion and poor parenting, will influence their identity, life course and mental state. Social ties are generally seen to affect a protective effect upon mental health (Berkman 1984, Kawachi and Berkman 2001), so conversely the lack of them is likely to increase the prevalence of mental health problems. Social support provided both in prison and after release from prison, is associated with higher quality of life (Jacoby and Kozie-Peak 1997). Problems during childhood and adolescence can lead to life trajectories in adulthood with a number of problem areas. The criminology (Farrington 2003) and psychiatric literature (Rutter 2002) reveal some consensus on the characteristics linking childhood development, exclusion, vulnerability, offending and mental illness; these include learning problems, impulsivity, poor conceptual thinking, low school attainment, hyperactivity and antisocial behaviour (Hawkins 2000, Rutter 2002, and Farrington 2003). Formative to these traits are often socio-economic factors linked to social exclusion, as well as interpersonal and peer factors. In conclusion, the shared nature of formative experience links many prisoners, limits future life chances and influences psychosocial status. Prison is likely to reflect the social

values and mores of the pre-prison experience of the majority of prisoners and this psychological environment is likely to form the backdrop to mental state within prison.

6.4. APPLIED THEME: LIFE ON THE 'IN' – REGIME AND MENTAL STATE IN PRISON

This section considers the regime related factors discussed in Chapter 3 and attempts to summarise and establish links between regime and mental state within prison. Chapter 3 focussed upon the prison experience (life on the 'in'), with reference to the literature illustrative of prison regime. Chapter 3 was organised around the concept of lived experience. The factors were: lived experience; prison regime; degrading conditions; injustice; dehumanising effects of prison; dislocating prisoners from their social worlds; compromised future life chances; public policy; hostile public opinion; pressure on prison places; paucity of regime; poor links to external agencies; adversarial social dynamic; rigid hierarchies; prison deleterious to mental state of many, particularly the most vulnerable individuals.

If it is possible to understand the mental zeitgeist in prison, an understanding of the hostile nature of aspects of custodial sentences is helpful. These hostile elements defy precise measurement using traditional epidemiological approaches due to their subjective nature, but are more accessible using softer qualitative approaches recording the lived experience of the individual prisoner. Whilst epidemiological approaches do help to describe the clinical status of populations and provide a starting point for the assessment of mental health status, qualitative data deepens appreciation of the 'nap and weave' of personal experience against the fabric of prison life.

The mental state of an individual prisoner is likely to be influenced by their long-standing mental health status pre-prison, and the psychological sequelae of being processed by the courts. Individual well-being, possibly already destabilized through a chaotic lifestyle and morbid substance misuse and mental health problems (Mitchell et al. 2002), is then tested in the individual's response to the limiting physical and psychosocial world of the prison (Blanc et al. 2001, Nurse et al. 2003). Within this environment many will use street drugs to cope with the pressures and boredom of prison life, especially given the lack of constructive activity available (Nurse et al. 2003). On release from prison, mental state will influence an individual's ability to 'go straight' and reintegrate into law-abiding society. Prison is therefore a critical proving ground where the life chances of already vulnerable individuals can be significantly enhanced, or further broken.

6.4.1. Stigma

Most convictions are for violent crimes, including assault, actual and grievous bodily harm. Acquisitive, drug-related and motoring crimes are also very common. These crimes are relatively stigma free in

prison. Arson is rarer as are sexual offences, manslaughter and charges relating to murder or attempted murder. Those convicted of murder are likely to serve much of their time in specialist 'lifer' units returning to a local prison prior to release.

Prisoner peer influences

The literature suggests a number of other factors particularly associated with poor mental health amongst prisoners, including coming off drugs and being 'on the rule', a reference to Rule 45 for the segregation of vulnerable prisoners (HMPS 1999). Prisoners who have been convicted of sexual offences are reviled by their peers in prison and often experience verbal and physical violence. They are invariably segregated for protection under Rule 45 which further constrains opportunities in prison. The social world of the prison is a formative crucible where the effects are profound and long lasting. The social role assigned by peers through the process of prison socialization, and an allocation of a place in the pecking order, is a key determinant as to how constructively custody will be spent.

An individual's place in the pecking order is determined by a number of factors. Criminal offence is one determinant, with armed robbery being considered the traditional pinnacle of criminal endeavour, and earning a lofty place in the order. In the middle ground prisoners jockey for position and influence using macho indicators, such as; aggression, muscular definition, weight training prowess, the ability to look physically intimidating and to look after oneself are tokens of worth. At the bottom end of the status scale are sexual offences, especially against children, which earn the epithet 'nonce' (prisoners who have committed offences of a sexual nature) and grasses (those providing the authorities with information). These are the most stigmatizing labels to be attached by prisoners to their peers and warrants assault and ostracization from the prison community. 'Fraggle', is another prison slang term, used to describe those deemed to be mentally ill, or at least odd or different by the prison community. Consequently, segregation or healthcare units used to hold mentally disturbed prisoners are known as 'Fraggle Rock' throughout the prison system. Whilst demeaning and pejorative, the term Fraggle does not carry the loaded and bitter prejudice of the term nonce or that other pejorative prison term, 'grass'.

Segregation

Some prisoners have to deal routinely with bullying and intimidation from their peers (Hochstetler 2004), some electing to 'go on the rule'.

Rule 45 states that:

> Where it appears desirable, for the maintenance of good order or discipline or in his own interests, that a prisoner should not associate with other prisoners, either generally or for particular purposes, the governor may arrange for the prisoner's removal from association accordingly.
>
> (HMPS 1999, rule 45-1)

Some prisoners elect to be protected by Rule 45, although it is highly stigmatizing and commands instinctive revulsion from the main body of prisoners due to its association with nonces and grasses, in order to be segregated from their assailants.

Attitudes towards prisoners with mental health problems

Individuals with mental health problems can be tolerated and supported by their peers depending upon their interpersonal level of functioning, offence and other relevant issues of prison sensibility. In an interesting distinction of tolerance 'my head's gone', is a common prison phrase to describe short-term disorientation and confusion, seemingly free of the stigma associated with being a Fraggle. The close kinship which forms between prisoners means that those with a close and supportive social circle can be well looked after, and supported, by their associates. There can be a high degree of intolerance also, James (2003b) tells the atmospheric tale of a bad night, reminiscent of some of the opening scenes of Stephen King's 'Shawshank Redemption'. In the early hours a man in the segregation unit had become hysterical and had started screaming out of his cell window, the response of the other prisoners was intolerance:

> The man's howls echoed around the deserted, spot lit prison grounds...I had woken with a start. Others, mostly younger men on the short-term wing...began shouting out of their cell windows, cursing the disturbed man... 'Shut the fuck up, you Fraggle'. 'Quiet, you nutter'.
>
> James 2003b p.43-4

6.4.2. Impact of prison

The impact of prison is likely to affect individuals differently, some prisoners responding positively to the structure of the institution, others being adversely affected. Most prisoners are already socially excluded before their entry into prison and there is evidence to suggest that social and personal problems are compounded by imprisonment, resulting in a significant weakening of already poor prospects. The effect of prison upon individual prisoners is likely to arise out of a combination of the exact nature of adverse events experienced prior to and in prison, the support offered to help the individual and the personality and personal coping mechanisms of the individual. The prison environment itself, especially when coupled with individuals' extant problems and prison health care shortcomings in assessing and treating mental health problems, is sufficient to precipitate emotional and more serious mental disturbance in vulnerable prisoners. Caraher et al. in their consideration of young offender institutions observe that:

> The process of imprisonment and incarceration is a traumatic one that can shift individuals who were coping with the stress and trauma of life to a situation where mental illness is one consequence.
>
> Caraher et al. 2000 p.8

It is often difficult for people, even on the outside, who have emotional or mental health problems to seek help or support, and unwillingness to disclose is common leading to approximately half of people with mental health problems not seeking professional help (Williams and Healy 2001).

> The issue of disclosure of mental health problems is therefore important for two reasons. Firstly, it represents a major problematic experience in the career of people with mental health problems. Secondly, disclosure is an essential step in the process of seeking mental health help.
>
> Williams and Healy 2001 p.109

For prisoners there are heightened concerns about being stigmatized and about the confidentiality of prison consultations, leading to anxiety that other prisoners or staff may find out about expressed concerns.

6.4.3. Suicide

The Prison Service affords a high level of importance to suicide awareness and prevention, but continues to have difficulty protecting these most vulnerable prisoners. There is a considerable body of literature associated with suicide amongst prisoners and a whole raft of initiatives aimed at suicide prevention. Current initiatives include the Safer Custody initiative which liaises with Suicide Prevention Teams in each prison. The work of each prison is guided by Prison Service Order 2700 (HMPS 2010). Most prisons now have access to the Samaritans, or specially trained inmates known as Listeners. Buddies (prisoners trained to accompany new prisoners through the induction period) are also increasingly available. Procedures at reception in particular have become the focus of attention, as it is often shortly after arriving in prison that many of the suicides occur. For 'at risk' prisoners, document F2052SH (HMPS 2004a) is used to assess, plan, implement and evaluate action in response to self-harm risk. This response forms the cornerstone of the Prison Service's immediate response to protecting self-harming, suicidal and vulnerable prisoners. It is now being superseded by a more integrated risk management process known as Assessment, Care in Custody and Teamwork (Shaw and Turnbull 2006). This procedure enables suicide prevention to sit within a more holistic consideration of prisoners' needs.

The majority of suicides in prison occur as a result of hanging from ligature points. Previous prison practice involved placing prisoners in a strip cell, where although there was a reduced risk of hanging due to the removal of ligature points, the overall environment was intimidating and often contributed towards feelings of depression, isolation and powerlessness. Strip cells are now being replaced by safer cells, which are specially designed and built to a much higher specification, in order to provide a more therapeutic environment. There is some evidence to suggest that the new procedures being practised across the prison estate are beginning to have a positive effect, with an overall reduction in suicides in English and Welsh prisons during 2005, the figure was 78, down from 95 in 2004 (BBC News 2006).

6.4.4 Life on the 'In' – regime: concluding discussion

The contemporary picture of general adversity, idleness, lack of constructive regime, and warehousing of prisoners is alarmingly similar to the picture painted by the Woolf report. Within the present decade, due to pressures on regimes, prisoners have had just 10 minutes more time spent on constructive activity than their 1990 peers did, and over 26,000 prisoners have been held more than 50 miles from their homes (Newell 2001). According to the Chief Inspector of Prisons (BBC News 2009), the risk of violence and disturbances in jails in England and Wales is a 'growing concern' stating that the prison system was still under 'sustained and chronic' pressure. Incarceration under such conditions can prove psychologically toxic. The immediate prison task is one of survival and self-preservation, or put another way, 'to try to emerge from the other end of the sentence mentally and physically intact' (James 2003 p.148).

6.5. APPLIED THEME: LIFE ON THE 'IN' – THE PRISON EXPERIENCE AND MENTAL STATE

This section considers the factors discussed in Chapter 4 and attempts to summarise and establish links between experiential factors and prison mental state. Chapter 4 focussed upon the prison experience with reference to current literature illustrative of prison life. The factors were: abuse; vulnerability; prisoner-vulnerability; prison environment; identity; common social experience; social world of the prison; individual roles; prisons hierarchies; stigma; social networks; socialization within the prison environment; Mental state as outcome of the lived experience of prison life; pains and privations of prison.

6.5.1. Vulnerability

Prisoners appear to be potentially vulnerable in a manner spanning 10 distinct, but overlapping, social, epidemiological, abuse, and service provision dimensions (Table 3). Within this discussion vulnerability serves as a conceptual means of combining background and experiential axis which negatively impact upon prisoners, and offers a perspective upon the situation of the prisoner which helps relate background factors to the prison environment and mental state. Vulnerability serves as an active ingredient within prison power-based relationship dynamics.

6.5.2. Power and identity

Prison research and commentary, conducted from a sociological or socio-psychological perspective, appears to fall broadly into two discernable constituents regarding the staff prisoner power dynamic and staff prisoner relationships in prison. On the one side there is a view arising from a largely US

perspective. Zimbardo (Haney and Zimbardo 1998) in the seminal psychological Stanford Experiment, identified a polarisation of power between guards and prisoners, with complementary dichotomous prisoner-guard roles, attitudes and behaviours. These roles clearly demarcated prisoners and their guards within the simulated prison setting. This sociological perspective might be seen as consistent with the psycho-sociological cannon of Erving Goffman (1991), who described the allocation of specific and limiting roles to both staff and inmates, within prison, as in other institutional settings and the extent to which role allocation determined role adoption and ensuing self-identity. On the other hand a European tradition identifies more subtle inter-agency staff prisoner relationships (Haslam and Reicher 2003, Reicher and Haslam 2002, Piacentini 2006).

6.5.3. Vulnerability, identity and mental state

In addition to creating a unique set of circumstances within which vulnerabilities can become evident, prisons also receive large numbers of individuals who are already known to be vulnerable. Prisons contain a large number of socially excluded and vulnerable individuals; the homeless, the unemployed, the poorly educated, people who are drug or alcohol dependent, those who have a history of mental problems or have experienced family break-up, whilst prison itself is likely to provoke symptomatology. Gunn (1978) identified that there is likely to be a decrease in symptoms as the individual became habituated into the prison environment. A critical aspect of management therefore appears to be managing the initial peak of distress, especially for the individual in prison for the first time, immediately upon reception to prison. Some prisons are running specialist First Night Centres to provide a more sensitive environment for prisoners to spend their first night (Mills 2005b). Thereafter, the prison environment needs to be conducive to long-term mental health, non-offending and general rehabilitation.

Prisons are environments within which individual prisoners can feel powerless and defenceless against the power, prestige and authority of the state and those officers of the prison charged with maintaining good order and compliance amongst the prison population. This authority is not always discharged with respect or concern, but sometimes with criminal brutality. A recent prosecution of prison officers at Wormwood Scrubs, following serious assaults on prisoners when locked up in their cells, is illustrative of how power can corrupt. This hidden and corrupt danger can place the individual targeted prisoner, who should at least be held in safe custody, in extreme peril. As one prisoner explains:

> at least on the landings you can take your chance among your fellow prisoners. Once behind your cell door it's a different story. If you can handle it you should be safe. But as events at the Scrubs proved, you are potentially at your most vulnerable.
>
> James 2003a p.7

The prison population has been described as being '...a highly vulnerable population' (Condon et al. 2006 p.19), in this context, Condon is referring to the general health and social status of prisoners and raised levels of morbidity across a range of illnesses. The use of the term vulnerable (Chapter 4) within the prison context has a number of more specific meanings, relating to the inability of the individual prisoner to cope with their prison experience and is often attached to prisoners who require segregating or who go on to self-harm or commit suicide. This is an important distinction which might help to identify the cohort of prisoners whom this research is attempting to identify, namely those prisoners who notwithstanding generalized vulnerability and social exclusion, or other circumstances remain vulnerable or become vulnerable in prison.

Vulnerable prisoners often have mental health, learning or other disabilities (Mills 2005a) or other distinguishing characteristics which set them apart from the larger prison population. Social, psychological and health related circumstances surrounding each individual prisoner appear to be material to the experience of imprisonment. These factors appear to shape the reality of the prison experience and influence the extent to which the individual copes, or is unable to cope with the hardships and privations associated with it. The inherent vulnerability of prisoners is noted by one commentator:

> prison is a frightening and depressing environment, which leaves many vulnerable people feeling isolated and helpless. This problem hasn't been helped by the overcrowding crisis in Britain's prisons...it is difficult not to conclude that our prison population is at least partly the result of our inability to provide effective community support to vulnerable people. The danger is we are turning a health and social problem into a criminal justice one.
>
> Corner 2004 p.6

Vulnerability in an individual is sensed by the prison population and often exploited. Individuals unable or unwilling to stand-up to their peers can be disadvantaged through minor incidents like repeatedly losing their place in a dining queue, to being 'taxed', such as robbed of their medication or belongings. Reviled prisoners such as sexual offenders live in fear of serious physical assault. There is a traditional ritualistic assault involving being scalded with boiling water by a welcoming committee for many sexual offenders, if they are located within regular prison accommodation. These offenders live in constant fear of being confronted with the main prison population who take every opportunity to show hatred and contempt towards nonces. Other individuals deemed to be vulnerable or poor 'copers' in prison officer parlance are also demoted to a lowly place in the pecking order, where life is much tougher than for those higher up.

Prison regimes are increasingly trying to maintain vulnerable prisoners within regular locations by the provision of generalized good management, personal officers, mental health in-reach teams, constructive regimes consisting of purposeful daily activity, and a prison service anti-bullying policy. However, the maintenance of vulnerable prisoners within regular locations cannot always be achieved, leading to reliance upon established ways and means of managing prisoners ostracized or threatened by their

peers. In effect this means that the vulnerable individual prisoner is removed from a regular residential location to a segregation unit, or where available a Vulnerable Prisoner Unit. Segregation allows closer monitoring of prisoners if they are deemed to be at risk of self-harm or are suicidal. Segregation itself however, is a stigmatizing and harrowing process likely to further compromise self-esteem and mental health. There are therefore strict protocols in place to ensure monitoring and evaluation of the prisoners' condition while segregated.

The alternative to segregation is a place within the healthcare unit, particularly if there are mental health, self-harming or suicide concerns. Prisoners who commit suicide fall broadly into 3 groups: serious long-term prisoners (who tend to be older), poor copers (who tend to be younger and have been convicted of less serious offences) and mentally ill prisoners (The Howard League for Penal Reform 2000). Remorse is identified as a factor in suicide amongst poor copers, as is fear, helplessness and isolation. Many individuals also react badly to situational factors such as the shock of being locked up, loss of contact with friends, bullying, 23 hour bang-up (confinement in their cell for up to 23 hours a day) and withdrawal from drugs.

6.5.4. Life on the 'In' – the prison experience: concluding discussion

Prison environments are likely to lead to specific role attribution relating to the status attached to being a prisoner (Haney et al. 1973), strong association, and shared identities within prisoner groups (Haslam and Reicher 2003, Reicher and Haslam 2002), and a focus upon achieving the most favourable accommodation possible with the official regime. Prisoners warehoused within non-stimulating and unconstructive environments remain likely to experience prison as hostile and deleterious to mental state (Nurse et al 2003). Moreover, they are likely to experience socially stratified and rigid institutional pecking orders (James 2003b), where some prisoners (especially those who have committed sexual offences and other especially vulnerable individuals) are reviled (Matravers and Hughes 2003) and assaulted by virtue of their status in prison. Within this milieu, a collective social existence is available to many but not all. The effects of admission to, or exclusion from, this collective is likely to impact upon mental state.

6.6. APPLIED THEME: LIFE ON THE 'IN' – HEALTH AND MENTAL STATE IN PRISON

This section considers the health-related factors discussed in Chapter 5 and attempts to summarise and establish links between health and prison mental state. Chapter 5 focussed upon the prison experience, life on the 'in', with reference to the literature illustrative of prison health. The factors were: prisoners health; threats to health; failure to detect and treat communicable disease; nexus of problems travel both sides of the prison wall; stress of prison impacts upon wellbeing; stressors associated with remand or early adaptation to prison; neurotic psychiatric symptoms or self-harming behaviours; coping; serious

mental illness; mental illness and personality disorder linked to suicide; psychological support mediates stress; prisons as iatrogenic environments.

Many prisoners share a common profile of social characteristics (Foster 2000, De Viggiani et al. 2005, Carr and Vandiver 2001, Carrabine et al. 2002, Ashby et al. 2005) which often impact upon health status (RCN 2001, Watson et al. 2004). Prisoners often further reflect their excluded socialization through substance misuse, drug addiction, self-harming and mental health problems (Ramsbotham 2003). Prisoners are also likely to have higher rates of sexually transmitted infections (Menon-Johansson et al. 2005, Mertz et al. 2002) and blood-borne infections due to risk-taking behaviours. Furthermore, homeless individuals are over represented within the prison population and are likely to present with multiple physical mental health and social problems (Martens 2001, Wright and Tompkins 2006). Mental disorder is a long-standing issue of concern, (Gunn et al. 1978). The nature of mental disorders amongst prisoners is often of a relatively transitory and reactive (but often severe) nature, arising from difficult life events, relationship problems or passage through the criminal justice process (Ramsbotham 2003). Conversely, problems may relate to long-standing forms of complex and serious, (often psychotic) mental illness and personality disorder (Shaw 2002). Social exclusion experiences can contribute to these mental states, either as specific stressors, or in contributing towards the overall and general levels of stress experienced by prisoners, thereby heightening the likelihood of mental health problems. The prevalence specifically of substance misuse, concurring within a mentally disordered prisoner, is a further complicating factor in terms of aetiology, presentation and management (Phillips 2000).

6.6.1. Substance Use

Alcohol is not essentially causative of crime, however, it is often a significant contributory factor. Alcohol misuse is linked to poor health, is responsible for considerable accidental injury, binge drinking and chronic drinking are particularly likely to raise the risk of harm (Bonds 2005). Half of all homicides and serious assaults are related to alcohol misuse (Martin 2001). Alcohol misuse, which is more common in younger prisoners and in prisoners with fewer educational qualifications, is a preventable major cause of ill health (Marmot 1997) which goes poorly treated in prison (Allison 2004). According to Foster, drug use and crime ameliorate the deadening experience of social exclusion and these form a nexus of interrelated problems (2000), 87 per cent of prisoners have a mental health or drug problem (Higginson 2003). Lack of diversion for drug users (Brabbins and Travers 1994) is problematic and prison is likely to make drug problems worse.

Drug misuse is an important problem in prisons because apart from the direct effect on health (intoxication, overdose), it also causes problems through dependency, injecting and needle sharing.

6.6.2. Suicide and self-harm

In the community, suicide occurs at a rate of one in six thousand (Simon et al. 2002). In prison it is estimated that a prisoner is up to seven times more likely to kill themselves (The Howard League for Penal Reform 1995). Our understanding of the suicidal prisoner is incomplete (Liebling 1999b) as is the ability to identify which individuals will perceive an additional strain (Liebling 1999b p.283) associated with imprisonment which may lead some to commit suicide. One in five male prisoners has attempted suicide at some stage in their life (MIND 2006). Local prisons bear the brunt of suicides:

> local prisons have to deal with a high turnover of prisoners going backwards and forwards to the local courts. A lot of prisoners are on remand awaiting trial and sentencing. It's difficult for staff to identify those prisoners that are at high risk, particularly in the first few days when they are feeling anxious and isolated. It's vital these people are identified and monitored carefully.
>
> BBC News 2004b

Speaking of the record number of suicides during the summer of 2004, Enver Solomon of Prison Reform Trust (BBC News 2004b) suggested that likely contributory factors were:

> that staffing levels are lower during the summer when prison officers take annual leave. As a result prisoners get less time out of their cells and more time alone, locked up. Their anxieties come to the surface more. Fewer staff don't have time to talk to prisoners.
>
> BBC News 2004b

The Prison Service affords a high level of importance to suicide awareness and prevention, but continues to have difficulty protecting these most vulnerable prisoners. There is a considerable body of literature associated with suicide amongst prisoners and a whole raft of initiatives aimed at suicide prevention. Current initiatives include the Safer Custody initiative (Samaritans 2009) which is implemented by dedicated staff in each prison (Liebling 2002). The work of each prison is guided by Prison Service Order 2700 (HM Prison Service 2002, HM Prison Service 2010). Previous suicide attempts, drug use and unemployment are potential indicators for further suicide attempts, whilst humanising and caring factors within the regime are significant determinants of reducing suicidal behaviour (Liebling and Maruna 2005).

6.6.3. Life on the 'In' – health: concluding discussion

Prisoners collectively display a health profile which represents a summation of deprivation, risk-taking behaviours, and often, self-neglect. The prison environment itself can be iatrogenic and poses particular problems of managing chronic health conditions such as diabetes and asthma, and providing a therapeutic environment conducive to promoting good mental health. Prisons are environments within which the maintenance of good mental health is challenging. Prison is particularly difficult for those individuals troubled not only by the experience of passing through the Criminal Justice System and the

social dislocation which imprisonment entails, but also specifically by the prison environment, its social customs and power-based relationships. These individuals are likely to be vulnerable to poor mental state in prison.

6.7. SUMMARY

The aim of this chapter was to act as a lens and focus all the factors identified within the literature review and relate them directly to the prison mental state question. A complex synthesis of early life development, social exclusion, prison experience, personal identity and health is alluded to. The chapter has explored potential associations between pre-prison factors, the experience of imprisonment, and poor mental state. Interpersonal relationships in prison often experienced within the medium of power are proposed as a focal point for the meeting of background factors and prison specific stressors, and may regulate experience and by extension influence mental state. Stigma and the experience of power in prison may contribute towards identity formation. Vulnerability and its antonym, invulnerability, may summarise contrasting coping identities. All of these constructs appear helpful in understanding the milieu within which prisoners' mental state exists. Antecedents from early life may have negative identity, personality, mental health and behavioural outcomes in adulthood, and are experienced by many within the prison system. It is suggested that stressors within the prison setting may act through identity and vulnerability, particularly in the absence of social support.

CHAPTER 7

STUDY DESIGN

7. STUDY DESIGN

7.1. INTRODUCTION

This chapter identifies issues for prison research arising from the literature review and in the light of these provides both a critique of existing prison research, and a rationale for the main features of the study design. This chapter looks at why the research was undertaken as it was, the following methods chapter, looks at how.

7.2. RATIONALE

This study attempted to identify correlates of the mental state of prisoners and add to the existing body of knowledge on this subject. This chapter justifies the research question and outlines the philosophical and methodological approach taken to address the aims and objectives of this study.

7.2.1. Summary of literature review findings

The prison based literature highlights endemic levels of social exclusion, psychological, substance related and mental health problems amongst prisoners. The themes of discontinuity, dysfunction and distress seem a fair summation. Furthermore, the wider literature revealed a prison society dynamic which appears to be of relevance in understanding the prison experience and contextualising the mental state of prisoners. However, to date, few prison related studies have attempted either to link mental health morbidity with these wider health and psychosocial variables, or to explore the stakeholder perspectives of prisoner, professionals and wider society. This study aimed to address that gap in the existing cannon of prison literature and research.

7.3. MENTAL HEALTH RESEARCH METHODS IN PRISON

Much prison research has focussed upon morbidity. Unlike populations in the community, which have been subjected to systematic public health research during the second half of the twentieth century (Joukamaa 1995, Lenihan 2005), prison populations are relatively new to health related research. However, the epidemiological approaches which have tended to be used, fail to take into account causative factors. Significant personal, experiential and psychological data is difficult to gather using solely an epidemiological approach, limited by the nosology or rigid classification criteria of psychiatric diagnosis (Johnson 1999). There are therefore sound reasons, when trying to understand aetiological and contextual relationships influencing mental state in prison, to utilise a broader approach than one defined by narrow diagnostic and epidemiological parameters. Given the limitations of traditional descriptive

epidemiological prison studies, that is that they do not facilitate exploration of potentially formative, causative or softer variables related to educational, psychological, social and offending factors; such approaches may require supplementing if a true picture of prison life and experience is to be captured. In a prison environment, exclusive use of epidemiological methods also invites the criticism that the data gained is remote and impersonal (Bosworth et al. 2005). Descriptive epidemiological prison research has gained official recognition as being the service planning method of choice. For example, the health needs toolkit developed at the Department of Public Health and Epidemiology, University of Birmingham, by Marshall et al. (2001) in conjunction with the NHS executive and the former Healthcare Directorate of the Prison Service, is contingent upon diagnostic criteria and has a clearly descriptive epidemiological focus. It follows a tendency of asking psychological and psychiatric questions of prison populations which are epidemiological in nature (Roesch et al. 1995), to the exclusion of broader, more complex, but equally legitimate questions relating to social background, life experiences and 'what works'. Studies into the mental health of prisoners have also often neglected the use of systematic needs assessment instruments (Harty et al. 2003).

7.3.1. Constraints

Needs assessment in prison, whilst trying to take account of needs arising from morbidity, has often failed to take into account real life criteria, including the experience of prisoners themselves (Caraher 2002). Given that prisoners mental health problems appear inextricably linked to the substance misuse, social and disease cultures inhabited before and during imprisonment (Watson et al. 2004) these issues need to be factored into research studies to understand the psychosocial inner world of the individual. Health is dependent on factors such as social deprivation, unemployment and isolation (Acheson 1998), and needs assessment research must take such factors into account if it is to accurately report the status of the studied individuals and populations. Contemporary research with prison populations has an opportunity to look at the wider psychosocial picture. For if:

> we accept and are to take into account that people have inner worlds and outer realities, then we have to understand the 'person in situation' whole (the psycho-social)
>
> Coulshed 1998

Despite a long-standing recognition of the need for more diverse multi-axial research methods to be employed to track career pathways of mentally disordered offenders, identify critical life junctures and determine service efficacy (Watson 1990), the majority of prison research studies have persisted within a descriptive epidemiological tradition in which the numbers of prisoners suffering from particular illnesses is measured. Epidemiological studies and many prison needs assessments isolate prisoners within their immediate prison environment, limit them to the label of prisoner and reduce them to a disease classification. Such research fails to take account of both the interpersonal and social world of the

prisoner inside and outside prison, and the intrapersonal world, arising from experiences and the inner-life of the individual. The tradition of medical and descriptive epidemiological research approaches, used in prison settings (for example, to predict suicide attempts), fails to generate insight into the real life, lived experience of prisoners (Liebling 1995). Furthermore, such studies can be criticised for failing to actively involve the very constituency (prisoners) whom they seek to serve, their families or staff (Caraher 2002). Birmingham (1997) noted that prisoners' opinions were not taken into account within the design or management of prison health services.

Prison mental health research has tended to ignore the subjective nature of need inherent within mental distress (Butler et al. 2005, Brooke et al. 1996). For this reason, this study utilised qualitative methods to supplement the survey data and give a more human touch to the survey data. Conversely few research studies have attempted to capture stakeholder opinions or the complexity of dynamic interaction between social background, prison milieu and prisoners' mental state. Useful dynamically complex but softer constructs such as quality of life or vulnerability (Harding 1989), are often absent from this strand of research. Notions of identity (which are later discussed in relation to a possible prison group identity and an identity dynamic relating to the effect which imprisonment exerts upon individuals post-release), figure within a range of social problem areas that have been identified as a government priority (Economic and Social Research Council 2006). However, identity fails to figure significantly within the mental health related prison literature.

Whilst Shaw concludes:

> the time is right to seize the opportunity to develop a robust mental health research strategy for prisons. This should encourage good quality multidisciplinary collaborative research, the results of which can inform service development.
>
> Shaw 2002. p.20

A wide range of professional disciplines have now contributed to the body of prison literature relevant to caring for mentally disordered prisoners. The literature includes, for example, perspectives from medicine (Bebbington et al. 2005, Gunn et al. 1991), nursing (Armitage 2003), psychology (Gray et al. 2004), criminology (Mills 2003), social work (Mullis 2001), probation (Bhui 1999) and penology (Wilson 2005). These disciplines retain different and sometimes competing emphases about the care of individual prisoners and are somewhat limited in implementing and managing interventions across a complex range of need. Person centred research studies that better illustrate the range of real life problems, which mentally disordered prisoners have and are likely to face, are at a premium.

7.3.2 Summary of prison research issues

Much prison research to date has failed to engage with the reality of the lived experience of prisoners:

- Purely epidemiological research approaches fail to generate insight into the real life experience of prisoners, whilst little prison research has combined sociological (qualitative) insights with epidemiological rigour (Liebling 1995)
- Useful dynamically complex but softer constructs such as vulnerability (Purdy 2004) are often absent from this strand of research
- Notions of identity figure within a range of social problem areas that have been identified as a government priority (Economic and Social Research Council 2006)
- However, identity has failed to figure significantly within the mental health related prison literature with some recent exceptions (Haslam and Reicher 2003, Reicher and Haslam 2002)
- Prison research studies concerned with mental state therefore need to combine sociological insights into the subjective feelings and experience of prisoners, within quantitative population based approaches (Liebling 1999b)
- Prisons are complex environments within which mental health problems are over-represented and under-researched (Shaw 2002, University of Oxford, Department of Psychiatry 2008)

7.4. PRISON RESEARCH IS DIFFICULT

Research into prisons is difficult, with problems including accessing prison populations, obtaining necessary permission from prison authorities, ensuring the rights and wishes of prisoners are respected and gaining the trust and cooperation of prisoners (Bosworth et al. 2005). Mills and Kendall (2008) similarly identify a series of practical issues that need to be addressed and overcome when undertaking prison research. The challenges facing researchers in prison are considerable. The problems identified by Mills and Kendall (2008) in summary are:

- **Negotiating formal and informal access**. Prisons as closed institutions are restricted environments. There are numerous security and bureaucratic checks to be satisfied in addition to the normal approval processes for research to be met, before the research can commence. Once inside the prison, prisoner and staff groups may need further persuading to cooperate and may scupper the research.
- **Suspension of personal beliefs alien to the prison culture**. A researcher who is perceived as a threat to the prevailing masculine and hierarchical culture of the prison is unlikely to be supported. Mills and Kendall suggest that outward conformity to the prevailing cultural norms of

the prison are a legitimate tactic for the prison researcher.

- **Security**. Researchers' movement around the prison is severely limited. The availability of keys to the researchers may facilitate this, but in itself poses ethical dilemmas for the researchers. Holding the keys may identify the researchers with the prison authorities in the eyes of the prisoners for example.
- **Fitting into the prison day**. Prisons run according to set and rigid schedules which research is not allowed to disrupt. Effectively there are periods of around two and a half hours after breakfast and a similar period after lunch when the prison may be open for business. The research activity has to be managed around these fixed schedules. Even this limited access is likely to be disrupted by staff shortages, staff reallocation, security scares and unexpected lockdown for checks.
- **Waiting to get in/waiting to get out**. Researchers are subject to security checks and searches, and the availability of staff to escort them to the venues where research within the prison has been sanctioned. This inevitably results in long delays.
- **Finding a suitable location to conduct the interviews or focus groups**. Prisons lack areas which are facilitative of privacy and quiet and this can make the identification of suitable venues difficult. In addition these areas may have been designated for other purposes when required by the researchers.
- **Reimbursement/Incentive/Payment**. Some prisoners may wish to receive a reward for participating in research, at the risk that such a transaction may compromise the integrity of the study.
- **Prisoners asking favours**. Prisoners asking researchers to help them (for information, to post letters, to get them seen by the doctor, etc.) What is acceptable?
- **Confidentiality**. Especially whether to tell prison staff when a prisoner is at risk of suicide or self-harm.
- **Leaving the Prison Gates**. Going from the prison at the end of a research day can lead to the difficulty of leaving behind emotionally challenging experiences and conversely the difficulty of dealing with those same feelings once returned to one's life-setting.

7.5. PHILOSOPHICAL AND DESIGN RATIONALE

The underlying philosophical approach to this study, was a belief in the need to view each prisoner as a whole (Coulshed 1998), embodying a unique set of personal, health, social and psychological experiences (Barker 2001), leading up to and following imprisonment. The research conceptualised the individual as being located within a milieu, involving prison, the wider Criminal Justice System and eventual social inclusion or further exclusion (Hazelrigg 1968). In order to capture these multiple dimensions of experience, a wide range of research methods were used (focus groups, staff survey,

Internet data). Such a combined method approach is known as triangulation (Brookes 2007), and is useful in investigating multi-dimensional phenomena. Within this combined method approach, a wide variety or multi-axial range of data were targeted. A multi-axial approach enables consideration of the impact of criminal, physical, psychological, social and personality factors upon individuals' health status and experience and embodies best practice within contemporary approaches to understanding mental state (Jenkins and Shepherd 1996), whilst a psychosocial approach develops a window of opportunity (Norman and Ryrie 2009. p.265) to understand the world view of the individual.

This position is consistent with literature asserting that prison research studies need to combine qualitative sociological and humanistic insights into the subjective feelings and experience of prisoners, within quantitative population based approaches (Liebling 1999b). Shaw (2002 p.7) comments that prisons provide environments within which mental health problems are over-represented and are 'ripe for research'. The so far unfulfilled opportunity for second generation research remains to build upon epidemiological baseline data in order to:

> help identify factors that may help prevent the 'revolving door phenomenon', which results in mentally ill people being volleyed among mental health, criminal justice, and community settings.
>
> Roesch et al. 1995 p.12

The study combined a primarily hard scientific and epidemiological paradigm focussing upon GHQ caseness, with elements of a softer methodology focussing upon lived experience. Whilst these differing research discourses are epistemologically divergent and approach knowledge from differing positions, in the reality of complex social research settings, they tensely coexist (Ramcharan and Cutcliffe 2001), but they do not need to be mutually exclusive and can be used within a mixed framework (Creswell 2003). According to Bowling (1997), whilst positivism (survey methods) and qualitative methods appear to be in conflict with each other, due to their differing philosophical positions, they can be successfully combined:

> As a compromise it could be said that people are influenced by their social situations, and they live in environments which do condition them, but at the same time they are never totally conditioned and constrained by these external factors
>
> Bowling 1997 p.114

Whilst Liebling (1999a) observes that there is a need for a pragmatic use of varied research methods within prison environments. Within this analysis, research in the prison environment must take into account subjective feelings belonging to staff, prisoners and researchers to guide and provide data for well grounded research. The truths of sociology's qualitative discernment of the lived experience and its revelation of the pains of prison life are valid, but require balancing against quantitative data capable of both generalising from prisoner populations, and discerning differences between prisoners and groups.

Liebling argues that such a balanced approach to researching prisoners may identify individual realities, whose origins may contain psychological, situational and sociological components.

Much of the study was exploratory and explanatory (Kerssens-van Drongelen 2001), with each of the constituent datasets contributing a component perspective in relation to the mental state question. The thesis combines the functions of each of the constituent data sets in order to achieve a triangulated perspective. To the broader contextual (panoramic) perspective, the thesis adds (precise) specific inferential and epidemiological perspectives, in order to identify correlates of mental state in prison. The research sought to achieve inferential analysis of mental state against a broad range of psychosocial and experiential variables. Through the datasets linked to prisoner, staff and public opinions relating to prisoner mental state, it was hoped to contextualise mental state against the wider needs of prisoners within a real life, societal dynamic. This aspect of the combination of paradigms may be characteristic of mixed method use, namely that linguistic research forms, more often characterised as qualitative research and favoured by the social sciences, occupy a different, less positivistic paradigm, than do analytic statistical studies as favoured by medicine. Within an iterative approach, questions are less static and more emergent, allowing concepts to form and become defined (Winter and Munn-Giddings 2001).

By comparing groups of prisoners for caseness, the study utilises a case-control approach which sits within the positivist epistemological paradigm. Epidemiology is the science of disease prevention which contributes toward service development and public policy in relation to health matters:

> the study of the distribution and determinants of health-related states or events in human populations and the application of this study to the control of health problems.
>
> Carr et al. 2007 p.57

Epidemiology is used to identify pathogens and risk factors associated with morbidity and mortality, 'Diseases do not arise in a vacuum; they result from an interaction of human beings with their environment' (Gordis 2004 p.1). Parahoo (1997) notes that in addition to this quest for aetiology, epidemiology is also concerned with the broader causes of disease, related to socio-economic conditions, the distribution of wealth and targeting of resources. This additional function of relating disease to underlying social conditions sits within a tradition of epidemiology which 'is concerned with the role of underlying societal and structural factors' (Parahoo 1997 p.55). Utilising an epidemiological method requires a quantitative population based approach to establish reliability and validity. A case study examines the possible relation of an exposure to disease by using a two group comparison method where exposure to a pathogen is the defining variable:

> the hallmark of the case-control study is that it begins with people with the disease (cases) and compares them to people without the disease (controls).
>
> Gordis 2004 p.161

Epidemiological approaches are effective at asking 'how many?' 'how much?' or 'how often?' questions (Murphy et al. 1998), and in prison research some limited use of systematic psychological tools, such as the GHQ-12 is reported (Gunn et al. 1978, Liebling and Maruna 2005). The development of the emerging themes (socialization, stigma, identity, vulnerability and power) was an iterative process (Morrison and Lilford 2001), where the concepts emerged through the course of the study consistent with iterative research processes where the:

> domain of inquiry...contains states of affairs holding independently of researchers' knowledge of them. These states of affairs feature entities, processes, activities, and so forth, some directly observable and some not. All of these can reasonably be expected to relate dynamically and in constant, patterned ways to each other and to the whole.
>
> Morrison and Lilford 2001 p.437

Iterative process is more frequently associated with action research methodologies, where stakeholders/research participants are often working actively towards a solution focussed outcome, but was utilised within this study to help draw together the multiplicity of data. Iterative working implies that the data collection develops through the study in line with the emergence of new lines of enquiry.

7.5.1. The role of researcher

Research into prisons which attempts to understand something of the prison experience, faces a fundamental problem of achieving a credible stance between the just entitlement of the state to imprison dangerous or antisocial persons, and an empathy regarding the plight of the prisoners (Piacentini 2006):

> For the prison researcher neutrality in doing prison research poses certain dilemmas. This is a debate that is not about whether to take a side, but whose side. Can prison researchers avoid taking sides...in the peculiar setting of the prison?
>
> Piacentini 2006 p.9

This tension between taking sides versus achieving objective neutrality is a theme which runs through the prison research literature conducted from a sociological viewpoint. The notion of taking sides is anathema to many researchers, particularly those outside of a sociological tradition, who prefer to locate their work within a scientifically objective and neutral paradigm. In taking such a neutral stance the researcher can be blind to the extent to which they are insulating themselves from both the painful existence which many prisoners face and also the extent to which study design can be remote from the experiential reality of prison, particularly when reduced to statistical data (Bosworth et al. 2005b). In the prison environment, the researcher may stake a claim for a scientific and objective authority. This authority requires clear demarcation lines between subjects and researcher, but runs the risk of failing to comprehend that which the researcher seeks to understand, namely the true nature of prison experience (Bosworth et al. 2005b).

Whilst recognising both the legitimate quest to punish the criminal and protect the public, and acknowledging the broken backgrounds from which many prisoners emerge, Piacentini argues that:

> On the one side, prisons epitomize the confinement of the difficult-to-manage persons, against whom society has won. All that is demonic about the human spirit is reflected in the prison and society's rightful deprivation of liberty is the justified response. The other side of prison is reflected in the personal background of those who society incarcerates; individuals whose drug and alcohol addictions, economic deprivations, marginality and disconnections from mainstream society challenge the first premise of the prison as the container of the dangerous. The prison...holds persons against whom society has failed.
>
> Piacentini 2006 p.9

According to Piacentini (2006), imprisonment reflects the subjugation of individuals affected by a deep seated social failure, and this reality must necessarily affect those researching the subject. It would be wrong to claim that the issues of taking sides or achieving neutrality were resolved in this study. Rather the pragmatism of Mills and Kendall (2008) resonates with the author's position, which can be summarised as: willing to try to fit in with the regime of the prison in order to obtain the data necessary for this study, and to suspend any personal beliefs or convictions which would prevent this.

7.6. SPECIFIC DESIGN ASPECTS

This study grew out of an earlier 2001 general health needs assessment in two prisons (Davies et al. 2001) and a mental health needs assessment research project in the same two prisons. The specific enquiry into correlates of mental state was the unique distinguishing feature of this PhD study.

7.6.1. Psychosocial rationale

An underlying but implicit assumption was that the wide-ranging socio-economic, health and psychosocial milieu both pre-prison and in prison, was of importance in understanding the prison experience and by extension the mental state of prisoners. Such an assumption can be supported by the importance attached within the mental health and social care literature to the centrality of the psychosocial concept in understanding the individual (Coulshed and Orme 1998, Rutter 2002). Whilst the psychosocial concept was inherent within the study design, for example through the breadth of the variables included within the 2002 questionnaire (but also within other elements of the study), it was not developed to the extent of being formulated within a formal hypothesis. In other words, the study supposed causal relationships might exist between the prisoners' total psychosocial experience and mental state in prison, but no predictive hypothesis linking specific variables was postulated within the research question. Therefore, solely in order to test the quantitative data, a null hypothesis was assumed, namely that no specific factors related to psychosocial background, prison experience or other factors would be linked to mental state in prison.

7.6.2. Questionnaire development

The content of the questionnaire was informed by the author's previous experience on the 2001 study. This related to the extent to which disadvantage before prison appeared relevant to prisoners' experiences and understanding of their situations. It was also apparent that prisoners disliked completing questionnaires which involved written cursive answers, however a tick-box approach appeared to be well received. The literature relating to prisoners' literacy shows that many prisoners have problems with comprehension, grammar, vocabulary and other dimensions of literacy. For example, in one UK study of young offenders in prison, when compared against acceptable limits for age; 43 per cent of participants showed a limited vocabulary; 73 per cent experienced problems with grammar; and 23 per cent problems with comprehension (Bryan 2004).

The questionnaire was designed to take into account the specific offending, mental health, social and substance misuse status of prisoners, and to enable study of the relationship between variables. In the absence of finding something off the shelf the research team developed a questionnaire. Firstly to complement and expand upon the mental health/psycho/social data generated from a previous needs assessment exercise (Davies et al. 2001). Secondly to maximise possible linkages between mental state, psychosocial variables, drug and alcohol use, offending behaviour, and other fields of data. It was felt that a self-report method was preferable to an approach dependent upon clinical rating scales. This approach was felt to have the advantage of being a flexible approach eliciting prisoners' views and experience directly and capable of being delivered effectively within the project resources. The survey was constructed in order to access information relating to four main domains:

- Background behaviour (life before coming to prison, childhood problems, history of offending and plans following release)
- Experience of drugs and alcohol
- Experience inside prison (impact of prison upon prisoners, prison mental health services, and mental health problems experienced in prison)
- Mental health history (previous service contact, current problems, experience of self-harming or suicidal intent)

In summary, the questionnaire was based on previous work undertaken in other prisons, but was enlarged and incorporated standardised validated instruments. A key feature of the questionnaire was that it required a tick-box response from prisoners.

7.6.3. The GHQ-12

The overall intention was to collect data on a wide range of psychosocial variables, grouped around the four domains: background behaviour, experience with drugs and alcohol, experience inside prison and mental health history, which could then be tested against prison mental state. It was important for the study that a reliable mental state measure was used for this purpose. It was also felt that the results of the survey would be more acceptable to some stakeholders, particularly medical colleagues, if it included a well recognized, valid and reliable measure of mental health. The earlier (Davies et al. 2001) study served as a pilot for the self-report format of the questionnaire, whilst the new questionnaire needed to incorporate a validated self-report tool to provide the mental state focus within the study. Within the earlier study the tools used were the SF-36 (Ware 1993) health status measure and the Euroqol EQ-5D (Coons et al. 2000) measure of life quality. For the purpose of this thesis, the author felt that a more specific measure of mental health was required. Some available scales for determining mental state, based on clear diagnostic criteria such as the SCAN tools (Wing et al. 1990), or ICD-10 schedules (Almeida and Almeida 1999), were ruled out. These tools are all dependent upon being conducted by a medical practitioner. The practical constraints of this study were such that the tools had to be self administered and short.

Alternatives

The final choice lay between the Hospital Anxiety and Depression Scale (HAD) (Zigmond and Snaith 1983) and the General Heath Questionnaire GHQ-12 developed by Goldberg (1992). The HAD is a brief assessment of anxiety and depression consisting of 14 items, but most studies concerning its use, reliability and validity are in hospital settings. The GHQ is the most widely applied self completion measure of psychiatric disturbance in the UK, and has been shown to work well in a variety of settings. It has a short form version, GHQ-12, and is a screening questionnaire for detecting independently verifiable forms of psychiatric illness but does not make clinical diagnoses. It is a pure state measure, assessing present state against usual/normal state. It assesses broad aspects of mental health including anxiety and depression. Whilst not intended to detect functional psychosis, it does have some capability in detecting functional psychosis, which is an advantage over the HAD. Due to its specificity to measuring mental state, the short form of the GHQ tool, the GHQ-12 (Goldberg 1992) was preferred. It consists of a checklist of statements asking respondents to compare their usual state with their recent experience on a four-point scale of severity 'less than usual', 'no more than usual', 'rather more than usual' or 'much more than usual.' The scale is self administered and takes about five minutes. Due to its construction the GHQ may miss long-standing disorders being considered 'no more than usual'. The scoring method for each item gives scores ranging from 0-12, where higher scores indicate both greater immediate distress and a

higher probability of clinical disorder. Caseness is usually determined by a score of either two or above, or three or above. The higher threshold of three was selected for this study.

7.6.4. Health of the Nation Outcome Scales (HoNOS) problem descriptors

The questionnaire also incorporated questions from the HoNOS clinician and patient questionnaires (Wing 1998). These are a set of scales created to measure the range of physical, personal and social problems, associated with mental illness. Although a Health of the Nation protocol specific to use in secure settings is available (Royal College of Psychiatry 2004), it was felt that this was more suited to eliciting data from mentally disordered persons deemed to have primarily offended due to their mental state and focussed upon forensic risk issues, rather than the more generalised mental state questions, which were of interest to the author. Within some of the other questions eliciting social or quality of life data, the researcher also used HoNOS descriptors. These questions aimed to examine the extent of problems respondents might be having with certain aspects of living. Respondents were asked to choose from a scale of severity on how they perceive the extent of the problem they are experiencing. To each question, respondents are asked to choose between 'no problem', 'slight problem', 'mild problem', 'severe problem', and 'very severe problem'. The extent of problems was also checked via the audit of records which used the same problem descriptors as the basis for the audit tool (Table 24 and appendix E).

7.6.5. Personality disorder questions

Additional questions regarding personality disorder, based upon self-reporting of personality typology, were suggested by Dr Paul Moran of the Health Services Research Department, Institute of Psychiatry in a lecture attended by an associate of the 2002 research. While standard interview schedules are available to diagnose personality disorder, there is little consensus as to how to assess them (Zimmerman 1994). The questions used in the questionnaires are considered as probes or screening questions, to be used by clinicians in clinical face-to-face interviews. Use within the context of a questionnaire had no precedents within the literature, and might justifiably be criticised for use outside of their intended clinical screening function. Each relevant response corresponds to specific personality disorders as described in ICD-10 and would warrant more formal structured assessment of a patient.

7.6.6 Focus groups

The qualitative aspects of the study were predicated upon the need to understand more about softer aetiological factors interacting to mediate prisoners' mental state. This included consideration of the life trajectories and range of prisoners' pre-prison experience and their perception of imprisonment. Therefore, the focus group data enabled development of a narrative deeply enmeshed within and

illustrative of prison culture. Prison is a dynamic of a social, interacting yet confined life, constantly referring to the outside, but organised upon deeply institutional conventions, and the narrative gives insight into the lived experience. The qualitative dimensions helped contextualise and make sense of the statistical findings. The choice lay between interviews and focus groups. Both methods have potential advantages and disadvantages.

Interviews as a data collection method

In prison knowledge is power and despite giving advice on confidentiality within a focus group, any sensitive information gained within a focus group by the prisoners might be used against other prisoners or staff (Personal correspondence 2009). Given these limitations, interviews might be thought of as a more appropriate method for the collection of intensely personal narrative. Interviews allow direct face-to-face contact to create rapport and a natural style of communication. Using a structured format promotes focus whilst a semi-structure facilitates both focus and respondent views in depth if they so choose. An unstructured approach allows respondents to concentrate on and further develop issues important to them. Furthermore, if they are well facilitated, interviews can elicit new data fields that were not envisaged (Silverman 2004). However interviews are not without problems; they are time consuming, liable to interview bias and some respondents find them uncomfortable. Respondents can stray from the topic and be difficult to marshal. The environment within which the interview is conducted can be unregulated and thereby prone to interruption and distractions. Transcribing is extremely time consuming (Mason 2006, Green and Thorogood 2009). Whilst acknowledging such limitations interviews are useful for exploring the experience of people in depth.

Focus groups preferred

Focus groups were chosen as the preferred method of collecting qualitative data following consultation with the team involved in designing the 2002 research at HMP Swansea and HMP & YOI Parc. Previous prison research which the author had been involved with had highlighted limitations of relying solely on a survey method (very poor response rate, data lacking a personal perspective). It was decided that in order to elicit a more personal narrative the survey data would need to be supplemented by a qualitative perspective. The choice of focus groups was made upon the basis that they offered a manageable method allowing participation of around thirty prisoners, which would be difficult to achieve using interviews, especially given the problems of access to prisoners. Focus groups have gained credence and popularity within health and social research over the past decade (Gulanick and Keough 1997) and have been proposed as an effective means of collecting data about perceptions, attitudes and beliefs (Clarke 1999), or participants' views on a particular subject (Fulton 1997, Cahill 1997, Jackson and Stevenson 2000), where there is an element of shared life experience common to the participants (Repper et al. 1998).

Debate surrounds the issue of focus group data analysis (Reed and Roskell 1997, Sim 1998, Wilkinson 2004). The debate centres upon whether simple coding techniques which are most often used, and advocated by (Braun and Clarke 2006), can sufficiently represent the complexity of meaning as created within the focus group setting and arising out of the complexity of linguistic use and the dynamic of group interaction. Conversational analysis offers a more detailed method of data analysis which is better suited to capturing this complexity, but requires a second person to note the interactions taking place within the group and poses problems of time-consuming and complex analysis processes and in achieving agreement concerning both verbal and non-verbal communication (Silverman 2004). There is also dependency upon the facilitator to maintain a neutral stance in order to elicit the range of views held by participants and to maintain validity and avoid contamination of the data (Clarke 1999).

There are also some inherent issues with focus groups which can limit their effectiveness. Sim (1998 p.348) reports that focus groups have an 'emergent property' of consensual agreement, which is likely to limit the articulation of views dissenting from the majority group dynamic. Furthermore focus groups are also likely to inhibit accounts of an intensely personal nature as opposed to more publicly acceptable accounts, and consequently ethical problems when using participative research methods with vulnerable groups have been identified (Tee and Lathlean 2004). Since this research was conducted some research ethics committees have moved to a position where they do not generally approve prison focus groups and any research protocol where prisoners have to discuss sensitive information about themselves are likely not to be approved (Personal correspondence 2009).

The strength of this research method is its ability to elicit data relating to the lived experience, for example research with mental health service users to identify their perception of quality of life and mental health service priorities (Hannigan et al. 1997) or professionals' experience relating to their role (Jackson and Stevenson 2000, Mallik 1997). Furthermore, focus groups are advocated as a means of directly engaging and consulting individuals on issues of importance to them (Peck at al 2002), and fostering cooperative enquiry between users of services and professionals (Hostick 1998, Mawhinney and McDaid 1997).

Use of focus groups in prison

Focus groups have been used successfully in prison settings to obtain prisoners' views on quality of life issues (Nurse et al. 2003b), focus groups have also been advocated as a means of researching hard to reach communities on 'their own turf' (Plaut et al. 1993 p.216). This description may seem particularly apt to prisoners, who are hard to reach by virtue of cultural isolation and physical captivity, with prison being their defining turf. Mills and Kendall (2008) also include focus groups within a range of research methods appropriate to the prison environment. Focus groups can also be used alongside other methods within mixed method studies (Wilkinson 2004).

7.6.7 Staff and public perceptions

In addition to identifying mediating factors and profiling the variables correlating to poor mental state in prison, it was decided to consider consequences of poor mental state in relation to professional and service responses to prisoners poor mental state and public perceptions. This seemed like a logical and achievable next step. This was achieved through a survey of staff working in prisons and their peers working in community settings who might come into contact with mentally disordered offenders and collating data from a BBC online discussion site. This data was used in order to link to a literature suggestive of a punitive populist attitude (Bottoms 1995, Garland 2001, Pratt 2002), by displaying public attitudes towards prisoners and the types of problems which they face.

7.7. AIMS AND OBJECTIVES MATCHED TO METHODS

The aims are summarised within the rephrased question; 'how do prisoners' circumstances and experiences affect their mental state in prison and beyond?' The specific objectives (matched to aspects of study design) are set out in Table 8:

Table 8: Objectives Matched to Study Design

Objective	Method	Discussion
Present imprisonment within an historical, social and experiential context	Literature review, focus groups	Establishing historical context was a function of the literature review, the experiential domains were encompassed within the focus group data
Identify the current social status of imprisonment	Literature review, focus groups, Internet data	The current social status aspects of the study were captured by the focus groups
Examine psychological, health and social status variables of prisoners before and during prison	Prisoner surveys, focus groups	The psychosocial and health related variables were described by the prisoner survey data
Identify variables associated with mental state	Prisoner surveys	The 2002 prisoner survey data when tested identified correlates of mental state
Contextualise mental state within lived experience	Focus groups	This was a function of the focus group data
Consider the necessary provision of services to meet prisoners mental health needs	Literature review, prisoner surveys, focus groups, staff survey	Some discussion of services came through staff participation in the focus groups, but the main focus of this element was in the staff survey
Explore the public dimension of imprisonment and its impact upon mental state	Focus groups, Internet data	The way in which prison is perceived was implicit within the focus group data and explicit within the Internet data
Generate theory which helped explain the data	Proposed within Chapter 12 - Discussion of findings	See Table 41
Make conclusions and recommendations	Proposed within Chapter 13 - Conclusions and Recommendations	See Table 42 and Table 43

7.7.1. Study features summary

This study utilised mixed methods including a survey questionnaire designed around the psychosocial domains; background behaviour (life before coming to prison, childhood problems, history of offending and plans following release), experience of drugs and alcohol, experience inside prison (impact of prison upon prisoners, prison mental health services, and mental health problems experienced in prison), and mental health history (previous service contact, current problems, experience of self-harming or suicidal intent). This was combined with focus groups and additional prisoner, staff and Internet data.

This thesis attempts to draw upon interdisciplinary perspectives; medicine, nursing, psychology, sociology and criminology, along with the staff, prisoner and public perspectives, and set prisoners' mental state against a more complete background than is perhaps found with single disciplinary approaches. Previous studies have measured often in isolation, the physical or mental state of prisoners, the social background of prisoners or the experience of prison itself. The dynamic interaction of factors is often ignored in research, whilst being critical to offending and the revolving door (Birmingham 1999, Harrison 2001) nature of exclusion and repeated imprisonment:

- No published studies have attempted to identify from the dynamic interaction of psychosocial factors (plus those of personality and crime committed), the precise factors which mediate mental state in prison.
- Nor have published studies explored the detailed practical means by which to address the unique ethical and operational issues arising from researching this special population.

<u>Novel features of this study</u>

The combined methodologies of the study constituted a novel approach to the study of prisoners' mental state. Novel features include:

- Linking closely to the running of two prisons for the duration of the data collection. This included the provision of additional funding for nursing care for the referral of subjects either reacting to the questions posed by the research, or exhibiting symptoms and previously unknown to the mental health care service within the prisons.
- The iterative combination of quantitative and qualitative data; the triangulation of prisoner, general public and professional perspectives against which the survey data was set.

These novel aspects supplement a snapshot mental state measure with contextual life events, to provide a more dynamic and balanced mental state picture.

7.8. SUMMARY

The literature reviewed in previous chapters linked prisoner mental state and health, with psychosocial and wider societal considerations. This chapter outlined the rationale for the design of this study predicated against the literature review findings and current issues within prison based research. Methodological shortcomings within prison research and practical difficulties in conducting prison research were reviewed as a baseline for this study. The centrality of a psychosocial approach which informed the development of the study was outlined. The case for the use of multiple research methods, and an approach where key concepts could emerge iteratively through the course of the study, was made. The chapter proposed the need for the study to combine methodological approaches, encompassing prisoners' own perceptions and wider societal perspectives, to supplement the epidemiological mental state data.

CHAPTER 8

METHODS

8. METHODS

8.1. INTRODUCTION

Chapter 7 outlined why the study was undertaken. It also identified the philosophical and design rationale. This chapter details the specific methods and processes used to undertake the study. The processes for data collection are set out first, followed by the means of data analysis. The process of presenting the descriptive data, inferential testing using the Mann-Whitney U and odds ratio tests, focus group, staff survey and Internet data is explained.

8.2. RATIONALE

This chapter discusses the specific processes undertaken within the study in more detail. Included within this discussion are issues pertaining to data collection, ethical approval, data presentation and data analysis. There is also discussion of the operational issues associated with undertaking a major research study in two prisons, and ensuring that both the rights and needs of prisoners are preserved whilst also ensuring that the good order of the prison regime is maintained.

8.3. DATA FROM HMP & YOI PARC AND HMP SWANSEA (2002)

Data was collected from HMP & YOI Parc and HMP Swansea in 2002 (Bowler et al. 2003a, Bowler et al. 2003b). These data were intended to enable consideration of the social context of imprisonment and its relationship to mental state, which the idea for a specific study into the link between social background and mental state was decided upon. All individuals resident within the two prisons at the time of the data collection were invited to participate in the needs assessment exercise by letter and in person by prison officers. The two prisons were HMP & YOI Parc a modern Category B local prison, with a capacity for 1,126 male adults (convicted), young offenders and juveniles (convicted and remand), and HMP Swansea, a Victorian Category B local prison, with a capacity of 422 adult males, remanded into custody or serving short sentences.

8.3.1 Ethical approval

Ethical approval was sought in January 2002 for a mental health needs assessment at HMP & YOI Parc and HMP Swansea, via the standard local ethical committee process. This application included reference to both a questionnaire based prisoner survey and the focus groups. A presentation was made to the local research ethics committee and the committee wrote to the author and co-principal researcher on 17 January 2002 with their observations. In summary the committee required that all documentation relevant

to the research should be submitted for further consideration and discussion, including information, consent, and questionnaire documentation. Furthermore the committee raised specific concerns about protecting prisoners' confidentiality in data storage, ensuring that there was no coercion in recruiting subjects, and providing support to illiterate or semi-literate prisoners. In addition to concern amongst the members of the committee of the possibility of coercion in recruiting prisoners, there was a concern that vulnerable prisoners might be sensitised through the asking of personal and potentially traumatic questions. It was felt that this might lead to deleterious effects upon mental state and may lead to incidents of self-harm. It was proposed that these possibilities needed to be guarded against and managed by ensuring that pastoral care and extra support was made available to participants.

Issues to address prior to ethical approval being granted

Approval from the ethics committee was secured only after significant further work to address consent and vulnerability issues. This work involved rewriting the protocol, consulting with management and staff at the two prisons and considering the exact means by which the data would be collected, therefore, addressing these issues constituted a significant piece of work. The author wanted to balance the requirement to attain as universal coverage of the prisons as possible, especially to access data from vulnerable and mentally disordered prisoners, with respect for the individual rights and immediate needs of prisoners. This was achieved through a lengthy consultative process with the prisons, especially care staff. The consultation enabled the design of a sensitive and ethical approach to data collection, whilst working within the fixed prison constraints of schedules and security.

The extent to which the prisons were active participants within the design, training of data collectors and other staff with contact with the research, and completion of the research, felt novel. None of the literature reviewed, discussed cooperation or collaboration to this level, in undertaking prison research. Much of the collaboration was designed to protect the emotional health of subjects. Commenting specifically upon prison research and its potential impact upon subjects, it has been noted that the:

> collective failure of scholars to acknowledge the pain their questions may evoke in their participants reveals a continuing, albeit unacknowledged, tendency to objectify our research participants. Although some scholars...may help their participants deal with any conflicting emotions that the research project may engender, few practitioners...are as careful.
>
> Bosworth et al. 2005b

In the pursuit of the study's objectives it was necessary to ask prisoners questions which were potentially distressing, for example; relating to physical or sexual abuse, intent and incidences of suicide, attempts or actual self-harm and psychological triggers to these events. As a result of the consultation and training the author requested extra funding from the commissioning health authority to provide the Emergency Assessment Clinic facility within the prisons' health care departments, in order to accept immediate

referrals as a result of the activity of the research teams. (The letter for ethical approval of this part of the study can be found at appendix B. The participant information and consent form is at appendix C).

Further submission for PhD ethical approval (2004)

A further submission was made to the local research ethics committee in February 2004. This submission sought approval for use of the 2002 data within the PhD study and requested permission to survey staff for their opinions as to the significance of analysed data. Permission was also obtained from the Governor at HMP Swansea and supported by a letter from the prison Healthcare Project Coordinator at the Welsh Assembly Government. Both the information documentation and consent form were prepared utilising pro formas made available from Iechyd Morgannwg Health Authority Ethics Committee. All of the documentation was submitted to and approved by the committee in their letter of February 2004 (appendix F). Further letters of approval and support were obtained from the Welsh Assembly Government, Prison Healthcare Project Coordinator (appendix G) and the Governor of HMP Swansea (appendix H).

8.3.2. Responding to distressed prisoners

The author met with health care staff and prison managers to discuss access to prisoners. The identification and appropriate handling, referral and treatment of prisoners in distress was felt to be of particular importance. The establishment of a specially funded Emergency Assessment Clinic ensured that there was an immediate crisis referral mechanism into the health care team of the prison, and an available and immediate response should the questionnaire or research process itself prove distressing to any individuals.

Method for data collection in 2002 survey

Through consultation with the staff and utilising previous ad hoc feedback from prisoners, it was intended to design a process that felt sensitive and safe. The team considered a number of ways in which the questionnaire could be administered. It was decided to organise data collectors into teams of around four to five to work with groups of approximately ten prisoners at a time. Although this was a resource intensive way of working, it was regarded as both safe for the data collectors and helpful to those with literacy problems, or potentially distressed individuals. This approach to data collection was intended to be supportive to prisoners and maximise coverage and thereby response rate, and enable any distressed individual to speak to a member of the research team and thereafter the health care team.

Team approach

The final model for data collection, following consultation with the prisons, was based upon data collection teams meeting the following specification:

- Two qualified mental health nurses trained in the use of the questionnaire tool and familiar with the aims, objectives and process of the research plus additional personnel (lecturing staff and/or third year mental health nursing students also trained in the use of the questionnaire tool). The data collection teams could therefore act as advisors for the questionnaire, assist with prisoners who had literacy problems and refer on distressed individuals to health care staff.

8.3.3. Induction of prisoners to research

In order to minimise the distress to individuals, prisoners were rigorously inducted into the research process, via the information and consent procedure in order that any who did not wish to take part were not coerced to participate. Team leaders were identified by the author to manage the teams of data collectors, and the data collection process. Their role was both research oriented and pastoral. For example they were required to brief prisoners following the consent procedure as to the nature of the exercise, giving further opting out opportunities.

8.3.4. Further issues

Discussion arose with prison and research staff as to the correct response to disclosure to data collectors, or within questionnaires, of suicidal or self-harming intent. It was felt that conceivably this might also apply to any disclosure of information prejudicial to the good order of the prison, such as threats against staff members.

Hypothetical scenario concerning suicidal intent and disclosure

Nurses and student nurses were involved in data collection teams and helping the prisoners as they completed the questionnaire. Ethical approval was granted on the basis that everything would be confidential. It was envisaged that a situation might arise where a prisoner asks for help in completing the form, but discloses that they are suicidal (for example) but won't take up the offer of help or referral to prison health care made by the nurse. It was felt the nurse may feel torn between competing priorities, firstly to undertake the research and secondly an overriding concern to ensure that the prisoner's health needs are met rather than to prioritise the collection of data. The prisoner may disclose self-harming intent, but be unwilling for this information to be passed on.

Nursing and Midwifery Council (NMC) Code of Conduct for Nurses (2002)

This specific conflict of ethical duty was discussed in detail with the prisons staff, author, research team and data collectors, with particular reference to the Code of Conduct for Nurses (NMC 2002), and the protocol which had been agreed by the ethics committee emphasising the requirement for confidentiality

of data. It was felt that the best practice in this situation was to prioritise prisoners' safety and that, as in other situations, preservation of life would have to take precedence over other priorities. Furthermore it was felt that this would be explained to prisoners in the final briefing before they completed the questionnaire. It was also felt that there needed to be an explicit explanation that staff were available for any individuals who felt that they needed help, but also that prisoners needed to make such requests clear and that information which was later uncovered within the questionnaires could not then be acted upon. This model of operating achieved consensual support, and was implemented. Although the model was a best practice approach aimed at maximising the quality of the data from a research viewpoint this was balanced with respect for prisoners' dignity and autonomy. The model aimed to both anticipate the potential for and minimise and manage the potential distress of prisoners.

Training for prison staff and data collectors

Training was designed and provided by the author and colleagues to those who would be collecting data and others involved in the process at the prisons with regards to; background, process and the exact nature and purpose of the research and a detailed preview of the questionnaire. The training days also covered topics such as safety within the prison, dealing with suicidal prisoners, referral processes for prisoners and follow-up.

8.3.5. Invitation to participate

Prisoners were invited to participate in the research by means of written letter and verbal follow-up from prison officers. Once present to participate in the research, prisoners were verbally and in writing reminded of the voluntary nature and purpose of the research, and if they were unwilling at this (or a later) stage, they were escorted back to their previous activity or location. Prisoners were supported in completing the questionnaire by the data collection teams, who the prisoners were invited to approach if they had literacy problems or mental health issues, which were unresolved and/or sensitised by the questionnaire.

8.3.6. The focus groups

Seven focus groups were held in all. Three were with staff groups (two at HMP & YOI Parc each with three participants, one at HMP Swansea with three participants). Four focus groups were with prisoners. Three were at HMP & YOI Parc (two adult with three and four participants and one juvenile group with three participants plus a supervising staff member who contributed), and one at HMP Swansea (adult) prisoners with three participants. Volunteers were sought and engaged within an informal group setting, using the focus group schedule at Table 8 as the basis for discussion. The groups were held in classrooms, craft rooms or other (quieter) settings as they were available in each of the prisons. The

author, assisted by either one or two colleagues, acted as a facilitator for the group. The focus group discussions were recorded and the data transcribed by a number of different staff within the department. The question schedule in the prisoner groups was used loosely in order to give groups a degree of autonomy to range over issues which they felt were important. The staff groups were less structured and consisted of a preamble outlining the nature of the research followed by guided discussion. They consisted of four mental health nurses (RN(M), two general nurses (RN), two prison officers with designated medical roles and one doctor. Table 9 identifying the schedule of questions for use in the prisoner focus groups follows:

Table 9: Schedule of Focus Group Questions (2002)

Life status	Question	Rationale
Pre Prison	How were you feeling on the outside and before your offence?	As per use of GHQ-12 at q5 of questionnaire - explores links between mental state and offending behaviour
	What triggers were there to your offence?	Explores possible psychological/environmental antecedents to offence
	Were you taking any drugs?	Explores links between substance misuse and drug taking
	Did you want to come off?	Establishes level of motivation
In Prison	How much help have you had with • Stress, emotional and relationship problems? • Substance misuse? • mental health problems?	Attempts to cover the range of mental health issues covered in questionnaire
	How does prison affect your experience?	Impact of prison upon mental state
	What could be done better?	Suggestions for change
	How well prepared are you for discharge?	Looks at key stage of transition from prison to outside life
After prison	How much follow-up is provided in the community?	Invites those with experience of having previously gone through the penal system to reflect on support levels on the outside
	What services would you like to help you on the outside?	Opportunity for suggestions as to what services are needed on the outside
	What help might stop you from reoffending?	A critical consideration in terms of enabling resettlement

Prisoners and staff were involved in separate focus groups in order to try to capture a breadth of opinion and to avoid any possible inhibition of the prisoners in particular. The group interviews were tape-recorded. Tapes were transcribed verbatim and transcripts analysed to identify significant themes within the data. Transcription was undertaken by members of the research team and then analysed by the author. Keyword descriptors were identified on reading through the transcript. The keyword descriptors

adopted were felt to resonate with the experiences expressed by prisoners. These descriptors were then adopted as the codes for grouping the transcribed data around.

8.4. AUDIT OF MEDICAL RECORDS

A researcher assisted by research or health care staff audited the notes over a period of approximately four weeks. 270 records were audited, approximately 21 per cent of the resident population at that time. The notes included entries completed by medical staff, nursing staff and other health professionals as well as prison health care staff. The focus of the audit was to check how much and what type of information the Inmates Medical Records contained in relation to mental health and drug problems. A simple audit tool consisting of a series of questions related to three main fields of data was developed. The first related to the occurrence of recorded mental illness. Following an initial inspection of notes, this question was refined so that more general problems based upon Health of The Nation descriptors (Royal College of Psychiatry Research Unit 1995) could be captured such as problems which had not been formally diagnosed. The second question related to quality issues regarding record keeping, including, had there ever been a care plan? The third question related to the prison processes, has the prisoner had a self-harm form, reception screen, transfer from other prison? (The audit tool used is at appendix E).

8.5. STAFF SURVEY OF PRISONERS' MENTAL HEALTH REQUIREMENTS (2004)

Following initial analysis of the mental health needs assessment data, it was decided to collect opinion data from staff working with, or likely to come into contact with, mentally disordered offender-prisoners. This would allow a testing of the identified correlates of mental state, against staff perceptions. The author also wanted to obtain data as to what areas of prison mental health care were perceived as priorities for development. Initially this was conceived as a Delphi study (Bowles 1999, Hasson et al. 2000), where a consensus would be developed over a number of data collection rounds. In the end a simpler survey approach was preferred. This was partly because the opportunity to develop a consensus on service development priorities had by this time started to appear less significant than the opportunities arising from the case-control aspect of the study. It was therefore decided that a single round of data collection would suffice and along with the other data sets this would serve to contextualise the mixed epidemiological focus group thrust of the study. (The participant information and consent form is at appendix I).

Rationale for staff survey

The rationale for this part of the study was to ascertain the extent to which staff showed an awareness of variables related to poor mental state in prison and to identify perceptions as to service development and priorities between client groups. In addition to the questionnaire other documentation was prepared. This

documentation included information for participants outlining the scope of the research, aims and objectives, source of ethical approval and contact details for further information. A separate consent form was also prepared.

8.5.1. Staff survey method

A four-part questionnaire with Likert-type scales was developed from themes and issues which emerged from an initial analysis of the questionnaire data. Respondents were asked to judge and rank the factors identified within the questionnaire. In effect this amounted to testing the opinions of expert stakeholders, using a survey approach. Staff were approached for inclusion within the research on the basis that they met the following criteria:

i) That they were working in a prison nursing, occupational therapy or medical staff capacity.
ii) That they were mental health professionals working in community locations, either in roles which were directly related to the care of mentally disordered offenders; or
iii) That they were working in community locations in roles which would sometimes bring them into contact with mentally disordered offenders.

Questionnaire design

In preparing the questionnaire an initial pool of statements was collected pursuant to the three areas of interest: mental state in prison, priorities for service development and priority client groups. The pool of statements attempted to capture significant findings and emergent themes arising from the mental health needs assessment data. A questionnaire was prepared which consisted of four parts. The four parts of the questionnaire related to:

A) Staff characteristic variables (4 items)
B) Variables related to poor mental state in prison (13 items)
C) Variables related to service development priorities (10 items)
D) Variables related to priority client groups (10 items)

Part A consisted of data obtained relating to staff identity (data was anonymised by allocation of a staff identity number), job role (nurse, doctor etc.), workplace (whether prison or community setting) and time spent in post (as an indicator of experience).

Transposition of findings within staff survey questionnaire

The development of part B of this questionnaire involved transposing initial findings as to correlates of poor mental state in prison. These variables were introduced into this staff questionnaire for ranking by staff respondents. Initial analysis of the mental health needs assessment data had suggested a number of variables as being associated with higher GHQ-12 scores amongst prisoners including; remorse, not having served a previous prison sentence, poor educational attainment, a history of having been in care, having been on remand, receiving abuse from other prisoners, having spent one month or less in prison, having spent more than 20 hours in cell, taking drugs, having committed a sexual offence, being employed prior to prison, feeling unsafe sharing a cell, having an antisocial personality and not participating within a constructive regime.

A five-point Likert scale was constructed using the value statements to enable judgements to be made as to the extent and nature, in the views of the respondent, of the influence a particular variable might have upon prisoners' mental state. The Likert scale statements were: 'extremely positive', 'positive', 'neither positive or negative', 'negative' and 'extremely negative'. Respondents were asked to indicate how much according to this scale they felt the particular experience variables would impact upon prisoners' mental state.

Service development priorities

Part C reflected themes regarding types of service provision which are absent or underdeveloped, such as diversion from prison. Again these themes were drawn from data and from the literature review which was previously undertaken. The proposed service developments were: develop alternatives to prison, improve screening and diagnosis, improved care management, more user focussed care, greater sharing of info and multi-agency work, training and support, more creative regime, transfer to NHS of disturbed patients, better functioning across and between prison departments, and development of inreach/outreach services.

The Likert scale used for part C of the questionnaire used the following descriptors: urgent priority, high priority, low priority, status quo and area for disinvestment. This scale was structured in such a way as to offer three possible options for identifying each service development as being a priority: urgent, high and low. These options were complemented by status quo and area for disinvestment. The rationale for this scale structure was the perception when designing the questionnaire that respondents were likely to see all of the proposed areas of service development as worthy, and therefore providing three options for distinguishing relative levels of worthiness, would avoid bunching responses within two priorities: urgent and high.

Relative priority of client groups

The fourth part of the questionnaire (part D) related to ranking client groups in order of perceived priority for example, prisoners with a co-occurring substance misuse and mental illness, using a Likert-type scale. The client groups included were: clients who misuse substances, clients with post-traumatic stress disorder, clients with psychosis, clients with a co-occurring serious mental illness and substance misuse problem, clients who are self-harming or suicidal, clients who are dangerous to others, clients with neurosis, clients with social needs, clients who are vulnerable, and clients with multiple and complex needs. The Likert-type scale used for this part of the questionnaire was the same as for part C: urgent priority, high priority, low priority, status qou and area for disinvestment.

Consultation on draft staff survey questionnaire

The draft questionnaire was shared with three colleagues with an interest in the research in order to test for face validity. Amendments were made in the light of their feedback. Explanatory text was included for parts B (prisoners' mental health) and C (service development priorities), to clarify the purpose of these sections. For example this text was used at the beginning of part C as an explanatory note:

> This part of the questionnaire is a '*once only*' judgement of the impact of prisoners' experiences upon their mental health. You are asked to tick how positively or negatively in your judgement a wide range of social and prison experiences would impact upon the prisoner's mental health using one of the 5 descriptors ranging from 'extremely positive' to 'extremely negative'. This data will allow a comparison to be made between respondents' judgements and data collected from the mental health needs assessment.

Part C (service development priorities) was shortened from 27 items to 10 by merging categories. For example: increased use of non-custodial alternatives to prison for non-serious offenders with mental health problems and diversion of more mentally disordered offenders away from prison to health and social care services before they arrive at prison, (which were used in the draft) were merged into alternatives to prison for mentally disordered offenders. These changes were undertaken firstly to keep the length of the questionnaire manageable for respondents and secondly, to clarify questions for respondents. Increased use of supportive text was made for the questions. For example, in relation to the question on diversion of mentally disordered offenders (just discussed), the following supportive text was included to clarify the meaning of the question:

> Increased use of diversion at point of arrest or before court, increased specialist psychiatric provision such as low/medium secure provision and non-custodial alternatives to prison.

8.6. DATA FROM HMP SWANSEA (2005)

These data were collected by the local health board principally to update previous HMP Swansea reports regarding prisoners' health status (Bowler et al. 2003b), to provide a basis for service commissioning and

service redesign and to work towards the strategic intent of achieving equitable service standards with the NHS (Swansea Local Health Board 2005). The author was not involved with the design or data collection of this component part of the study. It was incorporated within the overall study design in order to enable further description of relevant characteristics of prisoners. It provided a further opportunity (three years after the survey and focus groups which elicited much of the data reported on within this thesis) to broadly review data regarding the health and social status of prisoners at one of the studied prisons. The data was made available retrospectively (gifted in effect) to the author due to his continuing contact with both HMP Swansea and the Local Health Board, in order to further develop the thesis.

A snapshot survey was conducted on 23 July 2005 using the prison First Reception Health Screen (revised form F2169; HMPS 2004) to collect data from prisoners. The first reception screen reflects the state of the current health of prisoners arriving in prison and does not give a lifetime picture or a report of the prisoners at the time of the research. The first reception health screen does not specifically ask about blood-borne infectious diseases, heart disease or smoking. Information related to these variables was elicited by using the free text box that the reception screen has for other problems.

Table 10: HMP Swansea Prison Accommodation (Vidal-Alaball and Williams 2005)

	Capacity	Designation
Wing A	162	Remand or sentenced prisoners
Wing B	53	Resettlement placement for sentenced prisoners 6-8 weeks prior to release
Wing C	41	Segregated (Rule 45) vulnerable prisoners
Wing D	103	Voluntary testing drug-free wing for remand or sentenced prisoners
Wing F	58	Induction wing for remand or sentenced prisoners during first 7 days
Health Care Centre	8	Any prisoner

At the time of the 2005 survey, the accommodation at HMP Swansea (Table 10) comprised five residential wings and a health care centre with eight beds. Since the survey, the prison has moved towards a primary care model of health care delivered entirely on the wings and thereby decommissioning the health care beds.

8.7. BBC INTERNET DATA (2006)

In order to broaden the stakeholder approach to include a strand of public opinion, it was decided to collect data from a BBC online discussion site. This thread of comments related to a number of news stories which related to prison overcrowding and the place and role of prison within society. A constraint of this approach is that only one source of public opinion was tested, with the inherent danger that respondents to a BBC website may share common views, opinions and attitudes to prisoners. According

to Markham (2004) the Internet offers new possibilities for gathering information on values and attitudes thereby augmenting more traditional mediums of research. Furthermore the Internet also offers a naturalistic and safe environment within which views can be expressed. The Internet allows expression of 'ideas and values without censure' (Markham 2004 p.102). Researchers can therefore use the Internet as a way of 'studying how participants themselves constitute meaning in naturally occurring websites such as chat rooms' (Silverman 2004 p.4).

It was the abundance of publicly expressed views about prisoners on the Internet which suggested the inclusion of this data within the study, in order to exemplify commonly held attitudes towards prisoners. The use of this data alongside some more conventional statistical and qualitative data added a contemporary and highly illustrative element of discussion regarding prisoners' status in society, and the hostile dynamic which they face following release and provides context for the other data presented in the thesis. Following many stories in the news in recent years regarding prisoner numbers and associated issues relating to conditions (BBC News 2006c, BBC News 2006e), prisoners' rights (BBC News 2002), elderly prisoners (BBC News 2004a), the possibility of riots (BBC News, 1999, BBC News 2002a), overcrowding (BBC News 2002, BBC News 2004c, BBC News 2002a, BBC News 2005, BBC News 2005a), increased drug use in overcrowded prisons (BBC News 2004), suicide risk (BBC News 2004b, BBC News 2005a, BBC News 2005b) emergency measures to cope with a capacity population (BBC News 2006b, 2006d). October 2006 saw a new urgency to public concern as prisoner numbers approached 80,000 for the first time ever, and prisons simply ran out of places (BBC News 2006, BBC News 2006a, BBC News 2006c).

During October 2006, the BBC ran an online opinion forum for the public to contribute their emails to a debate as to how the prison crisis could be best resolved. This was linked to the online news story at the time of collecting the data. The data was harvested verbatim to contextualise the publicly perceived role, function and effect of contemporary imprisonment. Data was selected according to the extent to which it illustrated themes from the literature. The question which was asked by the BBC was 'What should be done to ease prison congestion?' The preface continued:

> Up to 500 places will be available in police cells by Thursday to help ease the shortage of prison space in England and Wales, John Reid has said. The Home Secretary announced several initiatives including an incentive scheme to persuade foreign prisoners to go home voluntarily. The prison population reached a record 79,843 at the weekend, and in theory there are just 125 more spaces left. What do you think of the new measures? Would you like to see more non-custodial sentences, or should we build more prisons? Do you have any experience of the prison system?
>
> BBC 2006

Users of the website were invited to respond to this set of questions. In addition, all of the comments received in response to an online BBC news story (BBC News 2006) covering a restorative justice project

to help prisoners face up to the consequences of their actions are presented. One of the participants within the scheme who had been bereaved through a murder commented:

> I wanted to know how murderers lived with what they had done. I asked them if they thought about it and they said 'all the time'. Then I asked them if they ever talked about it, they said 'never', seeing that people can change, giving them the opportunity to express remorse, has changed the way I think about what has happened to our family. The justice I was interested in was about healing and transforming a cycle of brutality into a place where people can meet as human beings, without the labels of victims and offenders.
>
> BBC News 2006

The story highlights the necessity of considering the wider situation of the offender, addressing such drug or mental health related needs as each individual presents with.

8.8. DATA REPORTING AND ANALYSIS

The descriptive qualitative and quantitative data from all of the data sets is presented in either Chapter 9 (results: pre-prison), or Chapter 10 (results: life in prison). Data which has been analysed using inferential methods, or deemed to be specific to the influencing factors within prison is presented in Chapter 11 (results: mental state in prison).

8.8.1. GHQ data analysis (2002)

From the total number of variables utilised within the questionnaire from the 2002 survey, discrete sets of variables relevant to: social exclusion, prisoner characteristics, offence, personality type, experience of regime and abuse variables were selected for inferential analysis against GHQ scores. These factors were identified on the basis that they most accurately represent and neatly constitute a profile of social exclusion and potential vulnerability factors with regard to mental state in prison, as identified by the literature. These variables were selected for testing against mental state scores as measured by the GHQ-12 tool. This test was to identify whether any of the selected variables appeared to correlate to caseness namely GHQ scores equal to or higher than three.

Mann-Whitney U test on SPSS

The Mann-Whitney U test is a non-parametric test for assessing whether two independent variables are significantly associated (Mann and Whitney 1947). It is often used within the social sciences with non-parametric data, that is data where the distribution curve is atypical (Sidney 1957). The Mann-Whitney U is the non-parametric equivalent of the ordinary parametric two sample t-test. In order to run the Mann-Whitney U test on SPSS, the total score for GHQ-12 was entered into the test variable list and each selected variable entered as the grouping variable. Groups were defined as 1 (positively experiencing the

defining variable) or 2 (not experiencing the defining variable) So for example, grouping variable '1' denoted prisoners *being* physically abused by other prisoners, whereas '2' denoted those *not* being physically abused by prisoners.

Missing data

Due to missing data, the number of prisoners within each Mann-Whitney tested grouping variable is lower than if a simple report is run against the grouping variable. For example, the number of prisoners simply reported as having committed a violent crime in Table 15 is 292, whereas in Table 32 where this grouping variable is tested for association with total GHQ-12 scores it is reported as 246. The discrepancy is accounted for by the number of prisoners who have self-reported having committed a violent crime but who have not completed the GHQ-12 questions on the survey.

Once SPSS has run the test it reports, indicating: the number of subjects who fall into the two defined populations, the mean rank score for each group, the z figure and the asymptotic two-tailed score. In addition, in the results section where these results are reported (Chapter 11), the tables include columns showing whether the grouping variable is associated with a higher or lower GHQ-12 score (the direction of influence), and a further column indicating whether the association is statistically significant for ease of reference. Variables were tested against the GHQ-12 scores using the Mann-Whitney U test due to the non-parametric nature of the GHQ-12 data.

Odds ratios

One of the difficulties with statistical tests of significance is understanding how the figure of significance relates to the studied population, in terms of prevalence or relative risk. For this reason an epidemiological test of association (odds ratios) was undertaken on variables displaying a statistically significant association with GHQ scores, following the Mann-Whitney U test. All variables showing statistically significant scores ($P = 0.05$) were further tested to calculate odds ratios against caseness (GHQ-12 scores ≥ 3). Odds ratios were calculated as for a case-control study:

> the odds ratio, can be obtained from either a cohort or a case-control study...In both types of studies (cohort and case-control studies), the odds ratio is an excellent measure of whether a certain exposure is associated with a specific disease.
>
> Gordis 2004 p.183

The odds ratio calculation gives a relatively straightforward and simple representation as to how significantly a variable is associated with caseness. If the odds ratio is greater than one, the variable indicates an association with caseness. If the odds ratio is less than one, the variable is displaying a protective effect.

Table 11: Method for Calculating Odds Ratio in a Case-Control Study

	Cases (with caseness)	**Controls (without caseness)**
History of exposure	a	b
No history of exposure	c	d

The odds ratio (Table 11) in a case-control study is expressed as a mathematical formula (a/c)/(b/d) = ad/bc (odds ratio). The inferential (Mann-Whitney) and epidemiological data (odds ratios) are reported in Chapter 11.

8.8.2. Focus group data (2002)

Data from the focus groups was transcribed by a number of staff involved within the mental health needs assessment, then coded and stored by the researcher in an Endnote library under these thematic headings:

- alternatives to prison
- receiving bad news
- behaviour
- Criminal Justice System/Remand
- concern
- cooperation
- counselling
- courses and constructive regime
- detoxification
- experience of staff
- first time in prison
- future problems
- interconnected problems
- knowing patients
- liaison with community agencies
- life in juvenile unit
- MHA 1983

- personal officer and good support
- police
- prevalence
- prisoners criminal lifestyle
- prisoners drug use
- prisoners feeling now
- prisoners getting into trouble
- prisoners life before prison
- prisoners medical and general grievances
- prisoners problems
- prisoners reformed/effect of prison
- prisoners resettlement
- prisoners supportive
- prisoners suspicion
- prisoners work/earning
- process and information
- psychiatry
- psychosis
- refusal to associate
- relapsing into drug use following release
- requirements
- self-harm.
- sex offenders
- shouldn't be in prison
- transfer to hospital
- vulnerability and association (socialization)

These headings were then merged into the broader headings used to present the data in Chapters 9, 10 and 11. Some data themes were reduced as they did not reflect the emerging thesis focus (such as those relating to the mental health act, or transfer to hospital), whilst others (relating to prisoner-prisoner support and association) are presented more fully. Data were modified and anonymised with due regard to protecting the confidentiality of prisoners and staff. All names and other potential identifiers such as place names (with the exception of prisons), or familial relationships have been changed. This anonymising process felt challenging; trying to protect identity, whilst presenting honest accounts of experiences gained in various prison establishments. In identifying themes within the overall cohort of participating prisoners, no distinction has been made as to which prison they are serving their sentence

in, but rather in identifying themes across the whole cohort. Professional status is denoted within the text obtained from staff, using the following abbreviations:

RGN - Registered General Nurse
RN(M) - Registered Mental Nurse
Dr - Doctor
Officer - Prison Healthcare Officer

As much of the focus group data is presented as possible to avoid the accusation of cherry-picking. However the data were further appraised and reduced following the identification of the emerging themes, examination of the thesis and in order to make the word count manageable. The final inclusion of the data was made upon the basis that it reflected and summarised the original themes (above) and the emergent themes (socialization, stigma, identity, vulnerability and power). This is best illustrated within the discussion in Chapter 12 where the data is integrated within thematic discussion. The process was funnel-like, with coding arising from immersion in the data, codes were then reported under broader headings and these were then refined according to relevance to emerging themes. This was an iterative process which was complicated by and interweaved with consideration of the statistical findings. Towards the final analysis of the focus group data, pending inclusion within the thesis, the approach was increasingly informed by Braun and Clarke (2006), although no claim is made to have replicated their approach.

Results chapter themes

Data from the focus groups are presented within the chapter which best reflects the topical focus, for example issues concerning drug use in the community, employment and life before prison are reported in Chapter 9 (results: life outside). Issues around most of the experiences of and in prison are presented in Chapter 10 (results: life inside). Data concerning mental state and socialization within prison as it might impact upon prisoners is reported in Chapter 11 (results: mental state in prison).

Difficulties of transcript analysis and presentation of data

The transcripts contained some partial text where speech had been inaudible or incoherent. This particularly applied to the prisoner focus groups, which were often characterised by rapid interaction between prisoners, reference being made to a shared experience and so on, all of which is difficult to capture within text. Furthermore the text sometimes appeared nonsensical due to difficulties of transcribing the vernacular, or a number of prisoners speaking at the same time. It appears very difficult to capture in a typed format the complete meaning of speech. Consequently the text required a considerable amount of remedial work to complete fragmented sentences or to enhance disjointed narrative structure. The professional groups by contrast, were characterised by a greater acceptance of

the conventions of formal interview situations, and generally were more orderly, structured, logical and sequential in their discourse.

Working with fragmented text

Similarly there was often a difficulty that a sample of text appeared meaningless in its immediate situation. Very often text was badly fragmented and samples of text would compete with other samples in a seemingly random fashion. This seemed to happen when there was a lot going on within a discussion, where lots of ideas were being generated but none perhaps followed through in a logical and sequential manner. This resulted in a disjointed and fragmented text. In order to overcome these problems, the device of putting additional text or contextual information italicised into bracketed parenthesis has been used. This cannot be an entirely satisfactory substitute for clear sequential and logically developed narrative, as it places an onus upon the researcher to interpret what was being said. This interpretation rests solely with the author, and whilst an honest attempt has been made to present the amended text within the original context and illustrating the original meaning, it cannot be certain that this has always been achieved.

Further remedial work with text

The textual difficulties also presented within two further issues of textual analysis and presentation. The first of these is the punctuation of text. Much of the narrative was extremely quickly spoken, almost as a stream of consciousness, in the vernacular and using a lot of slang often specific to prison. It was necessary to punctuate and edit this text in order to present it within a written medium. Individual mannerisms such as 'um' 'yeah' 'like' 'innit' or 'er' were sometimes edited out. Similarly where text rambled and meandered between one subject and another, editing was undertaken using the '...' convention, to denote missing text, or in order to join subject themes within the narrative. This process of punctuating and editing also formalises meaning and casts the text within a formal and conventional linguistic form, often missing from the original narrative. In fact, this formalising process underlay much of the remedial work undertaken on the text, and within the task of making the text legible and coherent for presentation.

Formalising the text

The formalising task contains a particular tension in both trying to preserve the authenticity of the original spoken medium, and crystallizing meaning in order to present the narrative within the text. This difficulty also applied to the coding exercise. Isolating narrative text and organising it under thematic headings of interest, again appears to give an organisation and structure to the narrative, whereas the original was often of a free-form, wide-ranging and unstructured nature. In formalising the text for presentation, some of the original richness and meaning of the text may have been changed or lost. Nuances of prison slang in particular are difficult to capture, contextualise and accurately present. For example the use of terms

such as 'going behind the doors' or 'going under the blankets', have a particular meaning concerning the behaviour of individual prisoners withdrawing completely from the normal regime and social interaction expected within prisons. Such phrases have huge significance within the prison environment, but are difficult for those of us outside the prison environment to appreciate. In fact prison culture is replete with phrases of this type which are laden in context specific meaning. Such phrases are difficult for researchers to detect, capture, understand and present. The justification for undertaking the remedial and formalising work is that it allowed much text to be presented, which would otherwise have been so fragmented or disjointed or lacking in context as to appear meaningless.

Reflection upon focus groups

A reflection upon the experience of working with the focus groups evokes recollection of groups of prisoners who were happy to join in the discussion and share their experiences and perceptions of their outside and prison life. There were occasional queries as to the confidentiality of the data in so far as establishing whether the officers would have access to the information. But such reservations were surprisingly few. Prisoners were more often frank and open about their experiences, thoughts and opinions.

Motivation for participating in the groups was possibly heightened by the incentives of:

i) A change within the usual routine (and often boredom) of the prison day
ii) The opportunity to meet some different people from outside
ii) The opportunity to talk about their experiences
iii) The opportunity to spend more time out of their cells
iv) The opportunity to spend some time in an environment away from custody staff

8.8.3 Data from staff survey (2004)

This descriptive data was all in the form of Likert-type scales. The data was collated on to an Excel spreadsheet. The results are reported in Chapter 11.

8.8.4 Data from HMP Swansea (2005)

The descriptive data collected from the survey of the First Reception Health Screen was collated and stored on an Excel spreadsheet. These results are all presented alongside other prison specific data and reported in Chapter 10.

8.8.5 Presentation of BBC Internet data (2006)

All of the contributions from the online forum were pasted on to a hard copy, read and analysed for content; sympathetic or antagonistic towards prisoners' problems. These were then themed according to content around the themes: prison doesn't work, drug rehabilitation, education, mental health problems, multiple problems, treatment, prison can be beneficial, restorative justice and community orders. The results are all presented as part of the attitudinal and social environment faced by prisoners and reported in Chapter 9.

8.9. ISSUES OF RIGOUR

The use of multi-methods (questionnaires, focus groups, Internet data) in this study allowed different types of data to be collected, thereby allowing differing perspectives upon related issues concerning mental state in prison. The validity of research data rests upon whether the data reflects truth, is reliable and adequately covers the research topic (Denscombe 2007). The reliability of the 2002 questionnaire is only claimed with regards to some degree of face validity arising through feedback from preliminary meetings with the prison staff and the response from prisoners who generally found it comprehendible. However, the GHQ-12 component of that tool is well established as a valid and reliable measure of mental state (Goldberg 1992). The author was involved in all of the focus groups and followed a schedule of questions (Table 9), although the schedule was only loosely adhered to in preference to giving prisoners a more naturalistic opportunity to vent their thoughts and feelings. The HMP Swansea data (2005) was collected using the prison First Reception Health Screen (revised form F2169; HMPS 2004) as a template. This method of data collection owes more to an audit type approach than research per se. The questionnaire and Likert-type scale of the staff survey was devised by the researcher and consulted upon before use. The BBC data was simply collected and presented verbatim and little claim can be made as to the rigour of this element of data.

8.10. THEMATIC ORGANISATION OF DATA

The combined data needed organising within the results chapters in a manner which supported the aims and objectives of the study. For this reason it was decided to present the data within the thematic constructs used to organise the literature review chapters. These themes were life on the 'out' (Chapter 9), life on the 'in' (Chapter 10) and 'my head's gone!' (Chapter 11). There is one results chapter for each of these themes, combining data from the various datasets. The first two results chapters, Chapter 9 and Chapter 10, present descriptive data, whilst Chapter 11 presents inferential data and qualitative data which develops a formulation as to which are the mediating factors influencing prison mental state.

8.11. SUMMARY

This chapter identified how the multiple methods of data collection and data analysis were undertaken. Issues relating to ethical considerations and rigour were also presented. The methods reflect a diverse approach to triangulating viewpoints upon the research question. The range of data collection processes was outlined. The means by which inferential testing was carried out was described, as was the method for analysis and presentation of the qualitative data. Presentation of the qualitative data involved considerable remedial work in order to present the data within conventional linguistic format, and this approach is discussed. The next chapter presents findings relating to life on the 'out'.

CHAPTER 9

RESULTS (i)

LIFE ON THE 'OUT': LIFE BEFORE AND AFTER PRISON

9. RESULTS (i) LIFE ON THE 'OUT'

9.1. INTRODUCTION

This chapter presents findings from analysis of a number of the datasets, relevant to life before and after prison. The findings link to Chapter 2 of the literature review (Life on the 'Out') and the summary at 6.2, which relates the life on the 'out' theme to the prison mental state question. Themed data is presented from the 2006 BBC Internet source, the 2002 survey and focus groups at HMP & YOI Parc and HMP Swansea. The data spans health status, social status, experiential and attitudinal domains. The latter part of the chapter briefly discusses the results presented. Further inferential analysis of component factors within the life on the 'out' theme is found in Chapter 11.

9.2. RATIONALE

The findings in this chapter are organised around the theme of life on the 'out'. This phrase is used within the prison vernacular to refer to life outside prison. The phrase has the effect of locating the pre and post-prison experience as separate, and apart from, life inside prison. This dichotomous polarisation of prison and outside prison life, whilst perhaps not acknowledging the invisible psychosocial links that draw the two worlds together, does reflect the immediate reality of the prison experience and the extent to which imprisonment, by default, then defines life on the 'out'. The data begins to link to and illustrate many of the themes from the literature review presented in Chapter 2, such as the discontinuity, dysfunction and distress involved in the societal circumstances of prisoners. A picture of the multiple and interconnected nature of problems faced by prisoners emerges. The qualitative data gives an insight into how these problems operate within the life story of the individual prisoner and how they impact upon offending and mental state. Some issues arising from the role of community agencies are also presented through the data.

9.3. DATA SOURCES

The findings presented in this chapter link to data both from outside and within prison. Two sources of BBC data were utilised followed by the 2002 survey and focus group data from HMP & YOI Parc and HMP Swansea. The BBC data is presented verbatim, inclusive of spelling and grammatical errors and consisted of two different collections of responses:

- The first was a BBC discussion board which received general comments in relation to a series of news stories that the BBC ran during 2006 in response to the increasing numbers of prisoners and the ensuing pressures upon the prison system.

- The second set of comments, also collated by the BBC in 2006, were more specialised and were drawn together on a separate site, and related to a specific project which aims to directly engage perpetrators and victims within what is referred to as a restorative justice model. The restorative justice idea being that direct engagement with victims of crime enables the offender to see the direct effects which their offending has had upon the victim, and challenges them to accept responsibility for their actions.

Data are then presented from the:

- 2002 survey at HMP & YOI Parc and HMP Swansea, followed by
- 2002 focus group data from prisoners at the two prisons

9.4. BBC DATA AND PUBLIC ATTITUDES TOWARDS PRISONERS

This first set of BBC data related to the more general discussion about the role of prison in society. 327 comments were posted. These comments tended to relate to issues around whether prison works, the deterrent effect of prison, prison as punishment and alternatives to prison. Comments have been selected upon the basis that they contributed towards themes within the study such as education, drug use, mental health problems and resettlement. To this extent the comments reproduced are not wholly representative of the contributions overall. These tended to be more retributive and are represented at 9.4.6 (Prison works). The range of comments was selected as fitting within the general topics covered throughout the thesis.

9.4.1. Reoffending

The first comment notes the paradox of the current system, namely that the majority of prisoners reoffend within two years of release from prison. The comments draw out the essential question relating to the purpose of imprisonment:

> So, there are stacks of comments here (*on the BBC website*) saying that we should have more prisons and there are equally as many saying that offending is habitual, so I conclude prison doesn't stop people offending. We have to understand what we're trying to do; lock 'em up or rehabilitate them? One sure thing though - if we do what we've always done, we'll get what we always got. So, how many prisons do we need, and who's back yard are they going in by the way?

The next comment captured something of the consensual view that the deterrent value of prison needed to be strengthened, whilst focussing also upon the rehabilitative nature of prison:

> For violent crime prison is firstly a deterrent, murderers need to know they will be locked up for life to deter them. If someone is convicted this has obviously failed. The aim at this point, for those who will be released, should be to stop them offending when they are released.

9.4.2. Drug rehabilitation

In this comment there is recognition of the extent to which drug use and crime are closely associated, and the role of current drug policy in criminalising many who end up contributing towards prison overcrowding:

> If we were to decriminalise or legalise drugs, we'd have a more fair drug policy and less people would need to be housed in over-crowded prisons.

Relatively few comments referred to drug use or the offending nexus:

> Prison doesn't work... The majority of prisoners have social or drug / alcohol abuse problems. If we can't solve these problems and make them our priority then crimes will continue to be committed.

9.4.3. Education

More commentators recognised and commented upon the rehabilitative role that education can play in rehabilitating prisoners:

> Inmates should be kept in one place and be given access to proper drug treatment and education so that when they are released they'll have a chance to become decent members of society. Otherwise they will end up back inside.

The majority of comments demonised prisoners as a 'them' to be locked away; only a few commentators located the issues such as illiteracy and drug use which plagues the prison population.

> Given the low levels of literacy and high levels of drug addiction among prisoners it would seem to me that we need more focussed education programmes to help with literacy and numeracy, more schemes to deal with drug dependency so that people are much less likely to be before the courts in the first place.

This commentator also goes some way towards recognising the multiplicity and interconnectedness of the problems facing many offenders:

> Until we have a system in place where we educate offenders & therefore enable them to address the issues of employment & housing on release, recidivism will continue to rise.

9.4.4. Prisoners' mental health problems

This commentator advocated more appropriate care for the mentally disordered languishing in prison, but with mental hospital beds at such a premium, the appropriate and safe accommodation, alluded to might be difficult to achieve, particularly when mixed with the requisite level of security:

> If you took ALL those with Mental Health problems OUT of the prison system and placed them in appropriate safe accommodation, that would release the places for the serious offenders and give those with Mental Health problems a better chance to recover.

Failure of the long-standing community care policy is identified as a major factor in mentally disordered persons being in prison:

> The large numbers of mentally-ill people in prison is because the 'care-in-the-community' system does not work, they should be in secure mental institutions.

9.4.5. Multiple problems

A number of contributors did recognise the multiple needs which many prisoners present with and the extent to which these are implicated within offending behaviour. The next comment highlights issues around illiteracy and mental health problems:

> 80% of prisoners have writing skills below that of an 11 year old. If we afforded everyone an equal education rather than the current 'postcode lottery' and private schools which mean the poorest suffer we would have less people who see crime as the only option. 66% of prisoners have mental health problems; if people with mental health problems received appropriate treatment their predilection to commit crime would be less. Prison population overflowing and people still argue 'prison works'?

Assessment of need is a cornerstone of penal practice, in order that sentence plans reflect the needs of prisoners. Constraints arise from the overcrowding and institutionalised approaches to remand and short sentence prisoners in particular. Better assessment of need was advocated by this contributor:

> Stop the one size fits all approach...Drug dependency? Secure rehab unit...Mental Health problems? Secure hospital and not released until improvement is shown with follow up appointments to maintain drug regimens...No qualifications? Vocational educational unit...Non-violent offence? USEFUL community work with secure accommodation...From a country with robust, humane jails? Deported before sentence, not after A bit of time spent assessing the offender's needs will actually better fulfil society's [needs].

9.4.6 Prison works

The majority of comments on the forum were retributive and penalising in nature. The next set of comments move closer to these views and focus upon the legitimacy of, and the requirement for, more punitive measures to act both as punishment and deterrent:

> It is an idealistic liberal belief that prison is all about 'meaningful rehabilitation', that is essentially the reason prison isn't working and crime is increasing, hence the overcrowded gaols. Prison

should be about punishment and should act primarily as a deterrent. Until the ruling liberal elite change their mindset we are going to see increased crime rates in Britain. The people know what's best but the politicians, as always, think they know better.

More hard time was advocated by a number of commentators:

> As an ex-copper and I've seen inside a lot of prisons and I know a lot of criminals. When one is sentenced to prison, one should lose ALL rights. No tv, pool tables, gym, no basket weaving lessons...nothing. Basic food and the bare essentials. Prison should so horrendous that no-one should want to return. A lot of the people I arrested just shrugged their shoulders and said, 'I can do it standing on my head. I can get a bit of dope inside too. (cannabis) It's cushy inside'.

9.4.7. Community orders

A number of comments led to calls for an increase in community orders, some ideological, others more pragmatic, including these three comments focussing on the waste of tax payers money:

> I would not mind if prisons were really for dangerous criminals, however incarcerating a person for non-payment of tax or fines or minor offences is a ridiculous waste of tax payers money.
>
> Jailing is most of the time wasteful. A visible community service especially in the community where the guilty lives will be very appropriate.

This posting challenged both the legitimacy and effectiveness of community orders:

> As a Probation Officer in Manchester I do not believe offender's should be kept out of jail. The Probation Service is struggling massively with the number of Community Sentences it has to supervise. Staff stress levels are incredibly high due to the sheer amount of offender's we have to supervise. The result is that offender's do not get enough 1-2-1 contact with their Probation Officer to complete any decent rehabilitative work and levels of reoffending are very rarely reduced.

9.4.8. Summary of message board narrative

The weight of comments appeared to consider prisoners as other, outside of the normal run of society. These comments are summarised in the section prison works (9.4.6). However this was not always so, with some commentators recognising the damage which occurred within traumatic childhoods or the ways in which drug dependency combined with other problems to make offending more likely.

9.5. BBC DATA CONCERNING THE RESTORATIVE JUSTICE PROJECT

The following data was drawn from the discussion about the restorative justice project. It is likely that this more specialised discussion drew comments from individuals with direct involvement or knowledge of the nature of restorative justice. All but one of the comments received in response to this project were positive about the potentials for rehabilitation and healing which may arise from the restorative model.

The first comment reflects upon a life changing experience and projects the nature of that therapeutic experience on to the restorative justice model:

> I live by the philosophies outlined. My understanding of consequence came after an emotional event. It's true, you have to understand consequence to move on and successfully navigate your way in the world. Understanding consequence opens the windows on life. There is so much to gain if you decide to look. Consequence should be introduced to us all.

Difficulties in integrating restorative justice schemes within current government policy were noted by the following comments:

> An admirable project. However with the government proposing to stop prison terms for such offenders as burglars, how will they be reached?

> It is a very admirable idea, and would no doubt have some effect on people already detained. However isn't it a case of closing the gate after the horse has bolted?

Proposed efficacy of restorative justice

Criticisms of restorative justice can highlight the potential for offenders not to engage fully with the facing up and curative elements of the programme, but rather to go through the motions. The following comment highlighted the reduction in reoffending claimed by restorative justice projects as evidence that such going through the motions is more myth than reality:

> Good stuff. There have been gestures towards restorative schemes before, generally successful. What's needed is for the Government to turn these ideas from pilots into policy - and sell them to a sceptical public. The reduction in reoffending rates is a powerful practical argument against those who dismiss this as a 'soft touch'.

Themes of wider social responsibility emanate from rehabilitative justice, and require a wider citizenship to understand and be empathic towards the principles of restorative justice. The following comment proposes awareness raising in schools as one way in which this might be achieved:

> It is brilliant to see some Light coming in. The power of Care is so healing. It would be good for documentary programs about this to be shown in schools. Children learning how we have to take responsibility for our actions on such intimate personal levels, may actually impress on them that a life of crime is not worth it.

Not all commentators felt that restorative justice was a realistic option within the real world scenario of prisons where a strong offending culture exists amongst prisoners, as this comment noted:

> Schemes like this will not work in prisons unless the prisoners are given private consorts with victims and counsellors because of the sheer amount of peer pressure within the prison walls; from other inmates and guards.

9.5.1. Summary of restorative justice narrative

The contributions to this message board had a very different feel compared to the general discussion board reported in this chapter. The restorative justice comments appeared far more considered and often emanated from some direct experience of working with offenders or experiencing the effect of crime first-hand. Most commentators were positive about the humanising effect of restorative schemes.

9.6. HMP & YOI PARC AND HMP SWANSEA (2002)

The survey at HMP & YOI Parc and HMP Swansea elicited a considerable amount of data pertaining to social circumstances and offence, and this data is presented in Tables 11, 12, 13 and 14. The mental health needs data collection at HMP & YOI Parc and HMP Swansea in 2002 was predicated upon eliciting a psychosocial perspective. There were 861 respondents.

Table 12: Social Characteristics and Exclusion Variables (2002)

	n	%
Previous sentence	429	50
Unemployed	322	37
History of drug use	614	71
Relationship problems	284	33
No GP	175	20
Ever been in care	216	25
Learning difficulties in school	215	25
Leaving school <16	428	50
Homeless	39	5
Long-term sickness	139	16
Ever detained under the Mental Health Act	27	3

Table 12 shows that one in two prisoners had served a previous sentence, whilst nearly three in four reported a history of drug use. It is likely that this is an under-estimation as some prisoners were reluctant to disclose what they considered to be prejudicial and which might count against them. A third of prisoners reported relationship problems, one fifth were not registered with a GP, one quarter reported having been in care, whilst the same number reported having had learning difficulties in school. Half of the prisoners had left school prior to the age of sixteen, 16 per cent of prisoners reported long-term

sickness, whilst 5 per cent reported being homeless and 3 per cent reported having previously been detained under mental health legislation.

Table 13: Ethnicity (2002)

	n	%
Bangladeshi	3	>1
Black African	3	>1
Black Caribbean	9	1
Black other	7	1
Indian	1	>1
Pakistani	4	1
White	776	90
Other	41	5
Missing	17	2
	861	100

Table 13 shows an overwhelmingly white population with the largest Black Minority Ethnic (BME) grouping being Black Caribbean. This reflects the ethnic mix of the populations served by the prisons, with South and South West Wales having relatively small BME populations when compared to major urban areas in other parts of the UK. Prison is difficult for individuals from BME backgrounds if there are limited opportunities for association, provision of multilingual information, religious expression or dietary requirement. Racism has also been a problem at one of the prisons (BBC News 1999), with anti-English sentiment also figuring.

Table 14: Age Bands of Prisoners (2002)

	n	%
Juveniles	14	2
YO's	267	31
Adults 21 - 25	223	26
Adults 26 - 30	119	14
Adults 31 - 40	156	18
Adults 41 - 60	54	6
Adults 61+	9	1
Missing	19	2
	861	100

Table 14 shows a predominantly youthful population, with 623 (72%) aged 30 years or under and 504 (59%) under the age of 26. This picture is consistent with the literatures' portrayal of the prison population reflecting a youthful age profile. It also has to be taken into account that South Wales is a net-exporter of young offenders with many going to Ashfield YOI in Gloucestershire or sometimes further afield to Portland YOI in Dorset or the West Midland YOIs at Swinfen Hall, Lichfield, Stoke Heath, Shropshire, Brinsford, Wolverhampton or wherever suitable places are available.

Table 15: Offences (2002)

	n	%
Violence	292	34
Burglary and Theft	267	31
Drugs	210	24
Motoring Offence	176	20
Other	132	15
Vehicle Theft	122	14
Sexual Offence	51	6
Murder or Attempted	37	4
Non-payment of Fines	34	4
Arson	28	3

Prisoners were asked to identify the type of offence they are currently imprisoned for. Many prisoners had been imprisoned for several offences and consequently appear more than once within the offence categories. This is an important point when the GHQ-12 data is analysed by offence type as the categories are not exclusive or discrete. Table 15 shows the descending order of frequency for each offence group, with the highest number of sentenced offences being related to violent crimes (29%). Acquisitive crimes (burglary and theft) often implicated in funding drug habits, also featured prominently, accounting for nearly one in three sentences (31%), whilst nearly one in four sentences was related to a drug offence (24%).

9.7. FOCUS GROUP DATA AT HMP & YOI PARC AND HMP SWANSEA (2002)

The qualitative data were categorised and organised thematically and are presented under the same thematic headings. The thematic sections are summarised and briefly discussed following the presentation of each data theme. Life before prison, or to use the thematic construct of this chapter, life on the 'out', did not feature as much within the focus group discussion as might have been expected. It

was almost as though it was easier to focus upon the here and now, rather than the life which had been left behind outside the prison walls. Amongst those who spoke of life outside a sense of loss was only sometimes apparent. The sense of belonging and communal identity which many prisoners derived from prison was palpable and is more evident in the data presented in Chapter 11.

9.7.1. Circumstances

The nexus of problems identified in the literature review, was evident in these mental health nurses' analyses:

> [RN(M)] a lot of crimes are generated by drugs, alcohol and the lack of finances and therefore they turn to crime and you have this sort of cycle really and it's hard to get out of.

> [RN(M)] [It is] very common for them [prisoners] to have...drug use, psychological problems, emotional problems, family problems, depression, adjustment difficulties, the whole range of mental health illnesses like schizophrenia, depression.

The social context and peer pressure attached to both offending and drug use emerged from some prisoner narratives:

> You just want to keep up with them... All different things 'init, like some people are stealing, some people taking drugs

Circumstances summary

The nexus of interrelated social exclusion and especially mental health and substance misuse problems allied to criminal behaviour so evident within the literature review, emerged particularly in the narrative provided by the mental health nurses. These themes also appeared within the prisoner narrative. Within the focus groups, everyone had a story to tell. There were almost as many reasons for being in prison as there were prisoners to tell their story, although there did seem to be common elements such as drugs, fighting and dodgy deals in many accounts. One officer remarked ironically:

> [officer] the prison is full, but you'll be lucky to find anyone who is guilty!

9.7.2. Coming in to prison

Some prisoners alluded to the instability and deleterious effect of serial drug use and offending behaviours before prison. In describing their mental state at these times, and more generally, some phrases were commonly used such as 'my head's gone', 'my head went' or just 'gone' as in the excerpt below, where a prisoner was relating how they felt prior to coming in to prison:

> 'Gone' to tell you the truth, feeling ill all the time.

Some prisoners acknowledged the extent to which their lives were chaotic often due to a combination of offending, drugs and the psychological effects of an unsettled, unstable lifestyle:

> I wasn't stable because you know it's a game that you play, I mean, most of us here are hyper-active [stealing, robbing etc].
>
> Well I was addicted to heroin it was so hard for me like. It's the place I come from.

Mental health problems or just feeling low were implicated:

> I was suffering from panic attacks...For me it was just a problem that had gone wrong like, do you know what I mean?
>
> Well I think everybody has at some point. Most people have a point where they go up and down in their lives where they've got some problems that make them feel down.

Coming in to prison summary

Feeling low was a common experience which seemed enmeshed within drug taking and offending, there was a strong sense that many prisoners felt that they lacked control over their lives. Many of the pre-prison lifestyles and backgrounds which were described sounded extremely chaotic. When combined with offending, prison became the almost inevitable destination given what was occurring for these individuals. Some prisoners related how prison could be beneficial for them, in giving them an ordered lifestyle. For these prisoners prison gave security, square meals, opportunities to use the gym or take courses and generally a chance to build physical and psychological health and strength prior to being released. The orderly, regular life of prison appeared in stark contrast to many prisoners' existence outside prison.

9.7.3. Interconnectedness of problems

There seemed to be an interconnectedness between prisoners' financial and drug problems:

> [I felt] low sometimes, when you run out of money and everything is going west and you've sold half the house, the dog...sold the dog for half a crown...you've got to... take drugs

The interconnectedness of prisoners' problems was reflected in an account from a mental health nurse at HMP Swansea who also identified the manner in which these problems presented within prison. This sometimes presented as the dual diagnosis of serious mental illness compounded by use of illicit drugs:

> [RN(M)] off the top of my head I'd say, 70 per cent plus [are using drugs]. Add in to that the sort of self-medicating people who have other issues. Quite often we see people coming in on regular depot [antipsychotic medication], they're also 'using'... it projects as a self-medication issue, yeah, we get quite a few people like that.

Interconnectedness of problems summary

There was a sense in which problems often seemed to multiply and crowd the individual before prison and overcame their capacities for problem-solving. Prisoners related that drugs or alcohol were their primary means of coping, which frequently exacerbated their situation. As well as more general social and lifestyle issues often related to the nexus of offending, social exclusion and drug use, some individuals had problems which were unique to their circumstances, and these prisoners posed significant management problems to a prison service which appears poorly equipped to deal with individuals in a person centred way.

9.7.4. Work

Work or the lack of it, featured heavily within the prison narrative:

> I've been on the dole for...well since I was 17, that's 5 years...[when I] get out [I will] try and get myself a job.

Prison was not felt to be a good preparation for finding work:

> prison doesn't seem to prepare you for working does it? It doesn't give you a skill.

Furthermore the stigmatising effect of a prison record was likely to count heavily against an individual:

> I have got... [a skill]...painting and decorating... it's just getting a job it is isn't it? Who is going to take me on with a criminal record like mine? It's very hard.

This individual prisoner noted the therapeutic effect of being employed and the likely beneficial effect that work would have on the overall lifestyle and well-being of the individual:

> You know if you got a lot of people [prisoners] who are using a lot of drugs, and they go out and they got a chance of a job...there's less chance they can use drugs for a start because they are working through the day, and they got to realise they can't do the job if they are drugged up anyway.

Work summary

The availability of work featured heavily within the prisoner focus groups. Work which provided good money was recognised as being a prerequisite for many prisoners to avoid a continuation of criminal activity. Many prisoners had no, or very low levels of educational attainment and poor work histories often without any formal training or skill. This theme linked very closely to the money theme which follows.

9.7.5. Money

There was a lot of discussion in one focus group as to the likelihood or not of being able to earn as much money through legitimate work, as through criminal activity, often involving drug dealing:

> I think for some people it's hard. Once you have, not so much an easy life but a good life of robbing and having loads of free time and money in your pocket. To suddenly change and work all day and have someone else saying 'do this'.
>
> [because I have a trade...] I can earn £300 a week...Whereas other people ...these guys here. They can go out and do that in one night. They enjoy the high life... that's not bad money is it?

This prisoner could see his future going one of two ways, depending on his ability to make some money; staying out of trouble if he could get work, but falling back into offending ways if he couldn't:

> Yeah it's all about money anyway isn't it? It's all about money. You have to have money to survive. But when I get out if I have a chance. If I can go back into you know back on the site, I will, I'll do that you know and things will calm down in other areas. But if not I will just be doing what I was doing before [criminal offences].

Money summary

Combined with poor work prospects, the lack of money seemed to drive many individuals into criminal activity, with drug dealing featuring prominently. Prison also brought some individuals into contact with others, who had taught them new criminal activities.

9.7.6. Drug use

Many of the prisoners were happy to talk about their drug use, reporting long-standing drug habits and identifying drug use as being implicated within their offending behaviour and its impact upon overall lifestyle:

> It started a long time ago, I used to smoke [hash] for years, then I tried other things ...drugs... and it became a habit - and that's why I'm here today.
>
> you're either right on your feet or right on your arse with drugs. It's good when it's all going good, crap when it's all going bad like.

Other prisoners noted the beneficial social standing which accrued from selling drugs:

> When you're selling it you're well popular aren't you ...when you've got everything. When you've got nothing you just gets bored.

Some prisoners were open about their drug usage and felt that it was not problematic for them:

> As long as I stay off the smack... I don't want to stay off anything else....I like my 'stuff' [drugs].

Drug use summary

Drug use amongst prisoners before, during and after prison was a common, even prolific, theme. Drug use was clearly culturally mainstream within this population and drug use was widely discussed amongst adult, young and juvenile offenders. Many prisoners were very open to the nature, extent and

consequences of their drug use and whilst many recognised the criminogenic nature of illicit drug use, others did not think it harmed anyone and wished to continue using. As well as featuring in the linked themes such as detoxification, and prevalence of mental health problems, drug use also featured in many of the other focus group themes such as money, and getting into trouble.

9.7.7. Getting into trouble

There was a strong sense from many of the prisoners that they were following a well trodden path of criminal activity, such that it was a way of life:

> [I was]...pinching cars when I was a kid...I couldn't get the knack of it. It wasn't for me and I just started doing a bit of street robberies ...And got five years for it. During that five years I thought 'five years for this!'

Other accounts of getting into trouble were set in more routine settings, such as going out to the pub, as this account shows:

> Anyone can get in a fight and end up in jail.

Feelings of regret, mixed with perceptions of bad luck were part of many of the stories which came out in the focus groups:

> been self employed I've had two mortgages...lost them all coming in here like...and I just feel... [I've lost]...two wives, fucking hell! [and] a few dogs!

Drug use was central to many accounts of getting into trouble:

> I was selling drugs as well; it's just the drugs that lead you into crime...If I had enough money I wouldn't have to.

<u>Getting into trouble summary</u>

There were almost as many reasons for being in prison as there were individuals willing to share their stories. Some were unlucky to get into a fight, others recognised that if you commit enough offences, sooner or later your would end up in front of the courts and in prison. Drugs, alcohol and fighting featured regularly in accounts provided by prisoners. Prison did not seem to serve as much of a deterrent to many of the prisoners, although they did talk about the disastrous effect it had, particularly upon relationships.

9.7.8. Rehabilitation

This individual enjoyed his previous fast lifestyle but was now having second thoughts:

> If I had just got a two or maybe three year sentence, I could be out on the street active [thieving] on the first day...because I would have tried to capture the lifestyle that I had before. I had a

'fast' life style and was 'fast' you know...Cocaine and cars ...when I get out this time, I'm going to be on top of the situation, I ...had to re-mortgage the house three times...I'm not interested in fast cars now...I would never get as bad as I was.

Trying to change

This prisoner was commenting upon how he had tried to change things following his last prison sentence:

> I didn't associate with so many people that I would have before I went to jail, because my views have changed towards them.

This individual had recognised how drug use was central to his problems:

> just got to change I have, haven't I? Can't keep taking drugs much longer because it doesn't get me nowhere.

Help in changing

The motivation of staff to help rehabilitate was articulated by this officer who worked with juveniles at HMP &YOI Parc:

> [Officer] If I can stop one offender from reoffending, I feel pleased with myself.

The potential for prison to have a beneficial or negative effect was captured by this individual:

> Prison can make you or break you.

This prisoner noted how prison could be a life changing experience:

> When I got out I was a youngster when I got out first time. Second time I got out the time in jail had changed me a lot.

Suicide is a problem upon release. Accesssing community services were implicated in this account:

> [Officer] my personal experience is there's a lot of bullshit, people say there's every facility for people when they leave prison, I would dispute that. It relies 100 per cent on the probation service and the capabilities of the probation service ...There has been contact by nursing staff with GPs regarding medications that prisoners are discharged with [but it's not enough]... A perfect example is a fortnight ago an inmate was discharged...and he was dead on the [day]... That was purely and simply a housing problem and if that had been picked up before discharge that may have been avoided.

Rehabilitation summary

Very often avoiding a criminal lifestyle would involve giving up drugs and finding a new social circle with which to associate. The reformative and rehabilitative effect of prison was touched upon by some

prisoners and staff, although staff in particular were critical of the paucity of support services available upon release.

9.7.9. Community services

In addition to the general level of support available to prisoners upon release, there were specific problems associated with health and social care liaison. Confidentiality was one of the problems cited of liaison with community services:

> [RN] we are not allowed [to pass on confidential information] because of the Caldicott report ...we are not allowed to... but there's a number of GPs that will ring in and ask us, you know, what was this gentleman on with you and we have to send in a signed [letter].

One of the prison doctors who was also a local GP offered this perspective on the problem of information flow:

> [Dr] as a GP I don't get any communication from the prison. If someone is released and he is my patient, I never know what he has been on, all I know is that when he's coming out of prison he is not on any addictive drugs, I know... but they will go to the GP and say 'when I was in prison I was on this drug and that drug and I want that' and he is given that because he said it.

However it was also felt that some GPs were not particularly interested in the needs of people coming out of prison, and that contact with GPs was a weak link in the resettlement process:

> [RN] but many GPs are so rushed that they can't be bothered, 'oh just leave it and get rid of them'. You know, that's a weak point. That, there should be a discharge letter to the GP.

Automatic prescribing

This mental health nurse was empathetic towards the plight of GPs who might be faced with aggressive or demanding ex-prisoners seeking prescriptions for methadone or other prescribed drugs, but was less supportive of the practice of automatically writing individuals up for medication upon release from prison:

> [RN(M)] I feel for the GPs. I mean here, it's an artificial situation. You're a doctor sitting on your chair, I'm sitting next to you, and there are 3 or 4 discipline officers in the area, if the inmate gets aggressive with a doctor, he's dealt with. I can picture myself as a GP sitting with a very aggressive, demanding 'if you don't give it to me I'm going to do this that and the other to you', I can understand why GPs write scripts. But I can't understand why they offer it voluntarily. I've got one chap, I know he's been clean for a year, he's going out very shortly and his dilemma will be when the GP offers him Subutex, an opiate substitute he's been on, when he's offered it, what does he do? Does he take it? Does he not?

Mental health services

Support from local mental health services was variable, with some accounts of good practice and other accounts which suggested that local liaison was a pressing development need:

> [RN(M)] General psychiatry it doesn't exist, it's very unsatisfactory. [*the local service*] will have nothing to do with us they will not cover, they will not respond to... our [referrals].

Things previously had been much better, but service reorganisation within local mental health services had led to deterioration in service provision:

> [Officer] we had an excellent relationship with [local mental health services]. We seemed to have more contact with them then and from my point of view it was ideal, we could get results ...a lot quicker than we seem to get now.

Other localities had much better contact with the prison medical services:

> [RN(M)] [local psychiatric hospital] are very supportive again, we get a lot of people through [...] hospital for prisoners who reside in that area. They give us information on the end of the phone.

Community services summary

Staff felt that there were a number of problems in trying to liaise effectively with community agencies, in order to ensure that prisoners received the necessary support at the point of release. Information exchange, unwillingness to accept referrals, differing prescribing practices and lack of follow-up care, support and supervision all featured within the narrative.

9.7.10. Resettlement

Many prisoners recognised some essential needs if they were to live crime free lives:

> I would need a place to live and ...a job though... just for the normal things.

Conversely, the lack of such help and provision would inevitably lead to further offending in the view of this prisoner:

> People are worried about getting out. They have nothing to go out to you know what I mean. Like living or what am I going to do for money? If people haven't got money...they have to do what they know best haven't they?

Drug rehabilitation, and the general difficulties associated with staying off, or limiting the harm associated with drug usage on the outside was often commented upon:

> This [prison] is the best place you can [be... to get off drugs]...Because you can't get it. I mean 'out there' you can get it, like. 'Out there' you have more chance of getting the drug. The only place to get off it is in jail.

Difficulties associated with release

This prisoner felt that home leave would make the transition to release easier, although the prison authorities were concerned about the likelihood of drugs being brought back into the prison:

> home leaves and that and short releases [would help]...But they don't do it here. Once you've got a reputation in this [prison]... you've blown it...They think you'll come back with drugs...they use it as an excuse.

Consequently, release was sometimes poorly prepared for and could be traumatic, often leading to an early reappearance in prison:

> Basically... they chuck you out with £50, you're homeless and everything... oh here we go again...what chance have you got? Realistically staying clean?

Sometimes things went badly wrong upon release. This example was given by a mental health nurse at HMP Swansea:

> [RN(M)] an example of that 'gap' [in resettlement service provision] would be this guy's going out tomorrow, everything is in place for him he doesn't know anybody out there except his wife and his kids, but since he's been inside his wife's decided he's not coming back to stay with her any more. Probation haven't got an issue there, as far as they're concerned he's got a home. He knocks on the door; if she says 'bugger off, I don't want any more to do with you' we'll have him back in a week.

Mentally disordered prisoners

The need for follow-up for prisoners with mental illness was emphasised by this mental health nurse, as was the need for more halfway home facilities to support mentally disordered prisoners in the community:

> [RN(M)] They should have some sort of half way sort of placement when they leave prison and when they are being discharged...a half way house or someone who knows the system, who will know what's happening you know and where some of these practical differences can be sorted out.

Some prisoners with mental health problems were expected to make a quick return to prison, following their release:

[RN(M)] he [named prisoner] usually goes out on a Friday and we keep his medication out because he's back and its ready for the Monday afternoon.

This prisoner commented upon another prisoner known to him:

he's going out next month, but he's going to go out into society, he's going to commit some other crime, either kill someone and then back in prison. Before he was in one of them homes. You know when the ....manager would let them all out, like care in the community...you know looked after carers and helpers, you know a home for them...because he's still in there they have just stared to give him pills .....but the minute he goes out all that's going to stop.

Difficulties faced by young prisoners

This officer felt that the younger prisoners with no home to go to fared worst:

[Officer] the youngsters seem to get the worst end of the deal, they're going straight back to the environment...because there's no alternative. And yet [local housing association] won't actually take him...they only want the people that are going somewhere, but what about the ones that don't want to go to work?

Resettlement summary

The lack of practical help and support with regards to a place to live and some work to provide good money were felt to be significant impediments to going straight and avoiding future offending. Services were intended to help prisoners with many of these needs but seemed ad hoc and sometimes unresponsive to individual need. Anticipating problems was not something which services seemed well placed to do, and this compromised their ability to respond to individual needs.

9.8. SUMMARY

This chapter reviewed the findings linked to life outside prison. Many prisoners were shown to exist on the fringes of society and frequently experience social exclusion whilst public attitudes are generally hostile and punitive towards prisoners. Consequently prisoners experience a range of interconnected problems which often compound one another. Chaotic lifestyles involving drugs, debt, poor levels of education and employment prospects were all seen to link to offending, as were impulsivity and becoming involved in fights. There was little confidence amongst prisoners or staff that many prisoners would be able to break out of their drug using and offending lives. Many prisoners and staff felt achieving the changes associated with leading constructive and law-abiding lives was constrained by a lack of targeted services with release being a particularly testing time. Follow-up for prisoners with mental health problems was patchy and often very poor. The number of prisoners who would end up with no fixed abode was highlighted as a particular issue.

CHAPTER 10

RESULTS (ii)

LIFE ON THE 'IN': PRISONERS' HEALTH AND EXPERIENTIAL STATUS

10. RESULTS (ii) LIFE ON THE 'IN'

10.1. INTRODUCTION

This chapter presents findings from a number of the datasets, relevant to life inside prison. The findings link to Chapters 3, 4 and 5 of the literature review (life on the 'in': regime, experience and health) and the summaries at 6.4 and 6.5 which relate these themes to the prison mental state question. Themed data is presented from the surveys at HMP Swansea (2005) and HMP & YOI Parc and HMP Swansea (2002), the audit of medical records at HMP & YOI Parc and HMP Swansea (2002) and the focus group data from the same two prisons (2002). The data spans health status, social status, experiential and attitudinal domains. The latter part of the chapter briefly discusses the results presented.

10.2. RATIONALE

The findings reported in Chapter 9 establish the social context for prison life. The findings in this chapter are organised around the theme of life on the 'in'. This phrase is used within the prison vernacular to refer to life inside prison and this chapter is therefore concerned with the immediate experience of prison. The themed data touches upon all aspects of prisoners' health, experience and the nature of problems faced in prison. In this way it is hoped to accurately portray something of the lived experience within the culture and milieu of the two featured prisons. Consideration is given to the impact of life circumstances and prison stressors upon mental state and the care and treatment offered in the prisons to individuals with mental health problems.

10.3. DATA FROM HMP SWANSEA HEALTH NEEDS ASSESSMENT (2005)

At the time of the 2005 survey HMP Swansea held 409 adult male prisoners of which the majority were convicted. The operational capacity at the time of conducting this aspect of the study was 425. The prison takes around 1800 new receptions each year with an average daily population of 414 prisoners. 1835 receptions were received in the period comprising from 1 June 2004 to 1 July 2005.

10.3.1. Age of prisoners

The two age groups for prisoners aged under 30 years of age contained 48 per cent of all prisoners as Table 16 shows:

Table 16: Age of Prisoners (2005)

Age	*n*	%
<20	0	0
20-24	100	24
25-29	100	24
30-34	65	16
35-39	64	16
40-44	40	10
45-49	17	4
50-54	12	3
>54	11	3
	409	100

Table 16 shows that the prison cohort reported on here is predominantly under the age of 30 years with both the 20-24 and 25-29 age groups each containing just under a quarter (24%) of the population. The age groups following these see a decrease in numbers. There are 23 prisoners over the age of 50 compared to 200 between the ages of 20 and 30. The average age of this cohort appears consistent with much of the literature identifying the bulk of the prison population being in their twenties (Fry and Howe 2005).

10.3.2. Status of prisoners

331 prisoners (81%) had been in prison previously; 320 prisoners (78%) were convicted, with the rest being held on remand, awaiting trial or awaiting sentence. Of the convicted and sentenced population, 95 (23%) are serving sentences of 12 months or less. Including all the prisoners who were remanded, awaiting sentence or serving sentences of less than one year, there were 184 prisoners (45%) to whom courses, and other elements of constructive regime available to longer term prisoners, would not be made available.

10.3.3. Home location of prisoners

Table 17 identifies home locations of HMP Swansea prisoners:

Table 17: Home Location of Prisoners (2005)

Home	*n*	%
Swansea	149	36
Other Welsh	214	52
Other UK	29	7
Abroad	2	<1
Not stated	15	4
	409	100

Tensions can arise in Welsh prisons based upon fierce local rivalries. The 52 per cent of Welsh prisoners located at HMP Swansea from outside the Swansea area may find themselves vulnerable to these tensions. Prisoners from the Cardiff area for example are likely to face some hostility particularly if they have an affiliation to the Cardiff City football club (The Bluebirds), with whom the local club Swansea City (The Swans) share a fierce, often hostile rivalry. Hostilities also arise from the miners strike of 1984 and other historical events. English prisoners may also face a degree of harassment due to ethnicity. The relatively closely drawn nature of the population was commented upon in the last Inspectorate report:

> Swansea is a small, genuinely local, prison; 70% of its prisoners live less than 50 miles away. One of its distinguishing features is the good relationship between staff and prisoners, often based on familiarity; many prisoners are repeat offenders.
>
> HM Chief Inspector of Prisons 2005

10.3.4. Medical and social status

A number of variables relating to medical and social status were collected and are presented in Table 18:

Table 18: Medical and Social Status (2005)

Medical and social status	*n*	%
Not registered with GP	58	14
Seen doctor in last few months	197	48
Receiving prescribed meds	186	46
Recent physical injury	70	17
Homeless in last year	122	30
Previously in prison	78	19
	409	100

58 prisoners (14%) were not registered with a GP, which would make it extremely difficult for them to access primary or specialised secondary health care for problems which they might have. Amongst those registered with a GP, 197 (48%) had seen their doctor in the months prior to prison, with 186 (46%) receiving prescribed medication. 122 (30%) had been homeless in the year preceding prison, which would make receipt of state benefits and health and social care extremely difficult. 78 (19%) of prisoners were receiving their first sentence, with all the attendant difficulties which first sentences entail.

10.3.5. Physical health status

A number of variables relating to physical health status were collected and are presented in Table 19:

Table 19: Physical Health Status (2005)

Physical status	***n***	**%**
Asthma	46	11
Diabetes	5	1
Epilepsy or fits	15	4
Chest pain	35	9
Tuberculosis	3	<1
Sickle cell disease	0	0
Allergies	52	13
Disability	1	<1
Hepatitis/HIV	11	3
Other	78	19

The physical health status of this population was largely consistent with community comparators, with most indicators falling within normal population prevalence. For example asthma is within the 10-15 per cent range reported for the general population (Simon et al. 2002), 11 prisoners (3%) reported that they had either hepatitis (B and C) or HIV. These numbers of prisoners are significantly lower than reported within the literature. HMP Swansea had 3 (0.7%) prisoners that reported having tuberculosis at the time of entering the prison.

10.3.6. Alcohol and drug use

Alcohol and drug use was ascertained from the reception health screens:

Table 20: Alcohol and Drug Use (2005)

Alcohol and drug use	*n*	%
Alcohol	277	68
Alcohol <21 units a week	139	51
Alcohol >21 units a week	135	49
Used drugs in last month	262	64
Heroin	146	36
Methadone	43	11
Benzodiazepines	122	30
Amphetamines	75	18
Cannabis	109	27
Crack/Cocaine	81	20
Other	38	9
Injecting drugs intravenously	93	24

The survey identified 277 (68%) prisoners who declared they drink alcohol. Of those, 135 (49%) were drinking above the recommended limit of 21 units a week before being received into custody. 262 (64%) had used drugs in the previous month with the most commonly used drug in the month prior admission to the prison being heroin (36%), but benzodiazepines and cannabis use was also very common (30% and 27% respectively). 93 prisoners (24%) had injected drugs in the previous month; this figure is similar to the 21 per cent figure found in the previous health care needs assessment conducted in 2001 (Davies et al. 2001). These figures reveal a problematic scale of substance usage, with its concomitant risks to health and links to offending behaviour.

10.3.7. Mental health status

Data regarding the mental health status of this cohort of prisoners is presented in Table 21:

Table 21: Mental Health Status (2005)

Mental health status	*n*	%
Outside psychiatric treatment	126	31
Depression	41	10
Schizophrenia	2	<1
Anxiety	12	3
Phobias	0	0
Other	58	14
Psychiatric inpatient	49	12
Psychiatric meds	88	22

The survey conducted at HMP Swansea identified 126 prisoners (31%) who had received treatment from a psychiatrist outside the prison and 88 prisoners (22%) that were receiving or had received medication for mental health problems. The first reception health screen does not have a list of mental health problems. In this survey diagnosis was captured using the free text space that the reception screen has to state the nature of the mental health problem. The number of prisoners with recognised psychiatric disorders was lower than the expected number and this may be due to the limitations of the survey method.

10.3.8. Self-harm

Self-harm data for this cohort of prisoners is presented in Table 22:

Table 22: Self-harm Status (2005)

Self-harm status	*n*	%
Tried to harm self	92	22
Considering harming self	20	5

The 20 prisoners (5%) who were considering harming themselves combined with the 92 (22%) who had tried to harm themselves in the past either in prison or outside prison, constitute over a quarter of the prison population.

10.4. DATA FROM HMP & YOI PARC AND HMP SWANSEA (2002)

Data collected from the 2002 survey related to status, experience and prisoner characteristics. The high remorse variable was a recoding of a number of other variables which related to the individual's attitude

to their offence. In order to calculate this new variable, a complete profile of other variables was required (relating to attitude to offence), which meant that due to missing data only a subset of the total population is reported upon.

10.4.1. Prison experience

Data relating to the status and regime of this cohort of prisoners is presented in Table 23:

Table 23: Prison Experience (2002)

Experience	*n*	%
Severe physical health problems	31	4
On remand	132	15
First sentence	272	32
<1 month inside	126	15
High Remorse	161	19
Physically abused by prisoners	142	17
Verbally threatened	202	23
In cell >16 hours	291	34
In cell >20 hours	114	13
Feel unsafe sharing cell	35	4
Limited daily regime	209	24
Visited by friends and family	589	68
Visited >1 per week	277	32
Sleep problems	375	44

589 prisoners (68%) had served previous sentences. The 32 per cent figure for first time prisoners at HMP Swansea and HMP & YOI Parc combined in 2002 is higher than the comparable 18 per cent figure for HMP Swansea (only) in 2005, reported here at 10.3.3. This would be explained by the youth offending function of HMP & YOI Parc, where a lot of HMP Swansea prisoners would serve their first sentence.

Regime and mental state

Constructive elements of the regime were constrained by some custodial practices. 405 (47%) prisoners reported spending more than 16 hours a day in their cells and of these prisoners 114 (13%) spent more than 20 hours a day in their cell. 209 (24%) prisoners reported a limited daily regime, with the increased potential for mental health problems. Furthermore, 375 (44%) prisoners reported sleep problems, and 35 (4%) reported feeling unsafe sharing a cell. Other factors which might impact upon mental state included 142 (17%) prisoners reporting being physically abused by other prisoners, 114 who did not receive

visitors and 31 (4%) who reported severe physical health problems. This data is consistent with literature concerning the composition of the prison population and their conditions.

Literature regarding regime and mental state

The pressure on prison places throughout the past decade has been a major constraint upon prisons achieving the kind of change which Woolf (Woolf 1991) recommended, leading to a 'poverty of experience' (Newell 2001 p.1). The finding that 114 prisoners spent 20 hours a day locked up, resonates with the poverty of experience citation, as it is difficult to imagine leading a fulfilling life in just 4 hours a day outside a cell. The 35 prisoners who reported feeling unsafe sharing a cell may have experienced some abuse from their cell mate. Within the prison context, living cheek by jowl with other prisoners who may also be their assailants, is one of the pains of imprisonment. Enforced living with such individuals may also be construed as rendering the assaulted party as being vulnerable to continued assault, and might also be expected to have an impact upon mental well-being.

10.4.2. Personality descriptors

Personality descriptors were used to enable identification of key personality traits:

Table 24: Personality Descriptors (2002)

Personality trait	***n***	***%***
Loner	106	12
Trust other people	337	39
Temper	454	53
Impulsive	318	37
Irresponsible	168	20
Worrier	391	45
Unusually high standards	322	37
Dependent on others	74	9
Get on with other people	652	76

The majority of prisoners described themselves as being generally sociable, with 755 prisoners (88%) seeing themselves as preferring company and 652 (76%) being able to get on with other people, whilst over a third (337 or 39%) were able to trust others. Some high levels of potentially anti-social traits were also noted however, with 454 (53%) describing themselves as having a temper, 318 (37%) describing themselves as impulsive, and 168 (20%) as being irresponsible. Neurotic traits of worrying (45%) and dependency (9%) were also reported.

Personality and mental state

Personality type is recognised as impacting upon mental state, well-being, ability to cope and social functioning. For example depression may be regarded as the interaction of vulnerable personality traits, long-standing problems and stressful life events leading to a psychological withdrawal of the vulnerable individual from experiences which are perceived as overwhelming (Ormel et al. 2001). The controversial diagnosis of personality disorder is also contingent upon diagnosing a fault or vulnerability within the personality to a certain determining trait, which can range from anxiety or depression to anti-social behaviour, aggression and violence. Self-harming is often associated with borderline personality disorder (Brodsky et al. 1995, Chengappa et al. 1995), the origins of which are thought often to lie in physical and sexual abuse in childhood. An individual's perception of their health status is also proposed as a factor within their sense of subjective well-being (Brief et al. 1993). Implicated within the experience of good health are likely to be the presence of adaptive personality traits clustered around positivity and optimism (Brief et al. 1993, Scheier and Carver 1987). Conversely, the presence of a maladaptive personality type clustered around depressive traits, is likely to be linked to perceptions of poor health. Consequently, without the self's positive perception there can be no real health (Prince 2007). Personality disorder has been recognised as part of the problem nexus experienced by prisoners which compound other difficulties faced by the individual (HM Inspectorate of Prisons 2007).

10.4.3. Data from Individual Medical Records (IMRs)

The figure for prisoners who had self-harmed or were considering self-harm reported at Table 22 (10.3.8. above) was 27 per cent, whilst 36 per cent of medical records identified this as being a problem, 27 per cent and 66 per cent were the respective audited figures for alcohol and drug-related problems. This compared to figures within the 2005 HMP Swansea audit which reported 49 per cent drinking above safe levels, 64 per cent using illicit substances in the month prior to prison, 52 per cent being referred to the prison medical service for substance misuse problems. It is difficult to comment upon the convergence of these figures as whilst all being thematically linked to substance misuse, they are all measures of slightly different things. The audited IMR figure for relationship difficulties (32%) however, is very close to the self-report figure (33%) in the 2002 survey. Data concerning prisoners' problems was also elicited from medical records, and presented in Table 25 which follows:

Table 25: Individual Medical Records (IMRs) Data (2002)

Problems documented in IMR	*n*	%
Problems with aggressive, disruptive behaviour	83	31
Harming yourself or attempts at suicide (indicated by known acts of self-harm or attempted suicide during their lifetime)	96	36
Problems with drinking alcohol (indicated by a current problem with alcohol on entering prison)	74	27
Problems with drug taking (history of drug abuse – 54% of which is a current problem on entry)	178	66
Problems with relationships	32	12
Problems with daily living – such as finding it difficult to walk	117	43
Problems with daily living – reading or writing	19	7
Problems with your job and ability to carry out your job	2	1
Problems with depression, anxiety, nervous breakdown, panic attacks, stress (indicated by a current problem with depression/anxiety/stress etc.)	138	51
Problems dealing with a traumatic experience that happened to you in the past (indicated by physical/mental/sexual abuse – death of a family member/road traffic accident etc.)	31	11
Problems with hallucinations and delusions, memory loss, hearing voices (indicated by a past history of and/or current problem)	33	12

10.5. FOCUS GROUP DATA FROM HMP & YOI PARC AND HMP SWANSEA (2002)

Data related to life inside was collected in the various focus groups conducted at HMP & YOI Parc and HMP Swansea in 2002 is presented in the following paragraphs.

10.5.1. Prisoners' problems

Many prisoners felt depressed at coming into prison, the response of this prisoner was typical, when asked how he felt about being in prison:

> Depressed, but you just got to get on with it.

Another reported hallucinating on reception into prison:

> When I came in here I was hallucinating.

The right support for individuals

Prison didn't seem to be the right place for this individual:

> [Officer] his disability is part of his problem, when he committed his crime he injured himself at the same time.

Prison makes problems more difficult

Prison was also felt to make practical problems such as housing and resolving personal issues more difficult:

> I've got to get myself some place now, because I've lost two flats now since I've been in jail...[I'm] in a relationship but that's gone now as well...or it's slipping away slowly, but it's hard for me to try and sort that out while I'm in here now because of my relationship differences like.

Family life

Family life was put under pressure by serving a sentence, as these comments show:

> It's not just you who suffers in jail, it's your family as well.

This prisoner expressed a feeling of censure emanating from his family:

> my family seem a bit off me because I'm back in. You know ...for a bit, because the first time I went in it really upset them a lot...but this time I think they are bit disappointed in me.

The reality of prison for some individuals is that they are going to lose everything:

> It's just not very nice is it? ...You got a nice missus, you got everything sorted...See it all go out of the window again...Good chance you're going to lose everything.

Relationships

Maintaining relationships was a particular difficulty for many prisoners. Prisoners did not always feel that they could confide in the prison officers or expect a sympathetic hearing from the authorities:

> My relationship has broken down since I have been in. I just had a baby as well. So I put in for compassionate leave so obviously I had different things to sort out but I never told any of the Officers.

Prisoners' problems summary

This part of the narrative highlighted the extent to which prison brought with it additional problems that individuals were poorly equipped to deal with. These included the immediate psychological effect of imprisonment, but the most prominent component of this part of the narrative, was the impact which imprisonment had upon family life and relationships. It would be true to say that this impact appeared to be wholly negative and often led to prisoners feeling as if they stood to loose everything. This distress impacted upon prisoners' morale and compounded the sense of loss of liberty underlying the punitive role

of imprisonment. Prisoners also often expressed frustration at their concerns not being responded to by inflexible services or unsympathetic prison staff.

10.5.2. Drug use

Staff recognised the extent to which drug use was prevalent within the prisoner population and in fact has become currency (the staple means of bartering) within the prison system:

> [Officer] 20 years ago the currency in the prison was tobacco, now it's diazepam.

Some prisoners play the system by asking for prescription medication, to be able to sell it on within the prison. This nurse noted that some prisoners:

> [RN(M)] are wised up before they get to reception, um 'we've been on this amount for a certain amount of time' etc, etc, tell them you're going to top yourself, or your wife's left you, or you're going to do this or that...the doctor will write you up...' He doesn't need it but he sells it.

Access to illicit drugs in prison

Keeping drugs out of prison was acknowledged to be an impossible task:

> [Officer] It's difficult to stop it. In fairness to [prison authorities], everything's in place, you can't fault the prison, or any other prison. But how literally do you stop it?

The practice of palming medication, or concealing it for later sale, was identified by this officer:

> [Officer] you get a new member of staff on the (*medication-dispensing*) hatch here issuing medications and the usual thing is you press the medication out and they say 'oh boss, can I have a paracetamol?' 'yes certainly'. You turn round and it's palmed, you don't realise, you've got to be up to these things, the pressure's tremendous.

Drug use summary

Staff were circumspect, although a little frustrated, about their inability to maintain prison as a drug-free environment. Prisoners were seen to be extremely resourceful in developing new ways of evading detection when drugs were smuggled into prison. Drugs had become culturally mainstream within prison to the extent that they had now replaced tobacco as currency. Staff also spoke of the practice of feigning illness to access medication and concealing prescribed drugs to sell-on later.

10.5.3. Detoxification

Given the extent of drug use, a considerable number of prisoners needed to be detoxified when they came into prison. Many of the staff involved with the detoxification process felt that it was effective

although more radical and time limited than comparable community programmes. Staff reported that many prisoners saw their sentence as an opportunity to get off drugs.

Efficacy of detoxification regime in prison

This doctor commented upon the efficacy of the detox programme:

> [Dr] I think its very, very effective and I would strongly recommend if anyone wants to come off substance abuse that they come in to prison, they would be offered everything. Guaranteed delivery....the moment, they go back out...they take an overdose, yes. But while in prison they are pure. There are people who have been on morphine for years; when they come into prison, within two weeks they're off.

Detoxification for heroin was completed within the first couple of weeks at HMP & YOI Parc. Detoxification at HMP Swansea took place over a slightly longer time-frame.

> [RN(M)] we have a detoxification programme, and when I look at other prisons' detox programmes, it's quite a generous one. It's a six-week withdrawal from benzodiazepines and 4 weeks for opiates.

Prisoner views

Not all prisoners were as supportive of the detox regime, feeling that their GPs were more knowledgeable about their needs, and that they should be kept on the medication regimens that they were on in the community:

> I was on 100 ml of Valium and 60 ml of methadone prescribed and doing about 2 gms of gear [heroin] every day. When I come in here they give 30 ml of Valium [and a] couple of codeine phosphate and ...

Some prisoners would not disclose their drug use to the prison authorities for fear of it being counted against them:

> As far as they [authorities] are concerned I have never took a drug in my life ...I would probably admit to having ...cocaine. I probably wouldn't now [admit to it] because it goes on your file.
>
> if I was addicted to the worst drug in the world I still wouldn't have told them.

Dedicated servicers are available to support prisoners once they have been detoxified, in order to try and maintain the individual to be drug-free:

> [RN] in the last few months we've set up a new voluntary testing unit upstairs...the rehabilitation wing ...where they spend 3 months ...They go onto a voluntary testing unit that is either on A wing or B wing and from there they wait their turn to go on the rehabilitation wing.

Staying clean

There was widespread recognition of the difficulties faced by prisoners attempting to stay drug-free upon release, by both staff and prisoners, and recognition that in many cases the temptation and security of belonging to a familiar peer group and falling back into old ways would prove to be too much:

> You come off it right but then you go back because for the simple reason is that you are mixing with the same people that got you on it in the first place. I lost a cousin 22 years of age. His Mam found him dead in bed.

Retoxification

One nurse noted, in a comment outside of the focus groups, an inherent difficulty with detoxification in prison. This was to do with the fact that some prisoners, having successfully come off drugs in prison during their sentence, anticipated fitting back into the same social circle upon release where drug taking was the norm. This can lead to problems of overdose if an individual starts to reuse at levels they could manage immediately prior to imprisonment:

> [RN(M)] some prisoners will actually ask to 'retox' before release because they know they are going to go straight back on to the drugs and they are concerned that they will be using at levels which are unsafe, unless they are prescribed something before release which builds up their tolerance.

GP Prescribing

A contrary view stated that the prisoners' GP was a weak link in helping to keep the prisoner off street drugs or prescribed substitutes when they were released, especially bearing in mind that upon release there was a much greater chance than at any other time that the individual would be clean:

> my issue comes when we have to go through an opiate withdrawal programme and they will be clean for a year, limited or no access to opiates and yet their GP will have their methadone ready for them on discharge. I can't really understand what we gain by that. I mean these guys are clean, some of them don't want to go back on the gear, but their GP will have their script ready on their first visit on the out.

Detoxification summary

It seems that prison can be a good location from which to withdraw from illicit drugs within a controlled environment. All prisoners known to be dependent are subject to a withdrawal regime, with the intention of them being detoxified within one month to six weeks. Detox programmes are therefore mandatory for all dependent drug users on reception to prison. In the community such supervised programmes, especially inpatient programmes, are extremely difficult to access and have with long waiting lists. The prison regimes are relatively quick and can be uncomfortable, but comply with protocols to ensure that prisoners receive necessary substitute medication to ensure as safe and comfortable a withdrawal as possible. Some prisoners felt the level of substitute medication was not acceptable to them. The central difficulty with such a regime is that prisoners are relatively passive, sometimes unwilling recipients of withdrawal programmes. Some felt that detox programmes were too harsh. Many prisoners will start using

again in prison, whilst others are open about their intention to recommence using when released from prison. Whilst detoxification programmes are effective at reducing physical dependency, there was far less emphasis given to management of the psychological and social factors implicated within drug using behaviours. A few prisoners were unwilling to disclose drug use, because of their perception that it would count against them and had to suffer severe withdrawal symptoms as a result.

10.5.4. Talking

Prisoners were mixed in their view as to whether it was necessary to be able to talk to someone in order to be able to get through a sentence. A common view was expressed by this prisoner, about getting by in prison:

> You have to talk to someone else like...

A similar view was expressed by this juvenile prisoner:

> Either speak to an officer or a counsellor, last time I was here there's a couple of people here from [Cardiff] that I knew, and now there's just the one that I know, he's not from [Cardiff] but I know's him on the out like.

Although listeners were available in both prisons, they were not always appreciated:

> I haven't bothered with the listeners. I'd rather talk to ...someone I know, rather than talk to a total stranger; [they] don't really care do they? They're only doing it for the parole.

Discussing things with listeners was felt to compromise some individuals who expressed a degree of hostility and suspicion towards them. The following comment typified a kind of macho attitude which eschewed any kind of emotional support mechanism, seeing it as a sign of vulnerability:

> If you tell them people too much they tend to try and have a little bit of a hold on you.

Talking summary

Generally prisoners acknowledged the importance of talking as a means of getting by, but were mixed in their attitude towards counsellors and especially the prison Listener scheme. Prisoners greatly appreciated the support available from talking to their mates but were generally appreciative of additional supportive counselling if it was available to them. Some the more prevalent attitudes are more fully reflected in the section dealing with prisoners supporting each other in Chapter 11.

10.5.5. Prevalence of mental health problems

Mental health problems of prisoners were felt to be extremely common:

[Dr] very much higher than average population

[RN(M)] I would say as a remand prison, I would perceive it's higher than a prison with a static population because the process of going through trial, being sentenced and being placed in prison is a very stressful experience. I would guess a lot of those issues are resolved in a place like this that is remand, in a prison where they would serve a sentence they would come to terms with the problems that we would help them with here.

Sometimes it was felt to be problematic in attempting to distinguish between genuine need and those who were perhaps just trying to get access to prescribed medication:

[RN] they come to medication hatch alleging that they've got ...mental health needs, and we refer them on if we feel the need, or the doctors refer them.

The reception process was crucial in identifying prisoners with problems:

[Dr] all new admissions are screened first and we have a fair idea as to how many people have genuine needs, some of them of course make up quite a bit of this. A heck of a lot of them are liars as we find out in this prison and...just because they want a bit extra drugs or sleepers or anything they will say anything. But when you sift through that, trawl through that, my impression still is that about 35 per cent of the population has genuine need.

Prevalence of mental health problems

All of the medical, nursing and custody staff who participated in the focus groups felt that there was a higher incidence of mental health problems within the prison population, than amongst the general population. The transient nature of the remand population was felt to be particularly likely to result in poor mental health amongst these prisoners. The narrative regarding mental health problems further developed themes of trust namely, trusting or not trusting what they were being told by some prisoners. Staff elucidated principles of sceptical listening in order that they would distinguish between genuine cases and those trying to elicit prescriptions to sell.

10.5.6. Serious mental illness

Nursing and medical staff felt that there were prisoners with psychotic forms of mental illness who should be in hospital rather than in prison:

[RN] some people should be in a psychiatric hospital and not here

Whilst this RN(M) commented upon the difficulty of distinguishing between drug specific and presentations with an underlying cause:

[RN(M)] I'm not sure whether it's the actual cause of the drug or what. It's hard to understand to know. They come in and their speech is [slurred] and they sort of have the shakes but often its masking [anxiety or depression]...once they are detoxed [they appear much better].

Providing a therapeutic environment

There were particular problems in trying to manage and provide a therapeutic environment for disturbed psychotic patients:

[Dr] some of those people [psychotic prisoners] can be difficult to manage, especially if they are getting ...aggressive and don't take their medication.

Establishing a therapeutic relationship with disturbed prisoners was an important and skilled part of prison nursing which could have tangible and positive outcomes for the quality of care:

[RN(M)] So someone who is very psychotic and who is in need of sedative medication, you just have to calm them down and take the edge off the psychosis... you just have to ask them and do your best to persuade them to take [medication].

Appropriateness of prison for individuals with psychosis

There were differing views as to how appropriate the prison wings were for individuals with psychotic illness:

[RN(M)] his offence was [serious offence of violence] in [a local psychiatric hospital]... it's difficult for them to accept him. He manages very well [here], actually.

[RN(M)] My question I throw back at you is, because someone has a psychotic illness, we're talking about care in the community; they wouldn't be locked up in an institution as they would have been 30 years ago, so why should they not serve a prison sentence?...Well, this guy's been mad for 20 years and he's lived in his own house, well, if his own house has now got to be a cell in D wing.

This mental health nurse felt that adequate support was available to support psychotic prisoners:

[RN(M)] we have trained psychiatric nurses, access to forensic psychiatry, consultant psychiatrists.

Serious mental illness summary

Overall, establishing a therapeutic relationship with psychotic prisoners was seen as essential, and the quality of the relationship was acknowledged as being particularly important for negotiating treatment options, especially in the absence of being able to treat prisoners against their will, under the provisions of the 1983 Mental Health Act. Nursing disturbed prisoners was intensive work and took up a lot of nursing time, due to the level of risk and degree of supervision which was required. There was also some discussion as to whether prison was always inappropriate for individuals who had a psychotic illness but who were well maintained and controlled.

10.6 SUMMARY

This chapter reviewed the study findings relating to life inside prison. Both of the prisons in this study tended towards being genuinely local prisons serving the South Wales and South West Wales areas. Prisoners were predominantly young, in reasonable physical health but often presenting with substance misuse problems. Regimes were sometimes limited, with prisoners often spending more than 16 hours a day banged-up. Detoxification regimes which were routinely available, were felt to be effective by staff but often unnecessarily harsh by prisoners. Other aspects of medical care were the focus of some grievances expressed concerning the experience of imprisonment. Prison was felt likely to worsen social problems. Staff felt that both the lack of recourse to compulsory treatment and the difficulty of transferring acutely psychotic individuals to hospital posed significant challenges in caring for and managing this particular group.

CHAPTER 11

RESULTS (iii) 'MY HEAD'S GONE!'

GHQ-12, INFERENTIAL AND EPIDEMIOLOGICAL TESTS, STAFF SURVEY AND QUALITATIVE DATA

11. RESULTS (iii) 'MY HEAD'S GONE!'

11.1. INTRODUCTION

This chapter summarises the study findings, subjects selected data to inferential, epidemiological or thematic analysis and formalises propositions arising from the survey and focus group data. The data links to the themes and topics covered in the literature review chapters, but particularly to Chapter 6 which focussed the themes on the prison mental state question. GHQ-12 data are tested for association with mean scores. Significant correlates to higher scores are then tested for association with caseness using odds ratios. These tested data are then set against the focus group narrative and data from the staff survey. The latter part of the chapter briefly discusses the results presented.

11.2. RATIONALE

The aim of this study was summarised by the question 'how do prisoners' circumstances and experiences affect their mental state in prison and beyond?' This chapter seeks to directly test variables consistent with prisoners' circumstances against GHQ-12 mental state scores. Furthermore, this analysed data is set within a context of staff survey data and a broader prisoner narrative. The variables tested fall within the life on the 'out', life on the 'in' and prison mental state themes. Also social exclusion, socialization, regime, experience, vulnerability, identity and health topics covered in the literature review.

11.2.1. Similarities with literature

The findings from this study are largely consistent with accounts of prisoner experience and prisoner characteristics as described within the literature. Both the literature and this study identify prisoners as experiencing the combination of social privations characteristic of social exclusion. Like the literature, a nexus of interdependent and dynamically interacting problems has been apparent. Data in this chapter further supports prisoner links with problems including traumatic childhood experience, low levels of educational attainment, substance misuse, unemployment and relationship problems. The data also suggests that the studied populations share with those reported in the literature, introduction to and maintenance within criminal behaviour, through their peer groups. Combined with the effects of social exclusion and punitive societal attitudes, individuals appear enmeshed, even trapped within a lifestyle predicated upon acquisitive crime, substance misuse and frequently more violent crime.

11.3. GHQ DATA

During the 2002 survey of 861 prisoners at HMP Swansea and HMP & YOI Parc, GHQ-12 data was collected from 713 prisoners; 436 prisoners (61%) scored totals of 0, 1 or 2; 277 prisoners (39%) were

found to score 3 or above, with higher scores indicating a greater probability of clinical disorder (referred to as potential cases and therefore exhibiting caseness). A score of 2 or 3 is considered to be the usual threshold for caseness. The GHQ-12 scores were not typically distributed, with a relatively high standard deviation of 3.98, therefore the mean score of 3.18 is a poor description of the central tendency better described by the median score of 1.0. From Figure 1 it can be seen that there is a long thin tail of data distributed between GHQ-12 scores 3-12.

Figure 1: Distribution of GHQ-12 Scores

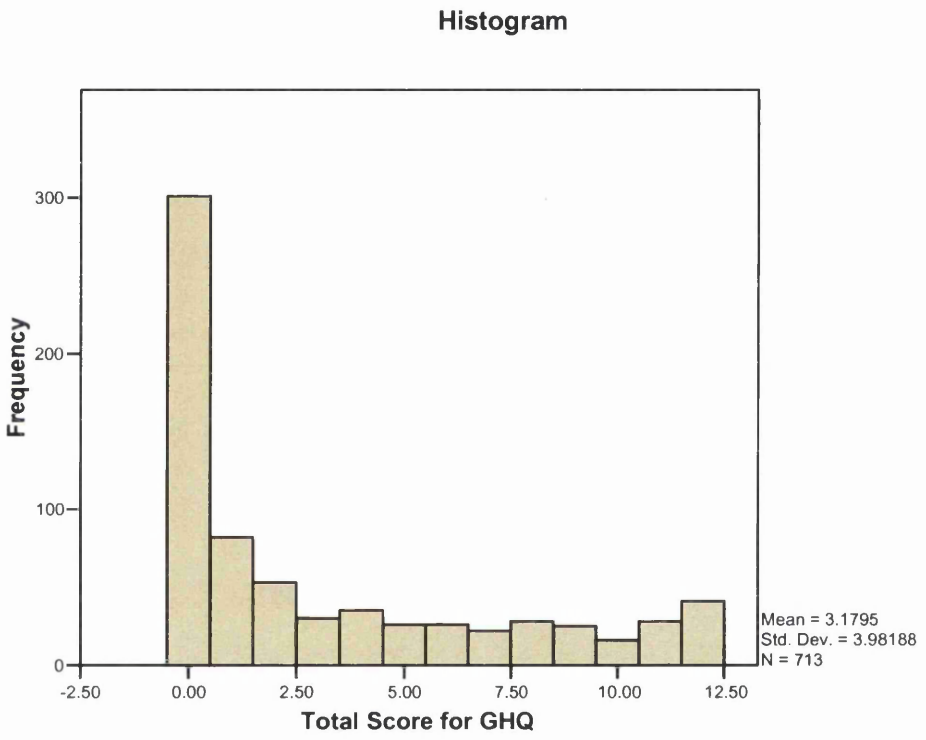

Figure 1 shows a high concentration of prisoners scoring 0, 1or 2. The data distribution resembling the letter 'L' is that of a Pareto pattern (Reed 2009). A practical consequence of this non-parametric pattern of data distribution is the necessity of carrying out non-parametric inferential tests for comparison of mean scores, such as the Mann-Whitney U test. The Mann Whitney test was employed to compare mean GHQ scores between groups of prisoners defined by variables of interest. These variables were primarily determined by themes apparent within the literature review and emergent from the descriptive data. These themes include social exclusion and the crime-problem nexus, drug use, vulnerability and socialization in prison. Variables were selected for analysis against mental state in so far as they could be representative of these themes. These variables were supplemented by variables which might further illuminate the dynamic of prison mental state, such as regime, offence and personality type. Through this

selection and analysis of dichotomous variables, it was possible to identify groups of prisoners who displayed poorer mental state, to a level of statistical significance. Where significant associations between mean GHQ scores and grouping variables were identified, these were further tested using odds ratios in order to determine and illustrate the epidemiological significance of the grouping variable. These data are set against a narrative illustrative of the data themes. The narrative develops themes such as the social process and milieu in prison, not coping and the beneficial effect of prisoner to prisoner association.

11.3.1. Selection of variables for testing against GHQ-12 data

Variables were selected upon the basis that each one reflected some aspect of psychosocial, health or experiential factor of interest to the study. The rationale for the selection of each of the tested variables is set out in Tables 26 and 27:

Table 26: Social Exclusion Variables and Rationale for Analysis with GHQ-12 Scores

Variable	Rationale	Comparator
Ever been in care	Being in care is often a result of family breakdown and is an early experience and potential determinant of further social exclusion	All prisoners who were not in care
Leaving school at age less than 16	Schooling is an important preparative social environment which awards formal qualifications essential to competing in the job market. Leavers prior to the age of 16 are unable to acquire formal qualifications and are therefore at a disadvantage within the job market	Prisoners leaving school age 16 or over
Learning difficulties in school	Learning difficulties in school are more likely to contribute towards exclusion within and possibly from school, as well as an overall low level of educational attainment. These factors would make entry into the job market and adult social environments more difficult	Prisoners who did not have learning difficulties in school
Unemployment	Employment assures a level of income usually above state benefits, a network of inclusive social contacts and is a gateway to further opportunity. Unemployment is amongst the most tangible and readily identified markers of social exclusion	Prisoners who had been in employment
Previous prison sentence	Prison is a stigmatising experience which further reduces opportunity following release from prison and is an experience likely to reduce and narrow further opportunity.	Prisoners with no previous sentence
Homeless	Homelessness is an indicator of extreme social exclusion and a precipitant of physical and mental ill health	Prisoners with fixed abode
Long-term sick	Long-term sickness is a contributory factor towards compounding poverty and limiting opportunities for reintegration into society via employment.	Prisoners who had been in employment (combined with unemployed)
Relationship problems	Unstable relationships can contribute to family breakdown which is another factor identified by the government Social Exclusion Unit as a determinant of social exclusion	Prisoners with no relationship problems
No GP	Access to the primary and secondary health networks of the NHS is dependent upon access through a GP. Therefore being registered with a GP is a significant determinant of health care access	Prisoners registered with GP
History of drug use	Substance misuse is a factor identified by the government's Social Exclusion Unit as often accompanying social exclusion. It is also a precipitant of some forms of mental illness and implicated within dual diagnosis as being a maintaining factor of serious psychotic illness	Prisoners with no history of drug use
Ever detained under the 1983 Mental Health Act	Detention under the Mental Health Act is an indicator of the most serious forms of mental illness often compounded by social exclusion. Detention itself can act as a tangible further excluding stigma	Prisoners with no history of formal detention under the Mental Health Act

Table 27: Age, Ethnicity, Prison experience, Offence and Personality Variables plus Rationale for Analysis with GHQ scores

Variable	Rationale	Comparator
Age	The ages of prisoners ranged from 15-76 years (mean age 27 years). Age groups were tested for association against GHQ scores	Prisoners outside specific age band
Ethnicity [White]	White prisoners were in the vast majority (approx. 90%) in the population studied. Non-white prisoners would therefore be a minority grouping, with limited opportunities of association, religious and cultural expression	Non-white prisoners
On remand	The process of going through trial, being sentenced and being placed in prison is a very stressful experience	Convicted prisoners
First sentence	Familiarity with the prison regime has been shown to be a protective factor for prisoners. First time prisoners have additional fears about imprisonment and initial problems adjusting to life inside	Prisoners with 2 or more sentences
Less than one month inside	Anxiety has been shown to generally reduce with more time spent in prison, the first month being the most difficult, particularly for first time prisoners	Prisoners who have spent more than one month inside
Expressing remorse	Acknowledgement of guilt and the expression of remorse are seen as indicators of reparation on the part of offenders. It is a measure of a subjective response to the individual's situation within prison	Prisoners not expressing remorse
Physically abused by other prisoners	Prisoners live cheek by jowl with their assailants. This close proximity makes physical abuse in prison particularly harrowing, with some individuals being constant targets for bullying. Abuse undermines self-esteem and can lead to long lasting psychological trauma	Prisoners not physically abused
In cell >16 hours	The amount of time spent inside their cell is one demonstrable indicator of the quality of the prison experience and the nature of the regime	Prisoners spending less than 16 hours in cell
In cell >20 hours	Prisoners can spend up to 23 hours in cell. This variable selected a lower, but still very restrictive threshold of 20 hours per day bang-up to measure impact upon mental state	Prisoners spending less than 20 hours in cell
Feel unsafe sharing a cell	The intimate nature of sharing a cell means that a prisoner feeling unsafe whilst sharing will spend a considerable amount of time in close contact with an individual they find threatening	Prisoners who feel safe sharing a cell
Constructive regime	Some prisoners access employment in prison in addition to educational or rehabilitative opportunities	Not engaged in constructive regimes
Visited by friends and family	Within our penal system there is an emphasis upon local imprisonment in order to provide the best opportunity to maintaining family and social networks whilst in prison	Prisoners not receiving visits
>1 visit a week	Access to, and maintenance of, family and wider social contacts is generally deemed to be helpful in facilitating resettlement	<1 visit per week
Offence type	Typical offences would not be stigmatising in prison. Prisoners who have been convicted of sexual offences are reviled by their peers in prison and often experience verbal and physical violence. They are invariably segregated for protection under Rule 45 which further constrains opportunities in prison	Prisoners convicted of other offences
Personality	Personality characteristics may be a further determinant of an individual's ability to function within a prison environment	Prisoners not displaying specified characteristic

11.3.2. Social exclusion variables and association with mean GHQ scores

The selected social exclusion variables were tested for association with GHQ scores. The following table shows the results when these variables were tested using the Mann-Whitney U Test for association with mean GHQ scores. The variables are divided into their binomial dichotomous constituents (eg. 'previous sentence', 'no previous sentence') in order to show how the results compare for the two groups defined by each the variables.This format also replicates how the results are presented by SPSS.

Table 28: Social Exclusion Variables and Association with Mean GHQ Scores (Mann-Whitney U Test)

Variable	*n*	Mean rank	Z	Asymp. Sig (2 tailed) *p=<0.05*	Association with GHQ score
Previous sentence	429	332.66	-3.136	0.002	Lower
No previous sentence	272	379.92			
Remanded	132	410.27	-4.045	0	Higher
Not remanded (sentenced)	565	334.69			
Unemployed	322	254.96	-2.506	0.012	Lower
Employed	213	287.72			
History of drug use	614	344.46	-2.200	0.028	Lower
No drug history	86	393.63			
Relationship problems	284	346.38	-4.610	0	Higher
No relationship problems	338	282.19			
Not registered with GP	175	366.95	-2.516	0.012	Higher
Registered with GP	497	325.78			
Ever been in care	216	368.37	-1.481	0.139	Higher
Never been in care	487	344.74			
Learning difficulties in school	215	382.65	-5.218	0	Higher
No learning difficulties	443	303.71			
Left school <16	428	360.07	-1.369	0.171	Higher
Left school >16	275	339.43			
Homeless	39	384.64	-1.186	0.236	Higher
Housed	658	346.89			
Long-term sickness	139	179.47	-0.457	0.647	Higher
Not long-term sick	213	174.56			
Ever detained under the Mental Health Act	27	168.15	-2.085	0.037	Higher
Never detained	249	135.29			

From Table 28 it can be seen that variables associated with social exclusion are widely experienced by prisoners. Analysing the history of drug use variable shows that 614 (71%) of 861 prisoners who returned questionnaires reported a history of drug use, 429 (49.8%) had a previous sentence and 428 left school before their sixteenth birthday. Seven variables produced statistically significant different (asymptotic significance, 2 tailed p=<0.05) mean GHQ scores between the excluded and non-excluded respondents. These variables were: relationship problems, registered with GP, unemployed, previous sentence, learning difficulties in school, history of drug use and ever detained under the mental health act. The

remaining variables all had an association with higher mean rank scores and therefore with higher GHQ scores but not to a level of statistical significance. Table 28 also illustrates the direction of influence upon the GHQ-12 scores and the level of significance of the Mann-Whitney U test results. The direction of influence for the variables relationship problems and not registered with GP, links them with higher mean rank scores and therefore higher GHQ-12 scores. The variables: ever been in care, leaving school before the age of 16, homeless and long-term sickness also showed higher mean scores than their non-excluded comparators, but these differences were not sufficient to be statistically significant. These findings might be considered broadly consistent with the literature linking these factors with social exclusion and, by extension, mental health problems. However the social exclusion variables: previous sentence, history of drug use and unemployed actually showed lower mean scores than their non-excluded comparators. At first sight this reversal of association effect, linking variables associated with mental health problems on the outside, with lower GHQ-12 scores in prison, appears counterintuitive. A more straightforward association between exclusion and mental state might have been expected. There may therefore be hidden factors within the prison setting, impacting upon the mental state of prisoners.

11.3.3. Age and ethnicity variables and association with mean GHQ scores

The selected age and ethnicity variables were tested for association with GHQ scores.

Table 29: Age and Ethnicity Variables and Association with Mean GHQ Scores (Mann-Whitney U Test)

Age/Ethnicity	*n*	Mean rank	Z	Asymp. Sig (2 tailed) *p=<0.05*
Ethnicity white	640	343.60	-3.261	0.001
Ethnicity non-white	61	428.59		
Age under 17	12	366.46	-0.296	0.767
Age over 17	687	349.71		
Age under 21	232	354.27	-0.410	0.682
Age over 21	467	347.88		
Age under 25	410	347.22	-0.451	0.652
Age over 25	289	353.94		
Age over 40	54	353.99	-0.157	0.875
Age under 40	645	349.67		
Age over 60	9	395.83	-0.713	0.476
Age under 60	690	349.40		

Table 29 shows that whilst ethnicity proved to be significant, none of the age related variables approached significance, although there was an increasing divergence between the dichotomous variable mean rank scores for prisoners aged under 60 years and those aged over 60 years, with the older prisoners showing higher mean rank scores.

11.3.4. Offence variables and association with mean GHQ scores

The selected offence variables were tested for association with GHQ scores. Table 30 shows the results when these variables were tested using the Mann-Whitney U Test for association with mean GHQ scores.

Table 30: Offence Variables and Association with Mean GHQ Scores (Mann-Whitney U Test)

Offence	*n*	Mean rank	Z	Asymp. Sig (2 tailed) *p=<0.05*
Violence	246	345.80	-0.860	0.390
Non-violent	462	359.13		
Murder or attempted	33	461.86	-3.216	0.001
Not murder or attempted	675	349.25		
Drugs	174	351.57	-0.226	0.821
Not drugs	534	355.45		
Arson	25	340.50	-0.363	0.717
Not arson	683	355.01		
Burglary and theft	217	343.79	-0.964	0.335
Not burglary and theft	491	359.23		
Non-payment of fines	27	386.63	-0.867	0.386
Not non-payment of fines	681	353.23		
Sexual offence	46	431.32	-2.743	0.006
Non-sexual offence	662	349.16		
Vehicle theft	100	354.66	-0.009	0.993
Not vehicle theft	608	354.47		
Motoring offence	144	354.04	-0.032	0.975
Not motoring offence	564	354.62		
Other	106	366.59	-0.688	0.492
Not other	602	352.37		

Table 30 shows that the majority of offence types had no association with GHQ scores. However prisoners reporting their offence as murder or attempted murder, or a sexual offence had a statistically significant chance of higher GHQ scores.

11.3.5. Prison experience variables and association with mean GHQ scores

The selected prison experience variables were tested for association with GHQ scores. 1 shows the results when these variables were tested using the Mann-Whitney U Test for association with mean GHQ scores.

Table 31: Prison Experience Variables and Association with Mean GHQ Scores (Mann-Whitney U Test)

Experience	*n*	Mean rank	Z	Asymp. Sig (2 tailed) *p=<0.05*
Severe physical health problems	31	417.02	-3.577	0
Not severe physical health problems	587	303.82		
On remand	132	410.27	-4.045	0
Not on remand	565	334.69		
First sentence	272	379.92	-3.136	0.002
Repeat sentence	429	332.66		
<1 month inside	126	399.48	-3.926	0
>1 month inside	553	326.45		
High remorse	161	121.34	-2.100	0.036
Low remorse	69	101.87		
Physically abused by other prisoners	142	411.35	-3.982	0
Not physically abused by other prisoners	563	338.28		
In cell >16 hours	291	369.26	-2.157	0.031
In cell <16 hours	409	337.15		
In cell >20 hours	114	399.75	-2.962	0.003
In cell <20 hours	586	340.92		
Feel unsafe sharing cell	35	244.40	-2.199	0.028
Feel safe sharing a cell	375	200.76		
Limited daily regime	209	395.34	-4.146	0
Constructive daily regime	488	329.15		
Visited by friends and family	589	352.18	-0.055	0.956
Not visited by friends and family	114	351.09		
Visited >1 per week	277	344.06	-0.162	0.871
Visited <1 per week	413	346.47		
Sleep problems	375	452.49	-14.730	0
No sleep problems	327	235.69		

Table 31 shows that prisoners who are: experiencing severe physical health problems, are on remand, serving their first sentence, in prison less than a month, being physically abused, spending more than 20

hours a day in their cell, feeling unsafe sharing a cell, not participating within a meaningful daily regime or experiencing sleep problems showed significant association with the overall GHQ scores. The sleep problem variable is confounded by its inclusion within the GHQ schedule.

11.3.6. Personality variables and association with mean GHQ scores

The selected personality trait variables were tested for association with GHQ scores. Table 32 shows the results when these variables were tested using the Mann-Whitney U Test for association with mean GHQ scores.

Table 32: Personality Variables and Association with Mean GHQ Scores (Mann-Whitney U Test)

Personality characteristic	*n*	Mean rank	Z	Asymp. Sig (2 tailed) *p=<0.05*
Loner	106	429.71	-5.645	0
Not loner	565	318.42		
Trust other people	337	289.66	-6.129	0
Not trust others	328	377.53		
Temper	454	342.06	-0.910	0.363
No temper	220	328.09		
Impulsive	318	344.51	-3.722	0
Not impulsive	318	292.49		
Irresponsible	168	328.52	-0.295	0.768
Not irresponsible	481	323.77		
Worrier	391	409.68	-11.787	0
Not worrier	283	237.78		
Unusually high standards	322	330.63	-0.864	0.388
No unusually high standards	326	318.45		
Dependent on others	74	445.07	-4.464	0
Not dependent on others	625	338.74		
Get on with other people	652	334.89	-5.825	0
Not able to get on with others	37	523.11		

Table 32 shows the association of personality descriptor variables with GHQ scores. Six of the nine personality descriptors showed a statistically significant relationship with GHQ scores. Trusting others and getting on with other people, both showed a statistically significant association with lower GHQ scores.

Loner, impulsive, worrier and dependent on others, all showed a statistically significant association with higher GHQ scores.

11.3.7. Abuse variables and association with mean GHQ scores

The selected abuse variables were tested for association with GHQ scores. 3 shows the results when these variables were tested using the Mann-Whitney U Test for association with mean GHQ scores.

Table 33: Abuse variables and Association with Mean GHQ Scores (Mann-Whitney U Test)

Abuse type	*n*	Mean rank	Z	Asymp. Sig (2 tailed) *p=<0.05*
Physical abuse	142	411.35	-3.982	0
Not abused	563	338.28		
Unwanted sexual attention	17	441.00	-1.880	0.06
No unwanted sexual attention	688	350.83		
Verbal abuse	181	413.98	-4.870	0
Not verbally abused	524	331.94		
Blackmail	43	464.69	-3.868	0
Not blackmailed	662	345.75		
Medication being stolen	15	552.83	-4.004	0
Meds not stolen	690	348.66		
Belongings stolen	26	534.88	-4.837	0
Belongings not stolen	679	346.04		
Taunted due to mental health problems	29	555.33	-5.695	0
Not taunted due to mental health problems	676	344.32		
Abuse due to skin colour	20	376.33	-0.542	0.588
Not abused due to skin colour	685	352.32		

Table 33 shows the results of the Mann-Whitney U test when GHQ-12 total scores are tested against prisoner abuse variables. All of the variables showed a positive correlation with higher GHQ scores. The only variable which failed to achieve the level of statistical significance was the skin colour variable and it was very close to achieving statistical significance. The results of this test suggest that abuse in prison is correlated to a statistically significant level with higher GHQ scores.

11.3.8. Odds ratios

If an epidemiological approach to the statistically significant data is adopted, and it is analysed in terms of odds of exhibiting caseness through an odds ratio calculated against the incidence of caseness (as opposed to a general association with higher mean GHQ scores, as with the Mann Whitney test), within each of the statistically significant variables it is possible to ascertain the correlation between each variable and caseness. Scores of less than one indicate a protective effect against caseness, scores of more than one indicate an association with caseness.

11.3.9. Odds ratios for significant social exclusion variables

Each of the social exclusion variables which had shown a significant correlation with mean GHQ scores was tested using odds ratios.

Table 34: Odds Ratios for Significant Social Exclusion Variables

Variable	***Cases***	***Non***	***OR***
Previous sentence	147	282	0.61
	126	146	
Unemployed	104	218	0.59
	95	118	
History of drug use	228	386	0.59
	43	43	
Relationship problems	138	146	2.15
	104	234	
No GP	77	98	1.35
	182	315	
Learning difficulties in school	112	103	1.24
	22	25	
Ever detained under the Mental Health Act	16	11	1.75
	112	137	

Table 34 shows the odds of exhibiting caseness within each of the social exclusion variable populations. The variables: relationship problems (OR = 2.15), no GP (OR = 1.35), learning difficulties in school (OR = 1.24) and ever detained under the Mental Health Act (OR = 1.75), all display an odds ratio associating

them with caseness. The reversal of association effect identified from the Mann-Whitney U test scores relating to the three variables: previous sentence (OR = 0.61), unemployed (OR = 0.59) and history of drug use (OR = 0.59) can also be seen in this table, with their odds ratios of less than one, indicative of a protective effect and suggesting that these social exclusion variables offer some protective effect against caseness within the prison setting.

11.3.10. Odds ratios for significant ethnicity, offence and prison experience variables

Each of the ethnicity, offence and prison experience variables which had shown a significant correlation with mean GHQ scores was tested using odds ratios.

Table 35: Odds Ratios for Significant Ethnicity, Offence and Prison Experience Variables

Variable	*Cases*	*Non*	*OR*
Ethnic minority	31	30	1.63
	242	398	
On remand	65	66	1.72
	207	358	
First time in prison	126	146	1.69
	147	282	
Less than one month in prison	64	62	1.78
	202	351	
High remorse	78	83	2.31
	20	49	
Physically abused by prisoners	74	68	1.95
	198	365	
>16 hours per day in cell	127	164	1.42
	144	265	
>20 hours per day in cell	54	60	1.56
	217	369	
Feel unsafe sharing a cell	19	16	2
	136	237	
Limited daily regime	100	109	1.76
	168	320	
Murder (or attempted)	21	12	2.66
	254	421	
Sexual offence	25	21	2
	250	412	
Physical health problems	20	11	1
	366	221	
Sleeping problems	236	139	14.04
	35	292	

Table 35 shows that when odds ratios on all groups of prisoners in the categories: ethnicity, offence type and prison experience, showing statistically significant Mann-Whitney U test results, were calculated for their odds of displaying caseness; prisoners reporting sleeping problems were massively more likely (OR

= 14.04) to display caseness. However this finding is confounded as sleep problems are one of the twelve screening questions used in the GHQ-12. Prisoners who had been convicted of murder or attempted murder showed the next most significant score (OR = 2.66) followed by those who expressed high levels of remorse (OR = 2.31), those feeling unsafe sharing a cell (OR = 2), individuals convicted of an offence of a sexual nature (OR = 2), those being physically abused (OR = 1.95) and those spending more than 20 hours per day in their cell (OR = 1.56).

11.3.11. Odds ratios for significant personality descriptor variables

Each of the personality descriptor variables which had shown a significant correlation with mean GHQ scores was tested against caseness using odds ratios.

Table 36: Odds Ratios for Significant Personality Descriptor Variables

Variable	***Cases***	***Non***	***OR***
Get on with others	237	415	0.16
	29	8	
Loner	64	42	2.76
	201	364	
Trust	98	239	0.41
	163	165	
Impulsive	149	169	2.05
	96	222	
Worrier	217	174	6.58
	45	238	
Dependency	43	31	2.44
	227	398	

Table 36 shows the odds ratios for the statistically significant personality descriptors. Trusting others and getting on with other people, both show a protective effect towards caseness evidenced by their odds ratios of 0.41 and 0.16 respectively. Being a worrier was most strongly associated with caseness (OR = 6.58) followed by loner (OR = 2.76), dependency (OR = 2.44) and impulsive (OR = 2.05). These personality factors further strengthen a thesis that socialization and the ability to fit in, is a mediating mental state factor. Personality traits are likely to regulate the extent to which individuals can function within the social milieu of the prison. Individuals who trust and get on with others consequently show lower levels of caseness than do those who define themselves through the terms loner, impulsive, worrier and dependant.

11.3.12. Odds ratios for significant prisoner abuse variables

Each of the prisoner abuse variables which had shown a significant correlation with mean GHQ scores was tested against caseness using odds ratios.

Table 37: Odds Ratios for Significant Prisoner Abuse Variables

Variable	*Cases*	*Non*	*OR*
Physical abuse	68	74	1.95
	365	198	
Unwanted sexual attention	10	7	2
	262	426	
Verbal abuse	95	86	2.16
	177	347	
Blackmail	29	14	4
	243	419	
Medication being stolen	13	2	12.5
	259	431	
Belongings stolen	21	5	8
	251	428	
Taunted due to mental health problems	25	4	11.11
	247	429	

Table 37 shows the odds ratios for the abuse variables which achieved statistical significance according to the Mann-Whitney U Test. Having medication stolen (OR = 12.5) or belongings stolen (OR = 8) massively increased the odds of caseness, as did being taunted due to mental health problems (OR = 11.11). Being blackmailed (OR = 4) was the next most significant finding, whilst being physically abused (OR = 1.95), verbally abused (OR = 2.16) and receiving unwanted sexual attention (OR = 2) all clustered around an odds ratio of 2. All of these abuse variables are linked to caseness. Abuse is likely to be inflicted upon weaker, vulnerable and stigmatized individuals who fall outside of the main social group of prisoners. Abuse is potentially a tangible marker of extreme exclusion within the prison setting.

11.3.13. Discussion of GHQ data

The link between the length of exposure to prison, poorer mental state and adjustment is made within the literature (Gunn 1978, Blanc et al. 2001) and repeated in these findings. This was displayed through

evidence of higher GHQ scores amongst prisoners with no previous sentence and those who had been in prison for less than a month. Variables related to impoverished regime also linked clearly to poor mental state as they also did in the literature.

Novel findings

The linking of the social exclusion variables of unemployment and substance misuse to better mental state do not appear in the literature.

Explanations

Explanations for this reversal of association (linked to worse mental state outside prison and better mental state in prison) include the possibility that the variables: unemployed, previous prison sentence, and history of drug use all have mechanisms which are independently and uniquely impacting upon the prison GHQ scores. There may also be an effect arising from the nature of the GHQ-12 questionnaire, whereby prisoners are responding to short-term improvements in their situation, relieving them of the negative effects of the specific social exclusion factors (e.g. drug use) and thereby producing a beneficial impact upon mental state via lower GHQ scores.

One possible alternative explanation for the GHQ 12 findings is that prison bestows a benefit of a regular lifestyle such as a bed and three meals a day for individuals whose existence may be chaotic and precarious outside prison. However this hypothesis that a simple benefit accrues from a more structured and less chaotic lifestyle does not appear to fit the evidence. Other social exclusion variables resulting in a chaotic pre-prison lifestyle (homelessness for example), fail to evidence a similar significant response to the structured and regular existence, of prison life. With specific reference to prisoners with a history of drug use, it is possible (likely even) that some individuals with pronounced substance misuse problems are responding positively to a more structured and less chaotic lifestyle in prison, resulting in better GHQ scores. However, this doesn't appear a sufficient explanation of the whole protective effect upon mental state. It is difficult to explain why this reversal of association effect only occurs in some of the exclusion variables.

Adaptive socialization-adapted identity hypothesis

Prisoners with the three characteristics: unemployed, previous prison sentence and history of drug use, appear to be responding positively to the prison environment in a way in which prisoners exhibiting other forms of pre-prison social exclusion are not. The explanation adopted in this study proposes that the three social exclusion variables exhibiting the reversal of association, enable entry into the social world of the prison. In effect then, the three variables are socially adaptive, in facilitating assimilation and inclusion into the social world of the prison. However, even with the inferential test results and narrative accounts

supportive of this proposition it would require further research to be able to confirm this finding or identify alternative explanations.

This emergent thesis suggests that adaptive socialization acts through: prison inclusion, development of an adapted identity and protects against vulnerability and poor mental state, and mediates GHQ scores. The adaptive socialization thesis is strengthened by other findings. GHQ data relating to ethnicity, offence type, prison regime, personality and abuse all point towards markers of inclusion yielding lower mean scores and lower odds of caseness. Conversely stigmatization, lack of constructive regime and exclusion yield higher mean GHQ scores and increased odds of caseness. The trends were therefore consistent in both the Mann-Whitney U test, and the Odds Ratio test.

Potential significance

The potential significance of the novel association of the variables unemployed and history of drug use with protective mental state properties, lies partly in the extent to which the converse applies. Prisoners from backgrounds centered upon being employed and no history of drug use are not routinely associated with being linked to high risk factors. However, these data suggest that this population is significantly more likely to experience poor mental state in prison. There are potential implications here for how risk is assessed at reception into prison. Socially included individuals may actually constitute a special group of vulnerable prisoners.

Furthermore, when considered alongside the previous prison sentence finding which is also identified as a protective factor, it appears as though prison lacks a longer-term deterrent effect despite its initially traumatic impact. Moreover prison appears to offer effective preparation for subsequent prison sentences, almost as a logical extension of the excluded, unemployed, drug using life trajectory. This poses a fundamental challenge as to the intended purposes of prison which are effective rehabilitation and preparation for law-abiding lives in mainstream society. Policy makers may wish to consider that prison is part of a wider social dynamic and not isolated from the communities which the majority of prisoners come from and to which they will return. Therefore prison should do no harm to those who are incarcerated, whether those harms are clearly visible results of assault or ostracization or the more long-term effects upon release concerned with stigma and continued exclusion.

11.4. FOCUS GROUP DATA

The focus groups provide a narrative which identifies many experiences as impacting upon prisoners' mental state. The data is arranged thematically and presented below.

11.4.1. First time in prison

Within the literature and within the prisons, first timers are recognised as being especially vulnerable to the pressures and privations of prison especially immediately after reception to prison as these comments testify:

> [Dr] it is a very dangerous period when they come in for the first few days.
>
> [RN] Very, very often the first 48-72 hours can be dangerous.

Prisoners reported how difficult and traumatic the first time in prison could be:

> a young lad come in here the other day. First time in jail... He looked frail ...But what they did they put him on basic [*basic regime with no special privileges*]. He was only on basic for a week and his head went. He thought people were coming to see him in the night and he is not a heavy drug user, he just smokes a bit of dope...he was put in the hospital in the other wing...Now I could see the signs way before this. You could see when you were having a shower or talking to him he looked white as a sheet. You could see it had hit him for six. He's just come into jail, and he is on 24 bang-up.

Reception into prison

Whilst a mental health nurse commented upon the importance of the reception process in picking up problems for first timers:

> [RN(M)] there will be transfers from other prisons and they know the system, ...they know where they want to go and what they want to do. Whereas the new admissions don't and you have to be more formal in-depth assessment then with regards to the mental health issues, drug abuse and alcohol abuse, family backgrounds. So it's a fairly comprehensive assessment that's conducted on admission.

There are many adjustment issues for individuals coming into prison for the first time:

> [RN(M)] the people that come here first time in prison for example, maybe have been living with their parents up until their imprisonment, and now all of a sudden they have to share their cell with someone they haven't met before, they've lost their liberty. Any relationships with others outside have been curtailed or very much limited. They have to face the problems of being separated from children, from their loved ones.

First time in prison summary

Being in prison for the first time was widely acknowledged as being particularly hard. Furthermore the first 48-72 hours, whilst the individual settled into their surroundings and often started their detox programmes, was felt to present a heightened risk of self-harm or suicide. Individuals who know the ropes are able to fit in much more quickly than first timers. It is especially important that anxieties and concerns

are picked up within the reception screening process so that appropriate arrangements can be made. Communication between staff groups is very important. The social experience of prison can make or break an individual.

11.4.2. Self-harm and suicide

Self-harm is common in prison and needs to be understood within the context of individuals feeling dispossessed, vulnerable and powerless. A mental health nurse suggested that:

> [RN(M)] A lot of the time self-harm is used as a sort of, I don't know it's like their biggest sort of shout, is self-harm or suicide... it's like I'm going to harm myself, I'm going to kill myself and I think some of them don't realise what they are saying and have no intentions of doing anything and other people know exactly what they are saying is 'oh I want a few days in Health Care', but the majority it is genuine.

The F2052SH Procedure

The procedure known as F2052SH (or 20;52 for short) for identifying and managing self-harm is adopted by all staff working in the prison. Speaking of the procedure one officer stated:

> [Officer] Well it determines space of watches [observation] basically, so that we go up every, say half an hour and check on the inmate and chat and talk to him if necessary, keep a very close eye on him. He gets reviewed, he gets to see a Doctor straight away obviously, as they all do from the very beginning. So you pick a lot of it up right from the beginning.

Emphasis was placed upon detecting self-harming intention at reception and initiating the 20;52 protocol:

> [Officer] if they mention that they have any concerns...on the self-harm side... then obviously then the review is to open [up a] 20;52.

Managing the risk

Consequently much of the activity of the custody, medical and nursing staff is aimed at identifying and managing the risk of self-harm:

> [Dr] if it is the first time for them to come to this prison...then [*depression*] is a normal reaction, he may get depressed, so we just keep an eye on them. But if it doesn't ease off after a while, their depression, then it is worth treating them after a while after they have been settled down in the prison for a while.

Different professional disciplines within the prison have differing responsibilities whilst a patient is on a 20;52 form, with custody and nursing staff having to carry out half hourly observation and doctors having to review every 24 hours. When commenting upon who raises concern about self-harming prisoners, this nurse commented:

> [RN] anybody, it can be nurse, clerical staff, custody officer, anybody, if they've got concerns they raise a 20;52 to protect the patient.

If during the time that the 20;52 procedure is being implemented, the custody staff become more concerned about the individual prisoner, they are likely to ask nursing staff or the doctor for further review or advice, possibly a move to health care:

> [RN] they [custody staff] carry out half hourly observations, they're not afraid of asking us if they've got concerns...they will come down and have a chat with an RGN or one of the RMNs if possible. If there are any concerns they will pick up the phone straight away.

Once the individual prisoner is deemed to be no longer at risk, they will be returned to their normal location and activities:

> [Dr] they would go back to the wing and we would still keep an eye on them.

However whilst prisoners are on an open 20;52 whilst the procedure is still being implemented, they receive no special treatment with regards to their regime for example a prisoner on basic remains on basic. This means that the individual might spend up to 22 hours a day in their cells, hardly a conducive environment for someone at risk of harming themselves:

> [RN] it's whether or not they can cope [with being locked up for example 20, 21, 22 hours a day], you assess that.

Precipitating events

Some of the pressures leading up to suicide attempts are difficult to identify even for experienced staff:

> [RN(M)] You can never tell, that is the type of pressures that you know, we didn't even know, there were pressures. He was out and about, he was associating with people, he was mixing, it was an ideal situation for us, and we didn't have to check him every 15 minutes 'is he OK?' A lot of people will go under their blankets, hiding, but this chap was fine.

Neither would prisoners always disclose a true account of their mental state or self-harming intent:

> [Officer] if the inmate isn't going to tell me the information I need to support or help him then I'm not going to be able to.

Night-time

The night-time procedures involved when officers respond to emergency calls were commented upon by prisoners and staff, and provide contrasting perspectives of the same topic. First the prisoner:

> I mean somebody could be seriously ill and they might not get anybody for a good half-hour, but in that half-hour a lot can happen.

However some of the safety issues about responding to prisoners at night, which go a long way to explaining slow response times, were explained during one of the staff focus groups:

> [Officer] I have had an incident at...where we had someone supposedly hanging, senior officer on nights has gone straight in and there's been a chap behind the door waiting for him with a chair and he's been literally battered and taken to hospital. So security has to come first I'm afraid, let's hope it never gets to that choice

Self-harm and suicide summary

Much of the staff and prisoner narratives revolved around the issues of self-harm and suicide within prison. These issues were part of the psychological environment of the prisons, not always immediately apparent, but always there as an important consideration. Some members of staff mentioned carrying rope cutting scissors all the time that they are on duty, in the expectation of cutting down prisoners trying to hang themselves. There was a common consensual view shared by staff and prisoners, that within a prison environment over which prisoners have little control, the one remaining aspect of control they do have is the choice as to whether to harm themselves or not. Reception into prison was a particularly important juncture at which to identify vulnerable prisoners who might go on to self-harm. Night-time posed particular problems for staff responding to prisoners on the wings. Prisoners with sleep problems might become acutely distressed during the long night-time lockdown, whilst lower staffing levels and security concerns made it difficult to respond quickly.

11.4.3. Behaviour suggestive of distress

In identifying individuals with mental health problems or generally not coping with the prison experience, staff were sensitive to prisoners' behaviour:

> [RN] People [present] with odd behaviour on the wing. I mean the officers are with them 24 hours a day so they notice the inmates that are acting oddly on the wings. If they seclude themselves, you know.

> [RN] you know, we get reports of people in their cells, talking to themselves. They are behaving oddly.

Changes in behaviour as indicators

Changes in behaviour were felt to be particularly significant and potential indicators of distress:

> [Officer] I have worked all four wings and personally I mean many, many occasions I will come in and someone will say you know he hasn't been out today, it's out of character and suddenly he has gone quiet.

Drug use

Drug use also played a significant part in how individuals presented:

> [RN] they might be quite wild and aggressive even on the outside but once they're in here and off the drugs, they are different people. They come in very aggressive and demanding the drugs, but within two weeks, they are quiet as a lamb.

Behaviour suggestive of distress summary

Staff and prisoners alike both looked out for odd behaviour or changes in behaviour which could alert them to distressed prisoners. The influence of drugs particularly with individuals being received into prison, could dramatically affect normal mood, presentation and behaviour. Staff prided themselves on their ability to get to know their charges and spot signs that all was not well.

11.4.4. Vulnerability in others

Some prisoners felt that they had inside knowledge in being able to recognise fellow prisoners who were thinking of harming themselves:

> You know we do look out for things, but we shouldn't have to...There should be people that the officers should notice ...but they don't because they are naive.
>
> I can see the ones who ain't coping on our wing like...common sense. If a dog is limping, you know it got a bad leg.

Similarly, some prisoners spoke about a communal perception of when things are wrong for an individual prisoner:

> you just see it. Some of them stick out to us... but they [officers] don't really bother...until something happens, then they start running and jumping about.

Staff and prisoners look out for these signs:

> [RN] they tend to tell us they won't come out of their cell. They won't associate.

An inability to deal with the association periods can lead to problems:

> [a willingness to associate] shows you're willing to mix with people...if you don't show you're willing to mix with people everyone will start thinking there's something wrong with you and that's when you start getting picked on, or start getting hassled.
>
> if you're quiet they start thinking that you're scared and it starts building up really. If you don't come out of your cell, they wonder why and when you do come out of your cell, they hassle you

'you're scared of that' and maybe that person will say 'I'm not scared' and they will take that as they are, and they slap you on the back of the head, and it goes on from there really

Staff working within the confines of the juvenile unit were confident of their ability to spot a prisoner struggling with association, although this might be more difficult in other locations within the prison, due to the greater numbers of prisoners:

> It would be very hard for us not to see something [an incident between prisoners] happening. Plus during induction they're informed how to report bullying, methods of reporting, why they should report it, and the bottom line is when they report it it's guaranteed that other people will have reported it before you. If one person reports it it's guaranteed it's reported by others.

Poor copers

Vulnerable prisoners were often referred to as poor copers by staff:

> [Prison officer] I have been 18 months there and I found that there were a lot of poor copers, self-harm, there's a lot more self-harm on the young offenders. They have all got something to prove or they get to a standard on the wing to prove something. There are a lot of issues on the wings.

Those coming into prison for the first time need special monitoring:

> [Prison Officer] they are scared of what's going on around them, the environment and they are suddenly put into a cell and they are weak and they are spotted as weak. Then there's things that go on around us that we don't spot straight away and it sort of develops from there and you notice that they go quite, self secluded and that's when we start picking up and try and get them to cope, but they also don't like to talk to us, they have this impression that it's them and us type of thing and they try and avoid us, so we have to prove to them that they can talk, you need to take time to talk, but on the wings you are too busy to.

Signs of an individual struggling to cope can be either going in on themselves, becoming very quiet, or paradoxically becoming loud and garrulous:

> It's very busy but they come in for a couple of months or whatever, they go all very quiet and sheepish or the opposite they are right loud and brassy and they are the ones to watch as well because they are just putting on a front, you have to be very careful how you deal with them.

> They act out and get very brash, others just stay behind and look at their meal and you have to be careful if they don't come out, then you have to be very careful then.

Vulnerability in others summary

The kinds of behaviour which are held to herald the likelihood of self-harm were articulated by many of the prisoners. The ability to detect and read the signs was almost viewed as a status symbol, and a matter of personal pride amongst some prisoners. It became clear that the association process carried an extremely important social function, and that a refusal to associate was an indicator of vulnerability and

distress. Refusal to associate was known as 'going behind their doors' and this was accompanied by 'going under the blankets' as the most extreme form of withdrawal.

11.4.5. Sex offenders

Prisoners who have committed sexual offences are widely despised and become the targets of vicious attack within prison. A typical attitude was displayed by this prisoner:

> Well these prisoners I have in this wing... [I don't mind]... but not sex offenders.

Some individuals convicted of sexual offences railed against the Sex Offenders' Treatment Programme (SOTP):

> It's a totally voluntary course...because it's barbaric, I've seen what it does to people... you don't ever want to know. You don't ever want to know. It's barbaric and it's disgusting.

Whilst others felt that they should be afforded dignity and respect, just like other prisoners:

> the thing is [we are] sex offenders...but we are still human at the end of the day.

Status and stigma

But it was acknowledged that the status of sex offenders in the prison was that of the lowest of the low, and there was a feeling that they were denied courses and opportunities available to other prisoners:

> They don't know what none of us are in for...I mean there are sex offenders on this wing...I would class myself as bad as that.

> because you're not a sex offender you can get [educational and vocational] courses lined up

The stigma surrounding these types of offenders increases the pressure on the individual prisoner, sometimes with tragic consequences:

> [Prison Officer] we... got a chap in on what we used to call Rule 43, sex offence accused of rape... my immediate summary was 'it's a discipline problem not a medical problem'...Next morning he'd hung himself.

Sex offenders summary

Prisoners who have committed sexual offences are reviled in prison and constitute an especially vulnerable group. There were occasional glimpses into the extent of the hatred the rest of the prison has for prisoners convicted of sexual offences. On one occasion the researcher was locked in the library of one of the prisons with a group of segregated prisoners. These prisoners are often prisoners convicted of sexual offences, removed from the main body of prisoners for their own protection. This group had completed the questionnaire survey and was being returned to their normal location, however due to a

problem with the next group of prisoners arriving early, the segregated prisoners had to be locked in the library. The prisoners in the other passing group banged on the windows, spat and shouted obscenities at the segregated prisoners. Individuals who have committed sexual offences are socially excluded from the mainstream of social life in the prison and physically segregated for their own protection.

11.4.6. Stresses associated with the Criminal Justice System

There was a perception amongst staff that remand populations were likely to feature a higher prevalence of mental health problems than the convicted population who are likely to experience different sorts of distress:

> [Officer] in a convicted environment they develop other problems, they then realise the family situation, they are missing the family, that develops worries and concerns there.

One mental health nurse gave a particularly vivid account of the difficulties faced by a remand prisoner who he had cared for:

> [RN(M)] he's got [15 years to serve] ...by which time his children will be gone from being [young]... they will be teenagers then, he will miss all their development. They will develop without a father figure around and he feels that. He get's quite anxious about it, I don't think, it's actually hit home how long he's going to be here, or how long he's going to be in custody for. It doesn't take long to say 15 years, but it takes a long time to do.

The difficulties faced by this prisoner's relatives in travelling long distances were considerable:

> The pressures it puts on [a serious offence, for prisoner's partner] because [they] don't know where [they are] going to visit. Could it be Long Lartin? Is it going to be Wandsworth? where's it going to be? At least when he's allocated they can sort their own domestic problems out.

<u>Court appearances</u>

Court appearances were acknowledged to be stressful, one juvenile commented:

> not knowing when court appearance will be... could be tomorrow, next day or in a few weeks.

<u>Drug use</u>

Drug use was often implicated within the initial offence and drugs were often used as a means of ameliorating the stresses of being processed by the Criminal Justice System:

> now if I ever don't go to court I always find myself in jail because of...Breach of bail ... I just turn to drugs to cover it

The concurrence of feeling low, court cases building up and drug taking to alleviate the stress was referred to by this prisoner:

> You do feel very low [laughter] You know all these court case building up, petty ones...it gets so much, and you think it's the end of the world don't you...you've got to go back.... Take drugs.

Lack of constructive regime on remand

Periods of remand to prison featured in the narrative:

> I'm on remand I am, I have had no help whatsoever. There's been nothing what they... [*other prisoners talking about educational courses and therapy provision*] [*are*] ...saying. No one has come up...That's what I can't understand nobody sees it from my point of view.

The distress of unfavourable verdicts and harsher sentences than expected took their toll on prisoners and was a frequent catalyst for self-harm:

> [RN(M)] another sort of difficult behaviour are people who are on remand and then they go to court, then they get sentenced and they get a sentence which doesn't go in their favour, whatever, or is not suitable or acceptable, therefore obviously they come back in a state of distress and will often harm themselves often because of that, or because they are back in prison whereas they thought they may have got off...You know obviously then you have to assess them and follow up the 20;52's from there.

Stresses associated with the Criminal Justice System summary

Remand to prison was generally perceived as a difficult time, with its associated uncertainties about further court appearance dates, trial outcomes, sentencing, disposal and allocation. Many accounts of being remanded to prison revealed the paucity of regime experienced by prisoners.

11.4.7. Regime

The regime at HMP Swansea accommodated the needs of remand prisoners to receive unlimited visits:

> [RN(M)] [re; visiting...for remand prisoners it is...] unlimited, daily, and when convicted, in Swansea 2 visits in a month. In another prison it could be one a month, because we are a remand prison.

Generally prisoners were relaxed with the regimes which they experienced and usually those who had been elsewhere were complimentary about HMP Swansea and HMP & YOI Parc, although they often attributed this to solidarity rather than the regime per se:

> there would be no way that sort of jail would be you could relax and fall asleep. Yet here you can. The door is wide open you can it's different jails. Yes so it's more relaxed. Yeah most of us here...off the screws...Yeah you can say what you like. They haven't a clue.

There was a feeling that other prisons offered more opportunities for prisoners to spend their time constructively:

> [I] had a sentence plan in Dartmoor...[I] get transferred down here, like, to visit... so they didn't start me on any courses. Right? But I have been here 10 months now and the sentence plans they give me in Dartmoor... the courses are not here.

Other prisoners at HMP & YOI Parc also felt demotivated at the difficulty of getting onto courses:

> I haven't been on a course yet... I'm not going to get anything out of it see. I'm not going to get my target so there's no point me doing it... I'm supposed to be going on an Anger Management Course for my target and I've only got just over 2 months left and the course has been ...2 months now but I'm supposed to do that to go for my target...I'm next on the list and that was about 2 months ago ...I need that course for my target and they know that I ask them every day, I have asked them this morning again. There's nothing you can do you got to wait for a place. It's just like a losing battle.

Custom and practice

The culture of prison was alluded to by this prisoner who noted the influence that the custom and practice of one generation of prison officers had upon the next generation:

> You know I'm not proud of it but I have done a lot of time. I was in when they closed down Reading, some of the young kids hung themselves...that's some time ago, but I have been in a lot of rough nicks...A lot of places have still got the same regime because it's the old ones [prison officers] learning the new ones. Instead of the new ones being learnt. The new officers being learnt by themselves, the old ones are learning them and it carries on.

A mental health nurse at HMP Swansea observed that prisoners are well catered for at HMP Swansea, to a degree which does not happen on the outside, perhaps throwing some light as to why some individuals might become institutionalised:

> [RN(M)] we do cosset prisoners at Swansea, we cater for their every whim, really, that doesn't happen outside does it?

Regime summary

There was a considerable amount of frustration amongst many prisoners that they did not have sufficient opportunity to undertake courses and receive education or training. Sentence planning was sometimes felt to be weak and courses too few by prisoners, but staff generally seemed to think the opportunities were there if prisoners wished to avail themselves of what was on offer.

11.4.8. Support from other prisoners

There were examples of prisoners who stated that they would never cooperate with the authorities in any capacity. This mindset is reflected within this brief excerpt where one prisoner enquired into the access which the prison officers had to the data:

> The screws definitely don't hear this do they?

Discipline staff reported a not entirely altruistic motivation for reporting a prisoner suspected by other prisoners of having a mental health problem:

> [Officer] A lot of prisoners don't like other prisoners with mental health problems. But they know if someone causes a problem they know they are going to be locked down while we deal with that problem, so they try to help in that way and avoiding these situations developing.

Prisoner staff cooperation

However they would sometimes be tipped off about individuals' difficulties and that element of cooperation could help to thaw the sometimes strained relationship between prisoners and officers:

> [Officer] they mention to us they give us [a] nudge like it's all to do with how they start respecting us as well, because they get to know us a bit better and so on. They will start a rapport with the wing cleaners and those sort of people that are out all the time so you look after them and they sort of keep you informed of what's going on the wings and they keep an eye on it.

Nursing and medical staff reported how they would sometimes receive information about prisoners whom their friends were concerned about. There may also be a sense in which the nurses were not as closely identified with the custodial and discipline elements of the regime:

> [RN] sometimes they will say they (prisoners) are concerned about someone else.
>
> [Dr] especially someone that has been depressed or suicidal they will be reported quicker.

Support from other prisoners summary

Prisoners are not noted for their tolerance of others with mental health problems, sometimes referring to them as Fraggles. Consequently, places of treatment for mental heath problems inside prison are referred to as Fraggle Rock. However there is also a culture of looking out for your mates, and sometimes asking for assistance on their behalf or reporting that they were experiencing problems. Even this caring kind of overt cooperation with the authorities is frowned upon by some prisoners. Other prisoners seemed intent on avoiding formal support mechanisms and utilising informal, prisoner to prisoner support only.

11.4.9. Summary focus group data

This section summarises themes which emerged during the focus groups and repeats quotations presented previously. A significant association between poorer mental state and sexual offences reported within the prisoners' survey data can be contextualised by accounts such as this, which allude to the inhuman treatment meted out to sex offenders:

> the thing is [although we are] sex offenders...we are still human at the end of the day.

The importance of the social support shared between some prisoners also emerged, with many prisoners preferring to keep things between themselves on an informal level rather than seeking help from staff:

> We chat amongst ourselves you know. We get to know each other, we all have everyday problems...you know like with family...wives ...we all know if we have a bad day or a good day. You know we take the good with the bad.

Such support was based upon being able to trust other prisoners:

> They are a good bunch of boys on this wing.

The existence of a nexus of problems was also apparent within the narratives of staff and prisoners. Problems often interacted upon other areas of experience and added to the overall difficulties faced by the individual:

> [I felt] low sometimes, when you run out of money and everything is going west and you've sold half the house, the dog...sold the dog for half a crown...you've got to... take drugs

> [RN(M)] [it is] very common for them [prisoners] to have...drug use, psychological problems, emotional problems, family problems, depression, adjustment difficulties, the whole range of mental health illnesses like schizophrenia, depression.

Vulnerability, identity and prison inclusion

The themes of vulnerability, identity and prison inclusion within the analysis of the prisoner survey data has some resonance with data which emerged from the focus group narrative. The focus group narrative continues to identify the problem nexus faced by prisoners but in this chapter has focussed more on: the impact of being in prison for the first time, reception into prison, the experience of being remanded to prison and the importance of association as specific stressors. The extent to which there was a social hierarchy within the prison was apparent from the references to, and personal accounts from, that most reviled of groups; individuals who had committed sexual offences. This narrative strand perhaps best exemplifies the emergent thesis that socialization or prison inclusion may be the mediating mental state factor in prison. It was apparent that little tolerance was shown towards this group and that they were universally despised. Opportunities therefore to participate within the mainstream of prison life, in effect to be included, were denied these individuals. This would also be true of those deemed mentally ill or in some other way vulnerable to an extent which took them beyond the informal support networks predicated upon prisoner to prisoner support.

Emerging themes

The study anticipated a strong focus upon the social conditions of prisoners. The study was also designed to explore the nexus or interconnectedness of problems, and examine how these factors influenced mental state in prison. Similarly, the conditions of imprisonment were of central concern to the study. As the study developed some further foci emerged including: the constructs of vulnerability, (Purdy

2004, Spiers 2000) and identity. The concept of a prisoner being vulnerable enabled thematic continuity within the study. For example, particular factors which predisposed the prisoner to poor mental state in prison could be interpreted within a vulnerability continuum, rather than be seen as isolated events. However, it was felt likely that this specific form of vulnerability linked in with other vulnerabilities, both inside and outside prison. The literature suggested prisoners experience multiple vulnerabilities, each of which impacted upon and compounded others, potentially resulting in poor mental state in prison. Vulnerability therefore acted as a linguistic and conceptual conduit linking the range of variables examined and informing the enquiry into mental state in prison. The concept of vulnerability became a consistent theme within the study.

Identity

In addition to examination of social background factors impacting upon prisoners, the immediacy of the prison environment with its own unique interpersonal and environmental stressors and dynamic forces, was of interest to the researcher. It was felt that these environmental factors were liable to impact upon pre-existing vulnerability factors through the individual's prison experience. As a result of the literature review, the issue of identity (Reicher and Haslam 2002, Haslam and Reicher 2003, Economic and Social Research Council 2006) suggested itself as being of utility in making sense of factors which might mediate mental state. Identity might amount to the extent that the individual prisoner internalised the external influences, and regulate the extent to which the individual could cope with the prison experience. Notions of identity (which are later discussed in relation to a possible prison group identity and an identity dynamic relating to the effect which imprisonment exerts upon individuals post-release), figure within a range of social problem areas that have been identified as a government priority (Economic and Social Research Council 2006). However, identity fails to figure significantly within the mental health related prison literature.

Belonging within the focus group data

In addition, the focus group data emphasised the importance of prisoner to prisoner support and resonated with the socialization thesis within a narrative of mutuality, identity and belonging. There was a measure of anecdotal evidence to support the theory that a sense of belonging or inclusion was essential to getting by in prison. Some prisoners related that they turned to individuals they knew in prison, for the inside knowledge and support which they needed. Some prisoners reported an easy familiarity with prison, such that they might be characterised as revolving door prisoners. Returning prisoners could expect to have a ready-made peer group within which they could immediately settle, which in turn might be expected to benefit mental state. It is possible that more prisoners with the three reversed social exclusion variables possess a ticket to admission into the prevailing mores, values, customs and attitudes which define prison culture.

11.5. STAFF SURVEY RESULTS

Sixty staff responded to a verbal or written request to complete a questionnaire. The first section dealt with factors which staff believed would influence mental state in prison.

11.5.1. Staff opinions: Influences upon mental state in prison

The results from the staff survey are summarised in Tables 38-40.

Table 38: Staff Opinions: Influences Upon Mental State in Prison

Influence	Mean score	Rank order
Spend 20 hours or more in cell	1.47	=1
Experience intimidation	1.47	=1
Unconstructive regime	1.70	3
Taking drugs before prison	1.82	4
Been in care	1.95	5
Anti-social personality	1.97	6
Educational attainment	2.02	7
Convicted for a sex offence	2.08	8
In prison for less than one month	2.47	9
On remand	2.40	10
Previous prison sentence	2.52	11
Employed before prison	3.32	12
Expressing remorse	3.35	13

Table 38 shows that staff viewed taking drugs before prison as amongst the most damaging influences upon mental state in prison, whilst they believed that coming from an employed background was a relatively protecting factor as it was ranked last but one of the factors. The factor ranking least damaging was expressing remorse. These findings suggest some discrepancy with the analysis of the GHQ data where previous drug use was actually found to be a protective factor and previous employment was found to be a pathological factor. The finding in this survey that expressing remorse was considered to be the most protective factor in the available options, also ran contrary to the GHQ data which showed a correlation between remorse and poor mental state.

11.5.2. Service development priorities

Staff were given a menu of service development options to prioritise. Table 39 shows the results of this part of the survey:

Table 39: Staff Opinions: Service Development Priorities

Potential Development	Mean score	Rank order
Develop alternative to prison	4.58	1
Improve screening and diagnosis	4.34	=2
Improve care management	4.34	=2
Greater sharing of info and multi-agency work	4.33	4
Transfer to NHS of disturbed patients	4.32	5
Training and support	4.28	6
Development of inreach/outreach	4.20	7
More creative regime	4.17	8
More user focussed care	4.00	9
Better functioning across and between prison depts	3.98	10

Table 39 shows that staff saw the development of alternatives to prison for mentally disordered prisoners as the top priority for service development. This reflects the literature which suggests that there remains a shortage of medium secure hospitals (Coid et al. 2001) which might offer such an alternative. The next priorities were improved screening and diagnosis and improved care management. These priorities reflect national initiatives such as the introduction of improved screening tools at reception into prison (Birmingham et al. 2000) and the introduction into prison of the Care Programme Approach via inreach teams (HM Inspectorate of Prisons 2007). There was recognition of the need for greater sharing of information between agencies and the difficulty of transferring patients from prison to hospital (Reed 2003, HM Inspectorate of Prisons 2007). Provision of training and support for staff, development of inreach and outreach teams and more creative regimes were the next priorities. The cultural shift that would see users more active within their care was a lowly ninth ranked priority. The lowest ranked priority was felt to be better functioning across and between prison departments.

11.5.3. Staff opinions: priority client groups

Staff were provided with a list of distinct client groups within the prison population to prioritise. Table 40 shows the results of this part of the survey:

Table 40: Staff Opinions: Priority Client Groups

Client Group	Mean score	Rank order
Psychotic	4.54	1
Dual diagnosis (psychosis and substance misuse)	4.41	2
Suicide	4.34	3
Complex needs	4.25	4
Substance misuse	4.14	5
Vulnerable	4.00	6
Dangerous to others	3.91	7
Post-traumatic stress disorder	3.90	8
Neurotic	3.49	9
Social needs	3.39	10

Staff felt that psychotic prisoners were a clear priority followed by those with a dual diagnosis of psychotic illness and substance misuse. Suicidal prisoners were third in the list of priorities (possibly reflecting a sense that a lot of measures are in place for suicidal individuals), followed by individuals with complex needs. This categorisation of a client group is one which was devised for this study, given the interlinking of problems and mental state which emerged from the literature and other parts of the data, rather than a term which is used routinely within services to identify a discrete client group. Next came substance misuse, vulnerable prisoners, dangerous prisoners, those experiencing post-traumatic stress disorder and neurotic prisoners. The lowest priority was afforded to those with social problems.

11.5.4. Staff survey: Discussion

The staff questioned in the staff survey thought that coming from an employed background and not using drugs would be protective factors amongst prisoners. This ran contrary to the findings from the GHQ-12 data and suggests the role that the social environment of the prison has in mediating mental state is under appreciated, and that the atypical (previously employed, non drug user) group may be hidden within the prison and harbour significant levels of undetected morbidity and unmet need.

The staff prioritised those prisoners with psychosis and a dual diagnosis of psychosis and substance misuse for service development. These priorities are exactly those of the inreach mental health teams now operating within the two prisons. In the literature inreach mental health teams are reported to be having some success in targeting prisoners with serious mental illness and introducing the Care Programme Approach process which should ensure regular review and treatment in prison and follow-up

on release. However they are severely constrained by a lack of funding (Kmietowicz 2006). Prisoners with social problems were felt to be the lowest priority amongst client groups, a finding which might simply reflect a perception that once in prison, social problems are someone else's problem. This perception however, may hint at the dysfunction of a criminal justice system which dislocates an individual from the environment from which they came and to which they will inevitably return.

11.6. SUMMARY

From analysis of the GHQ data, a number of biographical factors were found to be correlated with higher mean GHQ scores to a level of significance. These included: remand or no previous sentence, coming from an employed background, no drug history, experiencing relationship problems, not being registered with a GP, having learning difficulties in school and a history of being detained under the Mental Health Act (1983). A white ethnicity was correlated with lower mean scores. The offence variables murder or attempted murder and sexual offence were associated with caseness. Factors such as: having been in prison less than one month, high remorse, physically abused by other prisoners, in cell more than 16 hours per day, feel unsafe sharing a cell and limited daily regime were also associated with higher mean GHQ scores. When these variables were tested using the epidemiological odds ratio test for association with caseness, they were found to perform similarly and correlate to caseness. Personality variables, loner, not trusting others and worrier (amongst others) were also found to correlate to higher mean scores and caseness. Prisoners often felt that the first time in prison was hard especially for quieter individuals, whilst some prisoners were able to identify others who were not coping with prison life and who were at risk of self-harming. Self-harming behaviours were accepted as part of the environment and appeared to acquire special meanings related to the power dynamics of prison. Prison staff were found to not recognise some of the correlated factors with poor mental state. A theory focussed upon adaptive socialization and adapted identity is proposed as being protective of mental state in prison.

CHAPTER 12

DISCUSSION OF FINDINGS

12. DISCUSSION OF FINDINGS

12.1. INTRODUCTION

This study triangulated a wide range of data perspectives utilizing multiple methods, in order to identify factors mediating mental state in prison and to set those findings within a lived experience. In this chapter: the findings are restated in relation to other studies, propositions arising from the data are formally stated and an adaptation theory involving both socialization and identity is proposed.

12.2. RATIONALE

Within the study a number of findings have been developed through analysis of the data and are set out in Table 41 with reference to the literature. The central finding was that better mental state was associated with both being unemployed pre-prison, and having a history of substance misuse (the two typical variables). This finding was unexpected and unprecedented within the reviewed literature. It led to a consideration of these two typical variables alongside a further typical variable, that is having had a previous sentence and led to a proposition that a process of adaptation involving both socialization and identity was protective of mental state in prison. Further survey evidence relating to personality type, focus group data relating to the importance of belonging and prisoner to prisoner support plus data from a BBC website identifying hostility from the public towards prisoners, could also be interpreted as revealing how a dynamic in which an adaptive prison specific process could occur. This chapter discusses and considers the significance of the study findings and particularly the adaptation theory.

12.3. SUMMARY OF KEY LITERATURE AND FINDINGS

There has been a resonance between the literature and much of the data elicited within this study, a number of themes have featured prominently.

12.3.1. Summary of key literature

The health problem nexus of communicable disease, substance misuse and mental health problems amongst prisoners is linked to their socially excluded backgrounds (Watson et al. 2004). Prisoners present with a complex range of health and social need reflecting excluded backgrounds. However, morbidity often goes undetected in prison (Birmingham et al. 1997), whilst multiple health and social need are poorly targeted in prison and risk not being addressed post-release (Williamson 2007). Health status generally is acknowledged as a key contributor to, or constraint upon, quality of life (Ormel et al. 1997). Perceived stress (Ben-Sira 1984) and poor health, particularly chronic forms of illness (Pollock and Duffy

1990) are shown in the community literature to act as factors potentiating poor mental state, within a vulnerability based formulation of mental health (Zubin and Spring 1977). Outside prison, support (Kawachi and Berkman 2001) and personality variables (Haines and Williams 1997, Scheier and Carver 1987) are likely to mediate responses to stress. It is likely therefore that the individual prisoners actual and perceived health status, along with their available social support networks and personality type, will impact upon their mental state.

Prison life can involve spending a lot of time banged-up in a cell without a meaningful daily routine and often living in fear of a cellmate or of other prisoners. Furthermore, whilst confinement cheek by jowl with one's assailants is one of the pains of imprisonment, it may be inconsistent with any rehabilitative purpose. O'Donnell and Edgar (1999) cite fear as a common prison emotion as a result of witnessing or experiencing assault and verbal abuse which are commonplace in prison. Blanc et al. (2001) and Elger (2009) identify adjustment to prison as problematic, with sleep disorder (44%) as a common presentation, symptomatic of not coping within the prison environment. Blanc et al. (2001) also note social isolation and a heightened emotional response upon entry into prison. Self-harm is a culturally specific and mainstream practice in prison and suicide is far more common than outside prison (The Howard League for Penal Reform 1995). Prison environments lead to institutional roles (Haney et al. 1973) and shared identities (Haslam and Reicher 2003, Reicher and Haslam 2002). Some vulnerable individuals are reviled (Matravers and Hughes 2003) and ostracized. A collective social existence is therefore, available to many, but not to all.

Mental state is further determined by the interaction of biological, personality, psychological and social factors (Jenkins and Shepherd 1996). The individual's narrative, or their experience and understanding of their own life story as a summation of these factors, is central to mental state at any juncture (Barker 2001). The experience of prison is usually a subplot within each prisoner's narrative, rather than the main story itself. Family relationships, friendships, the social worlds of the individuals and their ambitions and aspirations usually continue and reside beyond the confines of the prison (Hardt 1997). These experiential factors form the backdrop to the lived experience of prison and also exert an influence during imprisonment. However whilst in prison, it is the social world of the prison itself which is the immediate crucible against which mental state is forged.

12.3.2. Summary of findings

Amongst the prisoners surveyed using the GHQ-12 tool, a number of dichotomous variables were associated with poor mental state. These included being on remand and being in prison for the first time. A beneficial association was found between having had a previous sentence and mental state. Two unexpected atypical beneficial associations with mental state were identified, being unemployed prior to

prison and a history of drug use. Other variables related to: anti-social personality, sexual offences, lacking a meaningful day and abuse in prison had significant associations with poor mental state.

Within the focus group data, crime was part of a lifestyle, either chosen or seemingly enforced. There was a clear sense within the narrative in which the offending social world of many individuals seemed to trap them into an offending future by a combination of: socialization, drug use, dependence, lack of alternatives and familiarity. The shared nature of pre-prison experience emerged through the focus group narrative, indicating life courses set upon negative trajectories. The prisoner narrative was replete with how individuals expected their lives to be adversely affected by doing time. In recounting their lives outside there was a strong sense of the temporariness of many of the lives. Jobs, possessions, money, drugs were all to be enjoyed now as there was no expectation that they would be there for long. This nexus of problems, particularly when combined with drug use and the stresses of the Criminal Justice System, seemed like fertile ground for the development of mental health problems. The prison narrative also gave many examples of the importance which prisoners placed upon group identity through the camaraderie which they experienced in prison, and the extent to which they would depend upon and look out for each other rather than the listeners, prison officers or any service provided by the system. The staff survey indicated that influential variables (employment before prison, non-drug use, social problems) were under appreciated as risk factors by staff.

The survey and focus group data identified high levels of repeat sentences, drug use, unemployment, relationship problems and having histories of being in care and educational problems. The data from the focus groups identified multiple factors which contributed towards the offences leading to imprisonment. Often these problems included: a lack of money, drug habits which needed funding, chaotic lifestyles, relationship problems, poor earning prospects and were often compounded by being impulsive and getting into fights. The prison community consists of individuals with elements of shared experience and some common values. This milieu establishes the backdrop to mental state in prison.

The staff survey suggested that staff may have alternative working constructs for interpreting the mental state of prisoners. The BBC data portrayed public attitudes which were often punitive and harshly judgemental of prisoners (Zimring and Johnson 2006), possibly consistent or indicative (Coomber 1997) of prevailing social attitudes and mores. The emphasis in this data was upon the retributive nature of prison rather than upon restorative properties. The much smaller number of contributors towards the more specialist discussion regarding restorative justice programmes per se were far more liberal and sympathetic towards the needs of prisoners. The BBC data suggests that prisoners are stigmatized (Schwartz and Skolnick 1962, Haney 2008), and are likely to face prejudice from mainstream society upon release, which is likely to limit employment and other social opportunities. Public opinion appears to be intolerant of prisoners multiple needs and may therefore present an obstacle to prisoners reintegration

into society and is a potentially aggravating factor in perpetuating exclusion, offending and poor mental state.

12.3.3. Adaptation hypothesis

The prisoner survey suggests a hidden influence mediating mental state in prison. This influence is suggested within the GHQ-12 data when subject to the Mann-Whitney U test for association with mean GHQ score, by the reversal of association surrounding the three variables (previous sentence, drug use and unemployed) identified with social exclusion, and by extension with poorer mental health outside prison, but with better mental state in prison. The GHQ findings are borne out by the odds ratio test for association specifically with caseness. The previous sentence, drug use and unemployed variables may offer some protection against: vulnerability; constitute markers of adapted identity; be socially adaptive and offer a ticket to prison inclusion. The constructs of prison inclusion, adapted identity, social adaptation and vulnerability are proposed as a description of constructs through which the mediating phenomena acts. The survey data suggests some linkage between the descriptive constructs of vulnerability, prison inclusion and identity with; ethnicity, regime, personality type, offence and abuse. These links are also supported by the Mann Whitney and odds ratio data analysis. The deleterious effect of prison upon vulnerable prisoners is evident within the tested GHQ abuse variables, whilst some of the narrative also identifies both the benefits of belonging or being included within prison as a protection against the pains of prison life. The data supports a hypothesis that adaptation, both in terms of socialization and identity, exerts a protective influence upon mental state in prison.

There is further evidence to support the adaptation theory within the personality variables data, which suggests that personality characteristics facilitative of social interaction and interpersonal competence such as being trusting and the ability to get on with others, are protective against caseness and associated with lower GHQ scores. Conversely, characteristics which might be likely to inhibit social interaction, or make relationships more difficult as defined by the variables worrier, loner, dependency, and impulsive, are associated with caseness and higher GHQ scores. Similarly, the evidence that a limited daily regime, which would limit prisoners' chances of association due to lengthy periods of time in their cells, add further credence to the theory. The findings suggest that inclusion within an adaptive prison group identity acts as a mediating factor for prisoners' mental health. In effect social exclusion outside prison, typified by three exclusion variables (previous prison sentence, unemployment and drug use), may be necessary for social inclusion and by extension better mental health inside prison. From these findings the central proposition of the thesis is developed. Acceptance within the cultural and social life of the prison appears to be the most significant factor in determining mental health within the prison environment. This will be referred to as the adaptive socialization theory. Conversely, the findings suggest

that atypical prisoners from non-sentenced, employed, non-drug using backgrounds, may possess a hidden degree of morbidity, significant levels of unmet need and difficulty 'fitting in' to prison life.

12.4. KEY FINDINGS

Key findings from the study are outlined in Table 41 and referenced to the literature. The fourth column, index to paragraphs, links each finding (sometimes broken down further into components numbered in superscript) to paragraphs within the thesis where the discussion relevant to the finding occurs. The sources of evidence (column 3) are shown below:

Sources of evidence for Table 41

(i) Woolf Report
(ii) 2002 HMP & YOI Parc and HMP Swansea survey
(iii) 2002 Audit of HMP & YOI Parc and HMP Swansea medical records
(iv) 2002 HMP & YOI Parc and HMP Swansea focus groups
(v) 2004 Prison and community staff survey
(vi) 2005 HMP Swansea health needs survey
(vii) 2006 BBC data

Table 41: Key Findings With Reference To Data Sources And Literature

The Statement	The Literature	Data	Index to Paragraphs
Prisoners experience a criminogenic problem nexus[1], linked to a common social background[2], which links generally to health problems[3], mental health problems[4] and a specific profile of prisoner related health problems[5]	[1]Foster 2000, Martin 2001 [2]HM Inspectorate of Prisons 2007, Social Exclusion Unit 2002, Foster 2000, De Viggiani et al. 2005, Carr and Vandiver 2001, Carrabine et al. 2002, Corner 2004, Home Office 1997, Williamson 2007 [3]Department of Health and Social Security 1980, Joseph Rowntree Foundation 2000, Acheson 1998 [4]Department of Health 1999, Howard League for Penal Reform 1999 [5]Novick et al. 1977, Potts 2000, Watson et al. 2004	i, ii, iii, iv, v, vi	[1]1.1.6, 2.3, 2.4, 2.6.1, 5.3, 5.3.1, 6.3, 6.6, 6.6.1, 7.3, 9.8 [2]1.1, 2.1, 7.7, 8.5 [3]2.7, 7.6 [4]1.1, 2.3, Ch's 5, 6, 10&11, Tables 7&9, 7.7.1, 8.5.8, 8.6, 9.4, 9.7 [5]1.1.2, 1.1.3, 5.5
Prisoners experience an incentive to subscribe to an adapted prison identity[1], whilst coping generally (not specific to prison) can be influenced by personality type and social support[2], there is evidence to suggest that this is also true of prison[3], with the adapted identity possibly based upon masculinity[4]	[1]James 2003, Haney and Zimbardo 1998 [2]Ben Sira 1984 [3]Michel 2005, Tajfel and Turner 1986 [4]Mills 2003, De Viggiani 2003	i, ii, v, viii	[1]4.6, 4.7, 6.5.2 [2]5.2, 5.5, 10.6 [3]Belonging 9.7, 11.4.9 social world of prison 3.2, 6.5.4, 10.6
Prisons are unsuited to working with the scale of complex problems	HM Inspectorate of Prisons 2007, BBC News 2007, Howard League for Penal Reform 1995	i, ii, iii, iv, v, vi	1.1.5, 7.3
For some prisoners prison regimes continue to be impoverished[1], which is likely to negate mental health[2] especially for remand prisoners[3], first time and newly received prisoners[4], whilst prisons remain under researched in relation to prisoners' mental health[5] and the lived experience of prisoners[6]	[1]Newell 2001, Farrant 2005 [2]Nurse et al. 2003 [3]The Aldridge Foundation 2008, Shaw 2000 [4]Gunn et al. 1978, Blanc et al. 2001 [5]University of Oxford [6]Liebling 1995, Caraher et al. 2000	i, ii, iv	[1]1.1.5, 3.8, 6.4.4, 10.4.1, 10.6 [2]1.1.5, 7.6 [3,4]3.2, 5.4, 5.5, 6.5.3, 6.6, 11.3.13 [5]1.2, 7.3 [6]1.1, 1.1.4, 1.2, 7.6, 7.7.1
Most prisoners go on to reoffend[1] and there are problems with prison linking effectively with community based agencies[2]	[1]Home Office 2004, Wilson 2005 [2]Lart 1997 and 1998, Vaughan 2000, Welsh Assembly 2001 and 2005, Hafal 2005	i, iv	[1]1.2, 2.3.2, 2.7, Tables 7-9, 7.3, 9.4.1 [2]1.1.5, 3.5, 3.9, 3.10, 6.4, 8.9.2, 9.7.5, 9.7.9, 9.8, 10.5.12, 10.6, Tables 7,8&39
Prison is especially deleterious to mentally vulnerable individuals[1], who fall outside the mainstream prisoner identity and fare badly in prison[2]	[1]Matravers and Hughes 2003 [2]Mills 2003, The Howard League for Penal Reform 1995, James 2003	i, ii	[1]Table 7 [2]1.1.4, 3.5, 3.10, 4.2, 4.4, 4.5, 4.5.1, 4.7, 4.9, 5.4, 6.4.1, 6.4.3, 6.4.4, 6.5.3,
Society is unforgiving, censorious and hostile to ex-prisoners and imposes further sanctions on prisoners post-release	Zimring and Johnson 2006	iv, vii	1.1.2, 1.1.5, 2.3.1, 8.8, 9.4.4, 9.4.5, Tables 7&8

The statements in Table 41 are further summarised and incorporated within recommendations made in Table 42, at 13.2 in Chapter 13.

12.4.1. Discussion of adaptation theory

Notions of socialization are predicated upon further notions of self and identity, all of which are staples of both the sociology, psychology and social psychology literature. The adaptive socialization theory posits that admission to the social world of the prison depends upon possession of an acceptable adapted identity, that is an identity deemed acceptable to the majority of the prison population, based upon markers of social exclusion and offence. The extent to which the self forms in relation to groups has been a main theme of this literature. Goffman famously outlined a chameleon type theory, proposing that the self alters in relation to the need to fit in (1969), an idea also found within the work of George Simnel (Wolff 1950). Individuals who deviate from social and cultural norms are always to be found, although there is no simple explanation for their deviance, rather 'a series of competing and contradictory visions of the nature of people, deviation and the social order' (Downes and Rock 1998. p.1.).

The self and identity

The individual inhabits a distinctive world of lived experience, necessarily involving others with whom the self comes in to contact with (Kidd 2003). Giddens discusses the extent to which the self reflexively monitors its social environment and subtly shifts and changes its structure in response to the environmental stimuli (Abbot and Chignell 1995, Craib 1994) in order to maximise adaptation. Within Giddens' conceptualization, the self is an evolving, rather than static entity, and one where the individual's biography, culture and social environment combine to impact upon the experience of self identity (Giddens 1984, Cohen 1994). In this way, individuals socialized within offending backgrounds and prison settings may come to define themselves through these experiences. Furthermore they may strongly identify with others who have had similar experiences and use offending, criminality and prison as reference points within their world and self views. Notions of identity have application to a wide range of social problems. Issues pertaining to prisoner identity warrant further enquiry given their effect upon mental state and recidivism. Research on identities and culture are identified as a priority in the government's plan for scientific investment for 2004-2014:

> Identity issues impact on the work of policy makers, national and local government, non-governmental organisations, practitioners in identity related fields and charities seeking to support those with troubled identities.
>
> Economic and Social Research Council 2006

The prison population may experience particular institutional determinants upon their self identity. For example older prisoners may face challenges related to aging within the confines of an institution, and the

absence of the shared experiences of peers outside. Whilst LaMere et al. (1996) develop an argument specific to older prisoners, arguably all prisoners face challenges related to:

> loss of family, employment, and sexual identity. His sense of autonomy is threatened by loss of self-selective behaviours, personal possessions, and privacy.
>
> LaMere et al. 1996 p.25

Traumatic experience, such as sexual abuse or (male) rape, which are more common within prison populations, are also likely to have negative effects upon identity (Rentoul and Appleboom 1997).

Group influences upon identity

There are well documented historical precedents which illustrate the importance of identity. The dehumanising effects of concentration camps were purposely used to weaken self and group identity, but such attempts were not always successful due to the strong bonds and coping mechanisms developed by inmates (Michel 2005). It was in the light of post-holocaust Europe that social psychology as a discipline was born, in an attempt to understand how and why the population of Germany could have come to support such a patently inhumane regime. A leading academic within this movement was a Polish Jew, Henry Tajfel. Theories of group identity reviewed by Tajfel (Tajfel and Turner 1986), propose a shared sense of awareness, such as belonging to a community defined by nationality as being a necessary pre-condition of identity and group formation. Groups then define themselves as much by those who are excluded as by those who are included. Furthermore he proposed psychological and health related benefits were attached to belonging to the prevailing group identity. Tuckman (1965, 2001) in his seminal thesis on group process cites the importance of social norms in shaping the forming stage of group development. Belonging to the group may mitigate against other hardships or privations in prison and promote an improved mental state. The protective nature of belonging may also be a factor with the finding that remorse is linked to poorer mental state. This finding poses fundamental challenges to the nature of imprisonment, where some reflective process on the part of the prisoner, and expression of remorse might be seen as a desirable even necessary function of imprisonment. However if remorse mitigates against belonging, there may be strong incentives not to be remorseful, such as retaining group membership.

Problems with the adaptation theory

The adaptive socialization identity theory proposes a benefit from three variables associated with social exclusion (previous sentence, unemployed and history of drug use), which is contingent upon them acting as tickets to inclusion within the social world of the prison. That is not to say that when accompanied by variables pertaining to trauma or abuse that they are sufficient of themselves to equate to better mental state. The theory precludes the possibility that individuals reporting these variables are responding positively to the prison environment, in a manner which is unique to each variable, rather than due to the

combined socializing effect. There is also the problem of the GHQ scores being dependent upon a judgement as to what constitutes usual. Using the 0, 0, 1, 1, scoring system, higher (worse mental state) scores are achieved for functioning at levels negative in comparison to usual. The GHQ scoring system guidance sets the past two weeks as being the threshold. Therefore prisoners are likely to be setting their GHQ scores wholly within the period of confinement. Nevertheless the fact remains, that for prisoners reporting the variables unemployed and/or history of drug use, also report better mental states than their socially included peers. This finding was unexpected as it runs contrary to the literature regarding social exclusion and mental health in the community (Department of Health 1999).

12.4.2. Adaptation theory and the purpose of imprisonment

The prison milieu may potentially undermine the rehabilitative aim of custody, by promoting and reinforcing an identity consistent with continued social exclusion and reoffending. Herein lies a fundamental problem for the prison service, given that potentially perverse incentives may exist for conforming to the prevailing prisoner culture, in the shape of admission to the social world of the prison. Reform of the individual, the aim of the official regime, therefore runs counter to the informal prison culture. Authoritarian regimes, predicated upon dichotomies of right and wrong and centered upon discipline and security seem likely to strengthen cultures centered upon a socially excluded and offending identity. This in turn may link with, and substantiate the popular association of prisons as universities of crime (Clarke 2005). Alternatively, and often more distressingly, some groups and individuals continue to face exclusion within prison. These vulnerable individuals may be typified by those who have committed sexual offences, or possibly those who experience a limited regime with little opportunity for association or constructive activity. Exclusion within prison is associated with poorer mental state, and higher incidence of self-harm.

Some characteristics of prisoners and their crimes also appear to have a link with worse mental state. Age does not appear to have a relationship with mental state. Ethnicity, sexual offences, murder and attempted murder are related to poorer mental state. There are particular problems for those inside for the first time and non-white prisoners, who in this study were a very small minority grouping, with limited opportunities of association, religious and cultural expression. Factors linked with adversity in prison appear to have a more straightforward association with poorer mental state. These factors include being new to the prison environment, being confined in a cell for more than 16 hours a day, not participating in constructive activities and being bullied/not feeling safe. Generally the theme of adversity seems relevant to the mental state of the prisoner. Those who have experienced traumatic antecedents to prison (as opposed to broad indicators of social exclusion) and those experiencing adverse aspects of prison life appeared to have higher GHQ-12 scores. Other groups fairing badly were those new to the prison

environment either by virtue of first sentence or recent arrival, those convicted of murder, attempted murder or sexual offences.

12.5. SUMMARY

An adaptive effect involving shared pre-prison socialization via a prison identity is proposed as being the critical mediating factor acting upon prisoners' mental state. This adaptation theory proposes that prison is either a contextually specific adaptive experiential process, or a maladaptive experiential process. The adaptive outcome is based upon social inclusion within prison, where mental state is maintained within a protective but 'deviant' penal culture, and an offending identity. The maladaptive outcome is based upon deleterious experience. Within the maladaptive outcome exclusion outside prison is further compounded by isolation, stigma, vulnerability and exclusion in prison, leading to poorer mental state and often self-harm or suicide. Neither of the adaptive or maladaptive outcomes appears promising in terms of prisoner re-entry into society. The first maintains mental state by reinforcing an identity defined by criminality, the second is defined by exclusion within prison at the expense of mental state, characterised by isolation, vulnerability and self-harm. For all these individuals, prison appears to act as a gateway to continuing social exclusion, and acts as a portal to limit life chances. These findings have implications for penal policy, the practice of imprisonment and specifically for the design of regimes and services aimed at promoting mental well-being amongst prisoners. In the final chapter conclusions are drawn and recommendations made.

CHAPTER 13
CONCLUSIONS AND RECOMMENDATIONS

13. CONCLUSIONS AND RECOMMENDATIONS

13.1. INTRODUCTION

This chapter draws together the conclusions from the study and proposes recommendations. The recommendations are set against an imperative to conduct further research into prisoner adaptation, to provide evidence based services to promote and maintain the mental health of prisoners, and to contribute more effectively toward their re-entry into society.

13.2. CONCLUSIONS

Conclusions from the study are drawn from known and unknown findings.

13.2.1. What the study found that we already knew

This study illustrated the scale and nature of prisoners' problems. Prisons are faced with a near overwhelming level of complex problems which are often implicated within offending behaviour. Multiple vulnerabilities are presented by prisoners, many of which are compounded by the experience of imprisonment. For example opportunities for maintaining employment, relationships or tenancies are all compromised by prison. The resultant fracture which prisons inflict upon life courses, further limit and reduce opportunity, and the individual's capacity to function within mainstream society. Prisons appear capable of only mitigating against the worst extent of this fracture, rather than addressing issues in a situationally direct and contextually specific manner.

13.2.2. What the study found that we did not know

Mental state, via socialization and identity, appears to be an important factor in determining the experience of prison. In this study poor mental state in prisoners was linked to specific problematic antecedents (no GP, relationship problems, learning difficulties in school, detention under the Mental Health Act, rather than broad indicators of social exclusion), and also to low prison status, hardship, abuse or exclusion within the prison environment. Re-entry into society for all prisoners is accompanied by negative and censorious public attitudes, and is fraught with risks of continuing exclusion, mental health difficulties and reoffending. This 'vicious circle' dynamic appears to implicate social processes within prison. Prison may serve to reinforce an adapted prison identity based upon social exclusion, offending and status in prison. This adapted identity appears protective of mental state in prison, but may not contribute towards the reformative mission of prison, nor equip individual prisoners with the necessary skills, confidence, opportunities or 'social capital' to function effectively upon re-entry into society.

A summary of the issues relating to prisoners' mental state in the light of the findings from this study follows in Tables 42 and 43.

Table 42: Findings and Recommendations

Finding	Note	Recommendation
Prisoners exist within a criminogenic problem nexus.	The multiplicity of offending, substance misuse, behavioural and social problems is immediately apparent from the literature and contact with prisoner groups.	Early targeting and intervention with families and individuals criminogenically at risk.
Prisoners experience an incentive to subscribe to a socially adapted prison identity, based upon social exclusion, substance misuse and offending.	This socially adaptive identity appears to be protective of mental state in prison, but not to assist re-entry into society.	Further research should address the nature of prisoner identity and its effect upon mental state, rehabilitation and reoffending.
Prisons are unsuited to working with an almost unmanageable scale of complex problems.	Prisons compound many of the problems already faced by prisoners. Prisons function as a default social care agency. Prisons fracture life courses.	Appropriate services and models of working with offender- prisoners need development and commissioning.
Prison mental health care and treatment need to engage effectively with each individual prisoner.	Care and treatment still adhere to a largely medical nosology, are constrained by security considerations and are not sufficiently oriented to psychosocial domains or individual need, whilst insufficient links exist to external welfare and care agencies.	Psychosocial constructs need inclusion in professional training, tools and care delivery. Prisoner involvement within care plans is imperative and district services need to link to prisons.
Prison design (both environmental and regime) is not sufficiently focussed upon social adaptation either internally or externally societal re-entry.	Elements of historically punitive, and isolating regime characteristics, alongside security considerations, define regime and therefore prisoner experience.	Sentencing policy and penal custody require rethinking and redesigning, whilst community based alternatives need resourcing.
Health, especially mental health, is not central to regime.	Mental well-being is viewed as a function of health care rather than a central mission of imprisonment.	Mental well-being needs to be reflected throughout each regime.
Prison is especially deleterious to mentally vulnerable individuals who fall outside the mainstream prisoner identity.	These individuals are less likely to experience a constructive sentence, and are more likely to experience poor mental health, self-harm or suicidal behaviour.	Alternative disposals must be developed for these individuals and will necessitate expansion of NHS secure units and other services.
There is inadequate preparation for release, given that release is a critical juncture for the life experience of the individual prisoner.	Prisons and other agencies only mitigate against the fracture which prison imposes upon the life course. Services are not sufficiently available to prisoners following release, are not referred on to, do not accept referral or do not consider offender-prisoners as within their remit.	Sentence planning must develop a person centred, re-entry approach as a coherent operational focus, and be adequately resourced inside and outside prison.
Society is unforgiving, censorious and hostile to ex-prisoners and imposes further sanctions on prisoners post-release.	The dynamic of the problem nexus, and hostile public attitudes towards prisoners, makes successful re-entry into society more difficult and increases the likelihood of continued exclusion, mental health problems and reoffending.	The government should consider how this form of prejudice can be legislated for and addressed.
There is an atypical group of prisoners with hidden morbidity and need.	Staff do not appreciate the significance of the unique atypical exclusion markers within prison (coming from an excluded social background).	Staff working with prisoners and offenders require specific evidence based training and preparation.

The idea of an adapted identity being a protective factor for those included within the social world of prison might be summarised with three outcome descriptors as outlined in Table 43:

Table 43: Identity – Outcome Descriptors

Before prison	Inside prison	Prison mental state outcome
Socially excluded identity before prison	Socially included adapted identity inside prison (socially adaptive)	Better mental state
Socially excluded identity before prison	Socially excluded identity inside prison	Poorer mental state
Socially included identity before prison	Socially excluded identity inside prison	Poorer mental state

13.3. RECOMMENDATIONS

The prisoner elicited data from this study was drawn from only two prisons. It would, therefore, be unwise to generalise extensively solely on this basis. Local factors in other prisons, such as the greater number of prisoners from minority ethnic backgrounds, or regime differences may significantly alter aspects of the prison dynamic. However there was much in the data from this study which was consistent with the literature. The recommendations are therefore proposed in so far as the data and literature are consistent or that the novel findings may prove significant following further enquiry.

The doctrine of 'less eligibility' which historically condemned prisoners to a lower standard of care than that which is provided to his or her peers through the NHS is now being openly challenged through reforms to health care provision within The Prison Service. These are issues which the current policy of ensuring equivalent standards seeks to redress (Department of Health, HM Prison Service 2001). With the NHS taking full responsibility for commissioning and managing prison health services from April 2006, service developments in prison have started to reflect service models and developments in community settings. Whilst baseline data now exists for the general prison population in terms of prevalence norms further work should be undertaken to elicit the needs of specific groups, such as older prisoners, ethnic minority and overseas prisoners, as well as vulnerable prisoners.

The scale of social problems amongst prisoners indicates much work needs to be undertaken with individuals and families at risk of criminogenesis, and with children at risk of being socialized within excluded or criminalised social structures and identities preparing them for offending. Work also needs to be undertaken to raise the profile of social problems within sentence planning, and to better link prisons

with social care agencies. Unified service structures possibly centred upon the National Offender Management Service might enable commissioning purchasing models which cater for prisoners' social needs especially at the point of release.

Service provision for individuals with serious mental illness needs expanding and better resourcing. Much of the mental health morbidity in prison appears to be specific to the interacting dynamic of the prisoner's background, the stresses of the Criminal Justice System, and the unique context of the individual's imprisonment. Reactions to the cumulative effect of these factors though severe may not fall within the 'serious mental illness' criteria prioritised by in-reach teams or community services. There is therefore a requirement for a comprehensive primary care model of assessment and treatment of mental health problems, development of psychological approaches to care and treatment, and also a wider health promoting duty for the totality of the prison regime. Services also need to be targeted at those with self-harming behaviours and suicidal ideation, based on an assessment and triage model, similar to that adopted within community practice, to bridge the gap between primary and specialist services (Sawyer 2007).

An enhanced primary care model such as that described by Chapman et al. (2004), is now being applied within some prison settings. Such a model consists of a multi-professional health care team working within the community context of the prison, delivered on the prison wings and in residential locations, rather than limited to a health care centre. To implement this model the health care team work in an integrated way with the rest of the multidisciplinary (non health care) staff to develop a broad holistic approach to care. Partnership working between local health organisations and prisons is also of vital importance. The essential elements of the primary care model in prison are the same as in the community and include services such as GP primary care services, nurse led triage, chronic disease management, community mental health services, substance misuse programmes, health promotion, self-harm management, and out of hours services. It has been suggested that case management approaches (Patrick et al. 2006) can be utilised to promote modern service patterns. Such models have found mainstream application in the care of mentally disordered persons in the community and might also be applied within prison settings.

In prisons, access to prison hospital beds may inhibit the development of health care, and this in turn makes it difficult to manage health problems. It has been suggested that case management approaches (Patrick et al. 2006) can be utilised to reduce dependency upon beds whilst higher levels of care can be provided by a day centre service. For patients with severe psychotic mental illness, transfer to NHS facilities must be available.

The deeply institutional culture of prison itself may impede and resist the introduction of change. What is likely to be as important as improved procedures or service design, is a fundamental cultural change in promoting prisoners as stakeholders within the prison environment, enabling them to help manage and take responsibility for their own safety, mental health, drug use, general rehabilitation, and preparation for release. Maintaining closer links in prison with family, friends and community may offer a moderating influence upon prison culture. Local community prisons have been proposed as a way in which remand prisoners and prisoners on sentences of less than four years can be helped and supported by family friends and community throughout the prison term, whilst receiving input from local statutory (health and social care) agencies, and voluntary agencies (Clarke 2005). Such a model should ensure resettlement, aftercare and rehabilitative services are more easily coordinated. The fact remains that prison is ill-equipped and ill-placed to deal with either the scale or nature of prisoners' problems. It often makes things worse, and is particularly deleterious to prisoners deemed vulnerable and those who have mental health problems. The primacy of security and punishment as constructs which shape prison regimes runs counter to a focus upon individual need. The primacy of these constructs is particularly damaging to individuals who require care, treatment and empowerment rather than punishment, custody and ostracization. The development of more community based alternatives to custodial sentences is recommended.

13.4. FINAL THOUGHTS

There is a dissonance between the purpose of prison, the experience of prison, and its outcomes. The historically punitive and retributive functions of custody appear to compromise opportunities for rehabilitation, fail to promote mental health, and are not consistent with successful societal re-entry. These punitive functions clash with the 'capacious social service' function referred to in the literature. The ambiguity around prison role and function, combined with inadequate resource provision both in terms of prisons themselves, and interlinking community based agencies, together significantly constrain prison regimes. These constraints, in turn, are deleterious to prisoners' mental state, whilst many prisoners enter prison with pre-existing mental health problems. Managing the shortcomings of the prison system, however, is a broader project than just altering penal policy or incremental modification of regimes. Addressing these shortcomings would require: working with public opinion towards prisoners; a fundamental re-modelling of criminal justice, health and social care policies; designing services around a case management approach to offenders' problems; greater use of community alternatives to custodial disposals; and the application of a restorative model of justice. The parallel processes of sentence planning and care planning within prison need to be integrated within a case management structure which is firmly focussed upon reintegration of the individual within mainstream society, and not 'success' within a prison environment.

In Wales it is possible that the Welsh Assembly Government may take increasing responsibility for prisons from the Home Office. This would provide an opportunity to rethink penal policy in Wales and develop more alternative disposals. A model of 'regional purchasing' of prison places, as with specialisms in health care which are commissioned through the Health Commission Wales organisation, might facilitate a more responsive, constructive and integrated range of disposals, and enable management of prisoners' problems within a broader spectrum of public service provision. As a range of low and medium secure services for mentally disordered offenders develops across Wales, and services to address personality disordered individuals are both pending and beginning to be developed, such a reform of prison services appears strategically consistent with these initiatives. Purchasing of prison places would enable a far more needs led approach, would enable the offending behaviours of individuals to be addressed, and would therefore further develop the public protection agenda which is driving service development within other public services. The National Offender Management Service in Wales may be the logical agency to take a lead and coordinate strategic planning processes. Recent developments in policy and practice, relating to health care in prison and sentence management, have the potential to better address the nexus of problems relating to the health, social and behavioural problems of prisoners. Developing regimes which directly involve and engage the individual prisoner is an immediate challenge facing the service, although the deeply institutional culture of prison itself may impede and resist the introduction of change. Furthermore, overcrowding remains a major obstacle in moving towards both humane and health promoting conditions generally, and individualised prisoner health care specifically. Further research opportunities exist across all of these policy and service areas.

The database containing the 2002 HMP & YOI Parc and HMP Swansea data, is so extensive, that further examination of the data could yield fresh insights into many aspects of the health and social status of the prisoners. Professor Pamela Taylor (Professor of Forensic Psychiatry at the Wales College of Medicine, Cardiff University, and Visiting Professor at the Institute of Psychiatry, King's College London) is utilising this database to examine in more detail the effect of substance misuse on prisoners' mental state. The importance of adaptive socialization in prison, within an adapted socially excluded, offending and prison identity, appears to have fundamental repercussions for criminal justice policy, prison practice and reoffending, and constitutes a priority for research. Similarly, the existence of an atypical group of prisoners with heightened but hidden levels of mental health morbidity and unmet need is a finding which invites further examination. Furthermore, the consequences of prisoners belonging to an out group, along with the effects of segregation upon identity and mental state, also merit further research. The difficulties in promoting prisoner responsibility and self-efficacy, particularly in relation to dealing with social problems, self-administered care, and mental health care, within regimes predicated upon discipline and control, would also be amenable to research through interview or focus groups. With the exception of the proposal concerning self-efficacy, these additional research questions could be developed, at least in part, through the existing data. This could be undertaken via regression analysis of the GHQ-12 data, but

all would be best approached through a triangulation of this existing data with collection of further narrative data.

13.5. POSTSCRIPT

'In the round' this thesis reflects the criminogenic backgrounds from which many prisoners are drawn. From the focus group data, multiple social disadvantage clearly plays a significant role in the trajectory taking individuals into offending lifestyles. This appears an easy enough statement to make and is found throughout the literature. Understanding why the lives of many individuals from the same backgrounds do not take the same offending trajectories therefore appears an equally critical project. The thesis specifically proposes an adaptation theory, namely that a process of adapted identity and adaptive socialization mediates mental state in prison. This was a finding that was neither anticipated nor initially looked for. It was in the process of learning about statistical tests that an initial review of the variables linked to social exclusion (as a discrete and manageable sub-set of 657 variables) started to throw up the reversal of association with the history of drug use and unemployed variables. This was contrary to expectation and started the researcher down the adapted identity and adaptive socialization line of enquiry. Whilst there does not appear to be any literature addressing quantitative prison data in the same way as this study, or drawing the same conclusions, as I have come to the end of the study I have become aware of other literature (Butler 2006) and research which has analysed the culture of prison and generated relevant theory qualitatively. This literature describes the enclosed separateness of the prison environment, its hierarchical and punitive *raison d'etre*, and its masculinist milieu predicated upon toughness (Mills 2003, De Viggiani 2003). Against such studies this thesis may find its proper context, and contribute a combined epidemiological and narrative perspective.

Participation in the research has felt immensely challenging, especially the requirement to understand the statistical data. Equally demanding has been the sheer scale of managing this wide-ranging PhD study part-time over seven long years. There were three or four barren years when I was unable to make the links between data sets, understand the statistical tests, cope with my workload, devote sufficient time to my studies, get anything at all written down, or generally see any constructive end point. It was at these darkest moments that I had to take ownership of the study and pull it up by its bootlaces. With hindsight I would change aspects of my preparation for research, and the study itself, particularly strengthening the link between data sets and questions concerning segregated prisoners as a sub-population of special interest. Perhaps the greatest challenge though has been my own lived experience of association with the prisons, the prisoners and those who work in all the prisons I have had contact with. I have enjoyed a special and privileged access to these closed institutional environments and continue to be deeply affected by the experience. Getting prisons right is a reformative mission of importance, not just for those

incarcerated or the victims of their crimes, but as a fundamental issue of social justice which affects all of us.

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Appendix a

Early Outline of Study (2003)

Is there an identifiable psychosocial profile amongst prisoners vulnerable to mental health problems?

Intent

- **Create a psychological/social profile of prisoners experiencing mental health problems in prison.**

Step One.
Divide the prison population into groups of those with mental health problems and those without.

Binomial scoring of GHQ via a threshold or cut off point (say 3 or 4). Transform, recode existing multiple variables into new binomial variables

Step 2.
Run frequencies of factors against these 2 groups
Cross tab.

Exact profile still to be determined
Profile by

- Length of time served
- being in care
- school leaving age
- employment status
- Number of visits received
- Type of offence
- Extent of remorse
- Sleep pattern
- Substance misuse
- Experience in prison
- Mental health history
- Personality type
- Self-harm
- Voice hearing

Discussion

If the profile is predictive it might inform assessment tools or procedures. The profile might allow some weighting of factors routinely assessed at reception to enable

- **further assessment**
- follow-up

Ideally we might be able to further sub-divide the problem group into those with long-standing problems and those who have had problems since coming into prison. In this way prison specific variables might be identified.

Further questions

Are any of these factors significant?
Are any of these factors predictive?
Could profile lead to improved screening tool, or process.

Nic Bowler. October 2003

Appendix b

Ethical Approval for Data Collection at HMP & YOI Parc and HMP Swansea (2002)

Morgannwg
Health

LOCAL RESEARCH ETHICS COMMITTEE
Chairman : Mr Scott Pegler - Drug Information Pharmacist
Secretary : Mrs Nicola John - Consultant in Pharmaceutical Public Health
Administrator : Miss Lawmary Champion
Direct Telephone : 01792 - 607416

41 High Street, Swansea SA1 1LT
41 Stryd Fawr, Abertawe SA1 1LT
Tel: (01792) 458066
Fax: (01792) 607533
WHTN: 1780
Internet: http://www.morgannwg-ha.wales.nhs.uk

Your ref / Eich cyf:

Our ref / Ein cyf:
2002.022

Enquiries to / Holwch:

Direct Dial No. / Rhif Deialu Union:
Lawmary Champion
Extension 7416

Mr N Bowler & Dr Ceri Phillips
Lecturer and Senior Lecturer
School of Health Science
University of Wales Swansea
Singleton Park
SWANSEA SA2 8PP

20/01/03

Dear Mr N Bowler & Dr Ceri Phillips

2002.022 Prison Mental Health Needs Assessment Swansea & Bridgend

The Local Research Ethics Committee of Iechyd Morgannwg Health, approved the above study. I would be grateful if you would provide the information required on the enclosed form.

It is a requirement that you keep the Committee informed of your Study and your response will give vital information about ongoing research in the County, as well as providing feedback on this Committee's activities.

Your reply by return of post would be very much appreciated but, if this is not possible, we would ask for your response at the latest by **25th February 2003**, (using the enclosed envelope). Many thanks.

Yours sincerely,

LAWMARY CHAMPION
ADMINISTRATOR LOCAL RESEARCH ETHICS COMMITTEE
Encs.

LOCAL RESEARCH ETHICS COMMITTEE

Appendix c

Participant Information and Consent Form for Prisoner Survey (2002)

Parc and Swansea Prisons Mental Health Needs Assessment

You are being invited to take part in a research study. Before you decide it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with fellow prisoners, relatives and the health care staff if you wish. Ask us if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part.

Consumers for Ethics in Research (CERES) publish a leaflet entitled 'Medical Research and You'. This leaflet gives more information about medical research and looks at some questions you may want to ask. A copy may be obtained from CERES, PO Box 1365, London N16 0BW.

Thank you for reading this.

1. What is the purpose of the study?

To identify the type of stresses psychological problems and mental health issues that prisoners may have.

2. Why have I been chosen?

As at the time of the study we are hoping to involve all prisoners in the two prisons being studied, Parc and Swansea.

3. Do I have to take part?

"It is up to you to decide whether or not to take part. If you do decide to take part you will be given this information sheet to keep and be asked to sign a consent form. If you decide to take part you are still free to withdraw at any time and without giving a reason. This will not affect the standard of care you receive".

4. What will happen to me if I take part?

You will simply be asked to fill in the research questionnaire, which will ask questions about your offence, whether you have ever had any mental health problems and how well you are coping.

5. What do I have to do?

If you agree to take part in the study you will be asked to complete a questionnaire, and also consent to allow your medical records in the prison to be audited. We will keep a register of prisoner numbers in order to enable us to track who has and who has not taken part in the

study but this is only to allow the researchers to keep track. You do not have to take part if you do not want to. There will be no punishment of any kind for not agreeing to take part.

6. What are the possible benefits of taking part?

It is hoped that the information provided will lead to more services being provided to respond to the mental health needs of prisoners. We hope that the information we get from this study may help us to treat future prisoners with mental health problems better.

7. What happens when the research study stops?

The information from the study will be put into a report by the University of Wales Swansea. The report will be shared with the prison managers and health care teams in order to see how things could be improved.

8. What if something goes wrong?

If you are harmed by taking part in this research project, there are no special compensation arrangements. If you are harmed due to someone's negligence, then you may have grounds for legal action but you may have to pay for it. Regardless of this, if you wish to complain about any aspect of the way you have been approached or treated during the course of this study, the normal Prison Service complaints mechanisms are available to you.

9. Will my taking part in this study be kept confidential?

All information that is collected during the course of the research will be kept strictly confidential, and will not be traceable back to you. Any information about you which leaves the prison will have your name and address removed so that you cannot be recognised from it. If you consent to take part in the research your medical records may be inspected by the researchers. Your name however, will not be disclosed outside the prison.

10. What will happen to the results of the research study?

A report will be compiled by the University, identifying where services could be improved.

This will be given to the prison managers and health care teams. No individuals will be identified in the report.

11. Who is organising and funding the research?

The Welsh Assembly has provided funds to Iechydd Morgannwg Health Authority to undertake this research.

12. Who has reviewed the study?

The local ethics committee of Iechydd Morgannwg Health Authority has reviewed this project and made recommendations as to how it should be carried out in such a way as to safeguard prisoners interests.

13. Contact for further information

For further information please contact Richard Benson, c/o the Healthcare Department, Parc Prison.

Thank you for reading this information, and should you decide to do so, for taking part.

- *Original and copy of consent form to be signed, copy to prisoner*
- *Copy of Information Sheet to prisoner*

CONSENT FORM

Centre Number .....

Study Number
2002.022.....

Title of Project **Parc** **Prison,** **Mental** **Health** **Needs** **Assessment**.....

Contact Telephone No .....

1 **I confirm that I have read and understood and the information sheet**

dated.....

for the above study and have had the opportunity to ask questions ☐

2 **I understand that my participation is voluntary and that I am free without my medical care or legal rights being effected** ☐

3 **I understand that sections of any of my medical notes may be looked at by responsible individuals from ( ) or from regulatory authorities where it is relevant to my taking part in research. I give permission for these individuals to have access to my records.** ☐

4 **I agree to take part in the above study**

Date .....**Signature**.....

Date .....**Signature**.....

Date .....**Signature**.....

Appendix d

Prisoner Survey Questionnaire (2002)

What are we trying to find out with this questionnaire?

Questionnaires filled in by prisoners last year showed that there is a major problem with mental health amongst inmates.

This questionnaire is designed to find out how many of you need and want to get help with any kind of mental health problem, and why you need help so that the right help is available to you.

We are also trying to find out if the prison is helping prisoners with their problems now, and if not, what recommendations can we make to the prison to change and improve the way they help you.

What are mental health problems?

Mental health problems can mean anything from emotional problems, depression, anxiety, a nervous breakdown, panic attacks, stress, behavioural problems, eating disorders, mental illness due to drug or alcohol abuse, self-harm and suicide attempts. Mental health problems are far more common than most people realise. For example, one in four people suffer from depression in this country. However, a fear of being labelled 'mentally ill' often results in people not seeking the help they need.

Background Information

1. How old are you? (years)

2. How would you describe yourself?

☐ Bangladeshi ☐ Black African ☐ Black ☐ Black Other
☐ Chinese ☐ Indian ☐ Pakistani ☐ White
☐ Other - please write what.....

3. How long have you been at Parc ☐ or Swansea ☐ prison? (Please tick the prison you are in)

Months/years.....

4. Are you.....convicted ☐ or on remand ☐ (Please tick which)

5. If you have been convicted, how long is your sentence?

Months/years.....

Section A Background behaviour

- Life before coming to prison
- Problems during childhood
- When you are released from prison
- History of offending behaviour

Before coming to this prison

The next set of questions are to find out where people lived and what people were doing before coming into this prison.

1. Before being in prison this time, who did you live with?

- ☐ With a partner
- ☐ With your partner and children
- ☐ With others
- ☐ With your parents in your family home
- ☐ Alone
- ☐ As a single parent with your children only
- ☐ Homeless
- ☐ Living in Bed and Breakfast
- ☐ Other.....please write what.....

2. Which area of the country, to the nearest town, did you live in before coming into this prison?

Please write here..

3. In the month before you came into this prison were you....

- ☐ Employed
- ☐ Self-employed
- ☐ Unemployed
- ☐ In full time education or training
- ☐ Retired
- ☐ Unable to work due to long-term sickness or disability

4. What job were you doing in the month before coming into this prison?

- ☐ Manual work such as Labourer, Doorman, etc....
- ☐ Office work such as computer operator, call centre.
- ☐ Skilled trade such as Bricklayer, Carpenter, Electrician,
- ☐ Manager of a branch or team of people.
- ☐ Professional such as a Teacher, Doctor, etc....

5. If you were unemployed before coming into this prison, tick the box which most applies to you below?

- ☐ Had casual jobs for a few months in the year before
- ☐ Was unemployed for up to one year before prison.
- ☐ Was unemployed for more than one year.

Problems during childhood

The following questions are to find out how many people had problems that were hard to deal with while growing up and may still be causing problems now.

6. At what age did you stop attending school?

☐ 13 or	☐ 1
☐ 1	☐ 1
☐ 1	☐ 1

7. If you left school before the age of 16, why did you? Tick as many boxes as you need.

- ☐ Did not have any real problems with school, it just had nothing
- ☐ Had problems and clashed frequently with your teachers and other authority figures at school and you wanted to leave
- ☐ Had to leave school to get a job and earn money because there was no one
- ☐ Wanted to leave school and earn money even though you had
- ☐ School left you depressed and miserable and you just wanted
- ☐ Found school work hard and had little help from your
- ☐ You were expelled or excluded from school
- ☐ Had a serious illness
- ☐ Other...please write wha

8. What kind of school did you go to?

- ☐ Local state comprehensive school
- ☐ Special Education Needs School
- ☐ Private Boarding school

9a. Did you have learning problems at school?

☐ Yes ☐ Don't know ☐ No *If NO, please go to QUESTION 10.*

b. Did you have any of the following learning problems at school?

- ☐ Problems with reading, spelling, writing, speaking,
- ☐ Problems with basic maths.
- ☐ Major problem with writing, putting letters together and writing in a straight line.
- ☐ Problem with co-ordinating your movements, find sport very difficult.

c. If you ticked any of the boxes in the list, did you have any help to deal with your learning problems at school?

☐ Yes ☐ No

10. If you did not receive any help at school, would you like help to overcome problems with reading/writing or any other kind of education or training if it was available? Please tick yes or no.

	Yes	No
Inside prison		
Outside prison		

11a. Were you ever in care?

☐ Yes ☐ No

b. If YES, how long were you in care for? Weeks/months/years.....

12. Did any of the following happen to you when you were growing up? Tick as many boxes as you need.

- ☐ Parents were unable to cope due to their own problems such
- ☐ Parents or brother/sister died.
- ☐ Had a brother or sister that was seriously ill.
- ☐ Parents were unable to cope due to your behavioural
- ☐ Sexual abuse
- ☐ Violent physical abuse
- ☐ Other...please write what.....

When you are released from prison

The following questions are to find out how much help you might need to settle back into your community.

13. When released from prison who will you live with?

- ☐ With a partner
- ☐ With others
- ☐ Alone
- ☐ Homeless
- ☐ Don't know
- ☐ With your partner and children
- ☐ With your parents in your family home
- ☐ As a single parent with your children only
- ☐ Other.....please write what....

14. Which area of the country, to the nearest town, do you intend to live in when released?

Please write here..

15a. Do you expect to be homeless?

☐ Yes ☐ Don't know ☐ No *If NO, please go to QUESTION 16*

b. If you expect to be homeless on release (or if you don't know), why are you going to live in that area?

- ☐ Area you grew up in
- ☐ Know the area – but did not grow up
- ☐ Know people who are likely to help you
- ☐ Want to stay away from the people that helped to get you into
- ☐ Do not want to go back to the area where you committed your
- ☐ Other....please write what.....

16. Are you registered with a doctor in the area you intend to live in?

☐ Yes ☐ No ☐ Don't know

The next set of questions are about your offence(s) NOW and in the PAST

17. What offence/alleged offence(s) are you in prison for NOW? Tick as many boxes as you need.

☐ Violent offence	☐ Murder or attempted murder	☐ Drug offence
☐ Arson	☐ Burglary/ theft	☐ Non payment of fines
☐ Sex offence	☐ Theft of a motor vehicle	☐ Motoring offence

☐ Other...please write what.....

18. How do you feel about the offence(s) you committed **this time**?

Please tick yes or no.

	Yes	No		Yes	No
Guilt			Don't care		
Unlucky			Shame		
Regret			It was not your fault		
Don't feel anything			Other.....please write what		
Acceptance					

19a. Have you been ever been **imprisoned** for any other offences in the PAST?

☐ Yes ☐ No *If NO, please go to QUESTION*

b. If yes, what type of offence(s) have you been **imprisoned** for in the PAST? Tick as many boxes as you need.

- ☐ Violent offence
- ☐ Arson
- ☐ Sex offence
- ☐ Murder or attempted murder
- ☐ Burglary/ theft
- ☐ Theft of a motor vehicle
- ☐ Drug offence
- ☐ Non payment of fines
- ☐ Motoring offence
- ☐ Other…please write _____

20. Have you ever been on any of the below in the PAST……?

- ☐ Probation
- ☐ Community service
- ☐ Youth custody

Using the table below, we would like to know **how you were <u>feeling generally</u> in the two weeks leading up to the time of your current offence/alleged offence.**

21. Can you remember how you were feeling generally during the two weeks leading up to your offence/alleged offence?

☐ Yes ☐ No

22. Read each question below carefully and the answers that follow each question. Please answer ALL of the questions below by circling the answer you think most applied to you at that time.

For example, if you were not having problems concentrating you might circle the answer '*same as usual*.

Had you been able to concentrate on whatever you were doing?	*Better than usual*	*Same as usual*	*Less than usual*	*Much less than usual*

Had you been able to concentrate on whatever you were doing?	Better than usual	Same as usual	Less than usual	Much less than usual
Had you lost much sleep over worry?	Not at all	No more than usual	Rather more than usual	Much more than usual
Felt that you were playing a useful part in things?	More so than usual	Same as usual	Less useful than usual	Much less useful
Felt capable of making decisions about things?	More so than usual	Same as usual	Less so than usual	Much less capable
Felt constantly under strain?	Not at all	No more than usual	Rather more than usual	Much more than usual
Felt you couldn't overcome your difficulties?	Not at all	No more than usual	Rather more than usual	Much more than usual
Were able to enjoy your normal day-to-day activities?	More so than usual	Same as usual	Less so than usual	Much less than usual
Were able to face up to your problems?	More so than usual	Same as usual	Less able than usual	Much less able
Had been feeling unhappy and depressed?	Not at all	No more than usual	Rather more than usual	Much more than usual
Had been losing confidence in yourself?	Not at all	No more than usual	Rather more than usual	Much more than usual
Been thinking of yourself as a worthless person?	Not at all	No more than usual	Rather more than usual	Much more than usual
Had been feeling reasonably happy, all things considered?	More so than usual	About same as usual	Less so than usual	Much less than usual

23. Describe your sleep pattern during the **two** weeks before your current offence/alleged offence?

- ☐ No problems
- ☐ Found it difficult getting off to sleep
- ☐ Broken sleep, waking in the early hours

Section B

Your experience with drugs and alcohol

The next set of questions are about your DRUG taking habits before you came to this prison.

1. Have you ever taken substances/drugs that were not prescribed by your doctor?

☐ Yes ☐ No *If you have never taken any drugs (see the list below), please go to Question 12.*

2. For each drug below, tick the box by the side of it if you have ever used it, and if it was prescribed for you by a doctor or not.

Drugs taken that were NOT prescribed for you by a doctor.

☐ Cannabis
☐ Heroin
☐ Valium/Temazepam
☐ Methadone
☐ Speed
☐ Crack
☐ Cocaine
☐ Solvents
☐ Ecstasy
☐ Other.....please write in the box what

Drugs taken that WERE prescribed for you by a doctor.

☐ Valium/Temazep
☐ Methadone

3. Have you ever shared any of the following with other people when taking drugs?

☐ needles ☐ water ☐ spoons ☐ filters ☐ syringe ☐ never shared works

4. Do you feel that any of these drugs were or are a problem for you? Please tick yes or no for the drugs you have taken.

	Yes	No
Cannabis		
Heroin		
Methadone		
Speed		
Crack		
Cocaine		
Valium/Temazepam		
Solvents		
Ecstasy		
Other...please write what drug below		

5. Which of the drugs you have taken did you enjoy the most and what to you were the benefits or reasons for using this drug?

	Please write by the side of the drug/s you have taken the benefit or reason for taking this drug.
Cannabis	
Heroin	
Methadone	
Speed	
Crack	
Cocaine	
Valium/Temazepam	
Ecstasy	
Solvents	
Other...please write what.....	

6. Have you **tried to stop using these drugs?** Please tick yes, no or stopped using for the following drugs.

	Yes - but still use 3	No 3	Stopped using drug 3
Cannabis			
Heroin			
Methadone			
Speed			
Crack			
Cocaine			
Valium/Temazepam			
Solvents			
Ecstasy			
Other...please write what drug.....			

7. If available, would you be interested in any of the following?

☐ Short term drug detox programme ☐ Drug education classes ☐ Drug counselling

☐ Long term rehab programme with education, counselling and support ☐ Help from a support group when you are released from prison

8. Have you ever taken a drug overdose on purpose?

☐ Yes ☐ No

9a. Do you experience any mental problems due to your drug use?

☐ Yes ☐ No *If NO, please go to QUESTION 10*

b. If you have ticked yes, what kind of mental health problems have you had? Tick as many boxes as you need.

☐ Anxiety ☐ Memory loss

☐ Depression ☐ Unable to concentrate

☐ Paranoia ☐ Aggression

☐ Addiction

☐ Other.....please write in the box what.....

10. Have you ever had help or treatment from any of the following due to drug problems? Tick as many boxes as you need.

	No 3	3 Yes - outside prison	3 Yes - inside prison

Community drugs project, e.g. DrugAid			
Narcotics Anonymous			
Carats			
Methadone maintenance programme			
Doctor, mental health worker, Psychiatrist			
Needle exchange			
Hospital inpatient for dug detox			
Other...please write who...			

11 a. Were you taking any of the following drugs **at the time of your offence/alleged offence?**

Drugs taken at the time of offence/alleged offence	Yes 3	No 3
Cannabis		
Heroin		
Methadone		
Speed		
Crack		
Cocaine		
Valium/Temazepam		
Solvents		
Ecstasy		
Other...please write what drug below		

b. Were you taking any of the following drugs **24 hours before entering prison?**

Drugs taken 24 hours before entering prison	Yes 3	No 3
Cannabis		
Heroin		
Methadone		
Speed		
Crack		
Cocaine		
Valium/Temazepam		
Solvents		
Ecstasy		
Other...please write what drug below		

The next set of questions are about your ALCOHOL drinking habits before coming to this prison.

12. In the month before you came to prison did you - drink alcohol on 4 days or more per week?

☐ Yes ☐ No

13. In the month before coming to prison - did you have 6 or more alcoholic drinks on a typical day when you were drinking?

☐ Yes ☐ No *If you answered **NO** to question **12 OR 13**, please go to SECTION C*

14. What are your reasons for drinking alcohol, if you are a heavy drinker?

Please explain.....

15a. Have you ever attended a programme to help you cut down or stop your drinking such as the Samaritans, Alcoholics Anonymous or any other support group?

- ☐ YES - in the last year
- ☐ YES - more than a year ago
- ☐ Never *If NEVER, please go to QUESTION 17*

b. If you did get help for you drinking problem outside prison, who helped you?

- ☐ Alcoholics Anonymous
- ☐ Samaritans
- ☐ Carats
- ☐ Probation
- ☐ Other...please write in the box who.....

16. Have you ever 'overdosed' with alcohol to harm yourself or attempt suicide?

☐ Yes ☐ No

17. Have you had help or advice in this prison because of your drink problem?

☐ Yes ☐ No

18. Did you want help or advice from this prison because of your drink problem?

☐ Yes ☐ No

19. Had you been drinking large amounts of alcohol at the time of your offence/alleged offence?

☐ Yes ☐ No

20. Do you think that you had a problem with alcohol at the time you entered prison?

☐ Yes ☐ No

21. When you entered prison did you suffer from alcohol withdrawal sickness?

☐ Yes ☐ No

Section C Inside Prison

- How does the Prison deal with mental health problems
- Your experience of mental health problems inside Prison

How does the prison deal with mental health problems

The next set of questions are about your experience of coming into prison.

Entering prison - RECEPTION

1 a. During RECEPTION to this prison, was enough time given to talk to the **nursing staff** about any mental health problems you have and the help that is available to you?

☐ Yes ☐ No *If YES, please go to QUESTION 2*

b. If NO, there was not enough time, how much time would you have liked?

☐ 15 to 30 minutes ☐ 30 minutes to 1 hour ☐ 1 to 2 hours ☐ 2 hours or more

2 a. During RECEPTION to this prison, was enough time given to talk to the **Doctor** about any mental health problems you have and the help that is available to you?

☐ Yes ☐ No *If YES, please go to QUESTION 3*

b. If NO, there was not enough time, how much time would you have liked with the doctor?

☐ 15 to 30 minutes ☐ 30 minutes to 1 hour ☐ 1 to 2 hours ☐ 2 hours or more

3 a. Would you have preferred to talk about your problems after reception?

☐ Yes ☐ No *If NO, please go to QUESTION 4*

b. If YES, you would prefer to talk about your problems after reception, why? Tick as many boxes as you need.

☐ There is too much to think about during reception already

☐ Too scared to say anything at reception, did not know what would happen to me if I said anything

☐ Don't trust the prison system

☐ Could not think straight during reception

☐ Want privacy to talk about mental health problems

Want to talk to someone you trust

☐

☐ Other.....please write what....

4 a. Were you re-assessed after reception so that you could talk about your emotional/mental health problems?

☐ Yes ☐ No *If NO, please go to QUESTION 5.*

b. If YES, you were re-assessed, were you happy with the re-assessment?

☐ Yes ☐ No

c. If NO, you were not happy with the re-assessment, why? Tick as many boxes as you need.

☐ There was not enouah time to talk
☐ Wanted to talk about problems, but the nursing staff did not seem
☐ It was too soon to talk about such problems
☐ Wanted privacy to talk about your problems
☐ Do not want to talk to a Prison Officer about your
☐ Do not want to talk to Health Care staff about your
☐ You have heard it all before and nothing changes

☐ Other....please write what....

Your experience of prison services

Getting help from Nursing Staff and Doctor for mental health problems.

Nursing staff

5 a. **Not including reception**, how many times have you wanted to see prison **nursing staff** because of depression/anxiety or any mental health issue while you have been in this prison?

☐ Never ☐ 1 time ☐ 2 times ☐ 3 times ☐ 4 times ☐ 5 times or more

If NEVER, please go to QUESTION 6

b. Were you able to see prison **nursing staff** about your mental health problems?

☐ Yes - every time you needed to see someone

☐ Sometimes - but not every time you wanted to see someone

☐ No

c. If yes, you were able to see a member of the **nursing staff**, on average, how long did you have to wait?

Number of days wait.....

The Doctor

6 a. **Not including reception**, how many times have you wanted to see a **Doctor** because of depression/anxiety or any mental health issue while you have been in this prison?

☐ Never ☐ 1 time ☐ 2 times ☐ 3 times ☐ 4 times ☐ 5 times or more

If NEVER, please go to QUESTION 7

b. Were you able to see a **doctor** about your mental health problems?

☐ Yes - every time you needed to see someone

☐ Sometimes - but not every time you wanted to see someone

☐ No

c. If yes, you were able to see a **doctor**, on average, how long did you have to wait?

Number of days wait.....

Getting help from the Psychiatrist

7 a. Did you want to see the psychiatrist?

☐ Yes ☐ No *If NO, please go to QUESTION 8*

b. Was it possible to see the psychiatrist?

☐ Yes ☐ No

c. If yes, you did see the psychiatrist, how long did you have to wait the **first time** you wanted to see him or her ?

Number of days wait.....

d. If yes, did you have enough time to talk about your problems?

☐ Yes ☐ No

In the table below are a list of people within the prison who are available to help you.

8. We would like to know how many of the people listed in the table you feel able to **talk to about your mental health problems**, and if there are any people listed you would not talk to about your mental health problems. Along side each person or persons listed below, **tick one box** depending if you *feel able to talk to them*, **or** if you *would not talk to them*, **or** if you *didn't know that they were available to you* in prison.

	Would talk to about problems 3	Would NOT talk to about your problems 3	Did not know about them 3
Doctor			
General nursing staff			
Mental health nursing staff			
Psychiatrist			
Day Care			
Samaritans			
Wing Staff			
Education Staff			
Psychologist			
Chaplains			
Listeners			
Buddy			
Probation			
Carats or Drug Officer			
Cruise or Bereavement Counsellors			

Someone else ...please write who			

Having visitors while in prison

The next set of questions are about the visitors you see while in prison such as **family, friends or a prison visitor** NOT legal or other official visits - and how this affects you.

9. Do your family and/or friends or a prison visitor visit you while you are in prison?

☐ Yes ☐ N *If NO, please go to QUESTION 13*

10. How often do family/friends or a prison visitor visit you? Please tick one box below.

☐ 3 visits or more every
☐ 1 to 2 visits every week
☐ 1 visit every fortnight
☐ 1 visit per month or less

11. Who visits you? Tick as many boxes as you need.

☐ Parents
☐ Children....under 16 years of
☐ Children...over 16 years of
☐ Prison visitor - *Please go to QUESTION 13*
☐ Partner/wif
☐ Other family members
☐ Friends
☐ Other....please write who....

12. Do your family and friends visit you as often as the prison allows?

☐ Yes ☐ No

13. What stops your family/friends from visiting you more often or at all? Tick as many boxes as you need.

☐ Family/friends live too far
☐ They don't like coming to the
☐
☐ The prison is not suitable for young
☐ Difficult to arrange a time to visit
☐ Cannot afford the cost of travelling to

Find the visiting system

- ☐ **Your children become very upset when they have to leave without you**
- ☐ Family do not know that you are in prison
- ☐ Do not have any family or friends to visit you - *Please go to*
- ☐ Other.....please write what...

14. Are the visits from family and friends important to you?

☐ Yes ☐ No

15. How does having a visit from your family and/or friends make you feel? Please tick as many boxes as you like.

- ☐ Helps you feel connected with your
- ☐ You can help your family cope with your imprisonment
- ☐ Helps you feel that you are still part of the
- ☐ You feel supported
- ☐ You feel less isolated
- ☐ Relieved to see that your family/kids are coping
- ☐ Important to feel that your family still care about
- ☐ It upsets you to see your family upset
- ☐ Other.....please write what...

16. If you DO NOT have regular visitors, how does this make you feel? Tick as many boxes as you like.

- ☐ Isolated
- ☐ Depressed
- ☐ Worried about what is happening outside
- ☐ Feel that nobody cares about you or what happens
- ☐ Worried about how your family are coping
- ☐ It does not bother you
- ☐ Feel like you are losing touch with your loved
- ☐ Feel like you are losing your family
- ☐ Worried about the effect your imprisonment has on

☐ Other.....please write what...

How do you spend your time in prison

17. In prison are you.....

☐ Employe ☐ Unemployed ☐ Full time education or training

18. While in prison, what type of job are you able to do?

☐ Fit and able to do any
☐ Can only do certain jobs.....please write
☐ Minimum labour, very limited ability to work...please write
☐ Too ill to work.

19. How much time do you spend locked up in your cell on average per 24 hour day/night?

☐ Less than 12 hours
☐ 12 to 15 hours
☐ 16 to 20 hours
☐ More than 20 hours

20. Do you attend any of the following? Please tick yes, no or if you would like to have the opportunity to take part.

	Yes	No
Education classes		
Offending Behaviour Classes		
Outdoor P.E. (Physical education)		
Indoor gym		
Religious services		

21. Do you receive money from friends or family?

☐ Yes ☐ No

22. How much money do you have to spend per week (including prison wages and private money)?

☐ £0 to ☐ £6 to £10 ☐ £11 to £15 ☐ £16 to

How safe do you feel in prison

24. Have you ever experienced any of the following from other prisoners? Tick as many boxes as you need.

☐ Physical violence
☐ Unwanted sexual attention
☐ Verbal threats, taunting
☐ Blackmail
☐ Forced to sell or hand over your
☐ Forced to hand over your belongings (taxing)
☐ Taunted because you suffer a mental health
☐ Abuse because of your skin colour
☐ Abuse because you are Welsh
☐ Abuse because you are Scottish
☐ Abuse because you are Irish
☐ Abuse because of you are English
☐ Other anti-social behaviour (please explain)...

25. Have you ever experienced any of the following from prison staff? Tick as many boxes as you need.

☐ Physical violence

☐ Verbal threats, taunting
☐ Unwanted sexual attention
☐ Blackmail

☐ Forced to hand over your belongings (taxing)
☐ Taunted because you suffer a mental health
☐ Abuse because of your skin colour

☐ Forced to sell or hand over your

☐ Abuse because you are Welsh
☐ Abuse because you are Scottish
☐ Abuse because you are Irish
☐ Abuse because you are English
☐ Other anti-social behaviour (please explain)..... [ ]

26. If you share a cell, do you feel safe sharing your cell with your cellmate?

☐ Yes ☐ No ☐ Do not share

Section D Mental Health History

- Have you suffered from mental health problems in the past
- Did you ever have any help when you lived in the community
- Are you suffering any mental health problems while you are in prison
- Self-harm and suicide

Mental health history

As stated earlier, mental health problems can mean anything from emotional problems, depression, anxiety, a nervous breakdown, panic attacks, stress, behavioural problems, eating disorders, mental illness due to drug or alcohol abuse, insomnia, self-harm and feeling suicidal.

1. Have you ever had problems with the following that would have benefited from help, but were **not severe** enough to need a psychiatrist?
Please tick yes or no for each question if you did have problems and tick if you had help or not with your problems from any agency inside or outside prison (for example, a support group or a health worker, etc.)

Did you have problems with any of the following…….	YES	Did you have any HELP with any of your problems?		
		YES -had help outside prison	YES- had help while in prison	NO- have not had help
1 - Problems with aggressive, disruptive behaviour				
2 - Harming yourself or attempts at suicide				
3 - Problems with drinking alcohol or drug taking				
4 - Problems with relationships				
5- Problems with daily living - such as problems with reading or writing				
6 - Problems with daily living due to physical health problems - such as finding it difficult to walk, breathing problems, etc…..				
7 - Problems with living conditions at home				
8 - Problems with your job and your ability to carry out your job.				
9 - Problems with depression, anxiety, nervous breakdown, panic attacks, stress.				
10 - Problems dealing with a traumatic experience that happened to you in the past.				
11 - Problems with hallucinations and strange thoughts, memory loss, hearing voices.				
12 - Other…please write what…. ……				

2. **If you did not have help** from trained people for your mental health problem, was this because... (tick as many boxes as you need)

- ☐ You did not want help
- ☐ You did not want to be labelled as mentally
- ☐ You wanted help, but you did not know
- ☐ You asked for help, but you did not get the help .....please write who you

3. Has any member of your family suffered with any of the following mental health problems? Tick as many boxes as you need.

- ☐ Stress, anxiety
- ☐ Depression
- ☐ Drug abuse or addiction
- ☐ Alcohol abuse or addiction
- ☐ Other type of mental health problem, please

The following questions are to find out if any of the mental health problems you have suffered were severe enough for you to need the help of a PSYCHIATRIST.

4 a. Have you ever seen a psychiatrist OUTSIDE prison?

☐ Yes ☐ No *If NO, please go to QUESTION 7*

b. If YES, why? Were you having problems with any of the following? Please tick yes or no for each question.

	YES	NO
1 - Problems with aggressive, disruptive behaviour		
2 - Harming yourself or attempts at suicide		
3 - Problems with drinking alcohol or drug taking		
4 - Problems with relationships		
5- Problems with daily living - such as problems with reading or writing		
6 - Problems with daily living due to physical health problems - such as finding it difficult to walk, breathing problems etc....		
7 - Problems with living conditions at home		
8 - Problems with your job and your ability to carry out your job.		
9 - Problems with depression, anxiety, nervous breakdown, panic attacks, stress.		
10 - Problems dealing with a traumatic experience that happened to you in the past.		
11 - Problems with hallucinations and strange thoughts, memory loss, hearing voices		
12 - Other...please write what....		

5. Have you ever been subject to a court order for psychiatric treatment?

☐ Yes ☐ No

6. Have you ever been sectioned under the Mental Health Act?

☐ Yes ☐ No

The next set of questions are to find out if you have been able to get help in the community for any mental health problem.

7 a. If you **did have help**, who helped you? *If you have NOT had help, please go to*
Tick as many boxes as you need.

- ☐ Your doctor outside prison
- ☐ Psychiatrist OUTSIDE
- ☐ Psychologist OUTSIDE
- ☐ A community drug project OUTSIDE prison
- ☐ A community drug project IN
- ☐ Home visits from a community mental
- ☐ Home visits from a health worker or a social worker
- ☐ A community support group such as MIND
- ☐ Help from prison health care services
- ☐ Other ...please write what...

b. If you had help OUTSIDE prison from any of the above, when did you have this help?

- ☐ Within the last 6 months
- ☐ 6 months to 1 year ago
- ☐ More than a year ago
- ☐ More than 5 years ago

c. If yes, you did have help, what kind of help did you have?
Tick as many boxes as you need.

- ☐ Medication — Please write what kind of medication you had...
- ☐ Group
- ☐ One to one counselling — Please write who you had counselling with....
- ☐ Other ...please write what...

The following set of questions are to find out if the **help you received in the community** actually helped you or not.

8 a. If you were given **medication** to help you with your problems, did the medication help you?

☐ Yes ☐ No *If you were NOT prescribed medication, please go to*

b. If you were given medication, how did the medication affect you?
Tick as many boxes as you need.

☐ Helped you to relax
☐ Made you feel tired
☐ Gave you energy
☐ Others think you are
☐ Improved your mood
☐ The course of medication was too short
☐ Controlled your problems
☐ Bad side effects such as sickness, shaking,
☐ Made things seem ok
☐ Didn't take the medication as it stopped you taking other drugs and drinking
☐ Medication is not having any affect on your
☐ The instructions for taking the medication were too complicated
☐ Other....please write what....

9 a. If you had **counselling** sessions, did you find them helpful?

☐ Yes ☐ No *If you did not have counselling, please go to QUESTION*

b. What affect did the counselling have on you? Tick as many boxes as you need

☐ Felt good to have support
☐ Too scared to talk about your
☐ The course of counselling was too
☐ Felt that you were not alone
☐ Did not want to talk about your problems in front of a group of other people
☐ Other...please write what...
☐ Gave you hope that you could overcome your
☐ It took too long to get help from the
☐ Did not feel that your counsellor
☐ Gave you motivation to sort yourself out
☐ Too embarrassed to talk about your

The following questions are about any mental health problems you are having NOW, **while IN PRISON.**

10 a. Are you on medication for mental health reasons NOW?

☐ Yes ☐ No *If NO, please go to QUESTION 11*

b. If yes, what medication are you taking?

Please write below what medication you are taking

c. If you are taking prescribed medication NOW while in prison, is it helping you?

☐ Yes ☐ No

d. How is the medication affecting you? Tick as many boxes as you need.

☐ Helps you to relax
☐ Makes you feel tired
☐ Gives you energy
☐ Worried others will think you are mentally ill
☐ Improves your mood
☐ Medication is not having any affect on your problems
☐ Other....please write what...

☐ The course of medication is too short
☐ Controls your problems
☐ Bad side effects such as sickness, shaking, etc...
☐ Make things seem ok
☐ Didn't take the medication as it stopped you taking other drugs and drinking alcohol
☐ Don't know - only just started taking medication

11. How would you describe your mental health NOW compared to the month **before you came into prison? Please tick one box that most applies to you.**

☐ Much better NOW than one month before prison
☐ A bit better NOW than one month before prison
☐ About the same NOW as one month before prison
☐ A bit worse NOW than one month before prison
☐ Much worse NOW than one month before prison

Using the table below we would like to know how you have been **feeling generally over the PAST TWO WEEKS INSIDE PRISON.**

For example, if you are not having any problems concentrating, you might circle the answer 'same as usual'.

Have you been able to concentrate on whatever you were doing?	Better than usual	Same as usual	Less than usual	Much less than usual

12. Remember we want to know about problems NOW, not in the past. Please answer ALL of the questions below, and read each question carefully and the answers that follow each question, circling the one that most applies to you now.

Have you recently....

been able to concentrate on whatever you were doing?	Better than usual	Same as usual	Less than usual	Much less than usual
lost much sleep over worry?	Not at all	No more than usual	Rather more than usual	Much more than usual
felt that you were playing a useful part in things?	More so than usual	Same as usual	Less useful than usual	Much less useful
felt capable of making decisions about things?	More so than usual	Same as usual	Less so than usual	Much less capable
felt constantly under strain?	Not at all	No more than usual	Rather more than usual	Much more than usual
felt you couldn't overcome your difficulties?	Not at all	No more than usual	Rather more than usual	Much more than usual
able to enjoy your normal day-to-day activities?	More so than usual	Same as usual	Less so than usual	Much less than usual
able to face up to your problems?	More so than usual	Same as usual	Less able than usual	Much less able
been feeling unhappy and depressed?	Not at all	No more than usual	Rather more than usual	Much more than usual
been losing confidence in yourself?	Not at all	No more than usual	Rather more than usual	Much more than usual
been thinking of yourself as a worthless person?	Not at all	No more than usual	Rather more than usual	Much more than usual
been feeling reasonably happy, all things considered?	More so than usual	About same as usual	Less so than usual	Much less than usual

13. Please read the following statements and tick one box which applies to you. In the past **two weeks**, I have.....

- ☐ had no problems with feeling sad or low
- ☐ been very sad because of something that happened or is
- ☐ been depressed, felt bad, low, tearful, guilty, low in self esteem, had little

- ☐ been very depressed, very low, guilty, felt no pleasure in life, lost my self esteem and felt like crying a lot of the time
- ☐ been so low that I just sit all day, lost all pleasure in life, felt guilty, worthless, can't sleep or eat, felt like crying all the time

14. Please read the following statements and tick the one box that applies to you. In the past **two weeks**, I have.....

- ☐ had no problem with hearing voices or seeing visions
- ☐ been behaving in a way that others think eccentric
- ☐ heard voices or seen visions but they didn't upset me or make me
- ☐ often had voices or visions upsetting me or making me do
- ☐ been severely distressed by my voices or visions, and this has upset

15. Describe your sleep pattern during the **last 7 days?**

- ☐ No problems
- ☐ Found it difficult getting off to sleep
- ☐ Broken sleep, waking in the early hours

16. Please answer (tick) yes or no to the following questions in the table below.

	Yes ☐	No ☐
Do you get on with people?		
Would you describe yourself as a loner?		
Do you trust other people?		
Do you have a temper?		
Are you an impulsive person?		
Are you an irresponsible person?		
Are you a worrier?		
Do you have unusually high standards?		

17. How much do you depend on others?

☐ Always ☐ Often ☐ Sometimes ☐ Occasionally ☐ Never

18. If you do have a mental health problem, what kind of help would you like? Would you be interested in any of the below if they were available to you? Please tick as many boxes as you like.

- ☐ One to one support from a trained counsellor
- ☐ Group support to help with problems such as stress or
- ☐ Medication
- ☐ More time out of your cell to talk to
- ☐ More time out of your cell to occupy your time such as work or training
- ☐ Support when you are released from prison to help you settle back into
- ☐ Education programmes to help you change or manage your behaviour

History of self-harm and suicidal thoughts

The next set of questions are to find out if you have a history of harming yourself.

19 a. Have you ever harmed yourself on purpose (not including suicide attempts)?

☐ Yes ☐ No *If NO, please go to QUESTION 20.*

b. If you have harmed yourself, when did this happen.....

- ☐ Only in prison
- ☐ You started during the year BEFORE you came to prison
- ☐ You have a long history of self-harm inside and outside prison
- ☐ You used to suffer periods of self-harm in the past, but have stopped now

c. How did you harm yourself.....(Tick as many boxes as you need)

- ☐ By cutting yourself
- ☐ Taking a drug/alcohol overdose
- ☐ Burning yourself
- ☐ Self-suffocation
- ☐ Banging your head, fists or feet against walls,
- ☐ Swallowing objects
- ☐ Self-choking
- ☐ Putting objects into wounds
- ☐ Other.....please explain....

d. What triggered the self-harm? Tick as many boxes as you need.

- ☐ To cause physical pain which reduces emotional pain
- ☐ It is a way of showing your emotional pain which you cannot put into words
- ☐ Other inmates have told you it is a way of coping with emotional pain
- ☐ Helps you escape from painful thoughts or feelings
- ☐ Helps you release painful thoughts and suicidal thoughts
- ☐ Family and/or relationship problems
- ☐ To punish yourself
- ☐ Severe depression
- ☐ Hear voices
- ☐ Withdrawing from drugs
- ☐ Other....please

The next set of questions are about any history of suicide attempts.

20 a. Have you ever thought about suicide?

☐ Yes ☐ No *If NO, please go to QUESTION 21.*

b. What triggered these thoughts? Tick as many boxes as you need.

- ☐ Cannot see how your life can get better
- ☐ Cannot see any other way out of your problems
- ☐ You cannot put your emotional pain into words
- ☐ Other inmates have told you it is a way of dealing with emotional pain
- ☐ To escape from painful thoughts or feelings
- ☐ You cannot see a future for yourself
- ☐ Family and/or relationship problems
- ☐ To punish yourself
- ☐ Severe depression
- ☐ Hear voices
- ☐ Cannot cope with the withdrawal from drugs/alcohol
- ☐ Other....please explain..

c. Have you ever planned for a suicide attempt, such as leaving a note?

☐ Yes ☐ No

d. Have you ever attempted suicide?

☐ Yes ☐ No

e. What caused the suicide attempt, please explain below if you can?

f. Has any close relative or friend ever attempted suicide?

☐ Yes ☐ No

How are you feeling right now?

21. Do you feel like hurting yourself at the moment?

☐ Yes ☐ No

22. If yes, please explain why below.

23. Are you feeling suicidal now?

☐ Yes ☐ No

IF YOU HAVE ANSWERED **YES TO FEELING SUICIDAL**, OR JUST NEED TO SPEAK TO SOMEONE, PLEASE SPEAK TO ONE OF THE NURSES IN THE ROOM OR A MEMBER OF THE HEALTH CARE STAFF.

THE NURSING AND RESEARCH STAFF ARE HERE TO HELP YOU FILL IN THE QUESTIONNAIRES, AND ARE HERE FOR YOU IF YOU NEED TO TALK ABOUT YOUR FEELINGS.

If you start feeling distressed in the evening or during the night please talk to one of the wing staff. They have been informed of the project and will

take you to the health care centre if you need to see one of the nursing staff.

Thank you for taking the time to fill in this questionnaire.

Appendix e

Medical Records Audit Tool (2002)

Audit of Prison Medical Records

On the audited records was there any evidence of these problems being recorded?

Problem descriptor	At reception	Following reception
1 - Problems with aggressive, disruptive behaviour		
2 - Harming self or attempts at suicide		
3 - Problems with drinking alcohol or drug taking		
4 - Problems with relationships		
5- Problems with daily living - such as physical illness,		
6 -Problems with daily living – such as the individuals ability to function		
7 - Problems with living conditions at home		
8 - Problems with work		
9 - Problems with depression, anxiety, nervous breakdown, panic attacks, stress		
10 - Problems dealing with a traumatic experience that happened in the past.		
11 - Problems with hallucinations and delusions, memory loss, hearing voices.		
12 - Other…please write what…. ……		

Is there any formal recording of a diagnosis against these groups

Diagnostic Group	At reception	Following reception
Adolescent Problems		
Functional psychosis		
Learning Disability		
Neurotic Disorder		
Personality Disorder		
Organic Illness? Neurological Disorder		
Substance Misuse		
Other		

Appendix f

Letter re: Ethical Approval for Staff Survey (2004)

Canolfan Gwasanaethau Busnes
Business Services Centre

LOCAL RESEARCH ETHICS COMMITTEE
Covering: BRIDGEND - NEATH PORT TALBOT - SWANSEA
Chairman : Mr Scott Pegler - Drug Information Pharmacist
Secretary : Mrs Nicola John - Consultant in Pharmaceutical Public Health
Administrator : Miss Lawmary Champion
Direct Telephone : 01792 - 607416 -e-mail :lawmary.champion@bscswansea.wales.nhs.uk

Mr N Bowler and Dr C J Phillips
RMN & Reader
University of Wales Swansea
School of Health Science
Singleton Park
SWANSEA SA2 8PP

2004.004

Lawmary
Champion
Extension 7416

25/02/2004

Dear Mr N Bowler and Dr C J Phillips

2004.004 Small Scale (Delphi) Follow up to Prison Mental Health Needs Assessment in HMP's Parc and Swansea

Thank you for your undated letter received on 25th February 2004, enclosing Amendments requested by the Committee. The following documents have now been approved and registered: Participant Information Sheet Version 2 dated 17/02/04; together with Consent Form Version No.1 dated 6th February 2004 and Questionnaire Version 1 dated 6th February 2004. This Study has now been approved via Chairman's Action Approval.

Please quote our Reference Number in all future correspondence. Chairman's Action Aproval will be ratified by the Committee at its 17 March 2004 meeting and also note:

1 The enclosed document is confidential and not for publication
2 Any publication resulting from the Protocol must define how subjects were chosen and to what extent they were volunteers.
3 That the form of consent must be read and signed by each subject or, if oral consent has been approved by the Committee, that the consent of each subject must be appropriately recorded. In either case, forms and records must be kept for subsequent examination, if required, by the Committee
4 That changes to the Protocol as approved must be referred to the Committee
5 Ethical approval does not imply acceptance of materials and drug costs by the Authorities or provider units
6 Any untoward incident which occurs in connection with this Protocol must be reported back to the Chairman of the Committee **without delay**.

Yours sincerely

NICOLA JOHN - CONSULTANT IN PHARMACEUTICAL PUBLIC HEATH
NATIONAL PUBLIC HEALTH SERVICE & SECRETARY OF THE LOCAL RESEARCH ETHICS COMMITTEE
cc Mr Dorian Edwards R & D Support Office

Appendix g

Letter of support from Rowena Williams

Llywodraeth Cynulliad Cymru
Welsh Assembly Government

Eich cyf . Your ref
Ein cyf . Our ref

10 December 2003

To whom it may concern:

Re: Application for ethical approval. Prison mental health follow-up study, Parc and Swansea prisons.

In connection with this application, I am writing to lend my support to the prison mental health follow up study in its submission for ethical approval. The previous study, establishing the mental health needs of prisoners at HMP Parc and HMP Swansea was conducted during April-June 2002, and reported to Iechyd Morgannwg Health Authority in January 2003.

This research was key to identifying the nature and scale of mental health problems in these two prisons and has helped inform decisions about how services will develop. The mental health needs assessment research conducted in these prisons has helped to shape the Health Improvement Plans (HimP's), which have now been developed in Parc and Swansea prisons.

This research showed high levels of mental health morbidity, substance misuse and services struggling to cope with modern standards of care. There was also evidence of unmet need, problems in arranging aftercare, as well as evidence of multiple mental health and social problems being experienced by many prisoners.

Parc Cathays
Caerdydd
CF10 3NQ

Cathays Park
Cardiff
CF10 3NQ

Ffôn • Tel:029 2080
GTN:1129
Ffacs • Fax:029 2082 3666

The Welsh Assembly Government through the Health Service Policy and Development Division, is now supporting the development of standard statements for prison mental health services. Priority areas for standard setting include care pathways for those prisoners with the most serious mental health problems, assessment, therapeutic activity and transfer of disturbed prisoners to NHS facilities.

This research will help to develop evidence-based standards in these areas in support of the improvement of mental health services in the prisons. The research will complement the work of the clinical teams within the mental health in-reach collaborative in Wales, and may well inform some of the future changes required to improve service provision for prisoners in mental distress.

Yours sincerely

Rowena Williams
Prison Health Care Project Co-ordinator
Health Service Policy and Development Division

Appendix h

Letter of support from Mr. P. Taylor

CARCHAR EM ABERTAWE

Carchar A Chanolfan Gadw EM
200 Heol Ystumllwynarth
Abertawe SA1 3SR
Teleffon 01792 485300
Ffacs 01792 485430

HM PRISON SWANSEA

HM Prison & Remand Centre
200 Oystermouth Road
Swansea SA1 3SR
Telephone 01792 485300
Fax 01792 485430

Llywodraethwr P.J. Taylor Governor

N Bowler
Lecturer in Mental Health Nursing
School of Health Science
University of Wales
Swansea
SA2 8PP

Eich cyfeirnod / Your reference

Ein cyfeirnod / Our reference PT/ES

Dyddiad / Date 02/03/04

Dear Mr Bowler

Thank you for your outline proposal into conducting further research that will help in the management of Prisoners with Mental Health issues.

As indicated at our recent meeting, I am happy for this research to be undertaken by you. As far as establishment liaison is concerned, I would see your natural points of contact to be Kath Long and Richard Fifield.

I would like to receive regular updates on the progress of the project; the exact timing of these can be determined when the project is underway. In the first instance the issue of you adopting a clinical role can be discussed with Richard and Kath, but I would not want any movement on this issue until I have been fully briefed. The same can be said for utilising our Healthcare environment for the training of Mental Health nursing students. I can see the potential of this but need to be fully briefed before any action is taken.

Any reciprocal agreement will need to be considered in the round, as I do not want to interrupt the workings of the Local Health Board and the Prison Health Steering Group.

So, to summarise, yes the project as discussed can go ahead, the additional elements will need further discussion before any action can be taken.

I look forward to meeting you again and look forward to the progress reports and eventual completion of your research.

Yours sincerely

P J Taylor

Mr P J Taylor
Governor

Appendix i

Participant Information and Consent Form (2004)

PARTICIPANT INFORMATION SHEET

Follow up to Prison Mental Health Needs Assessment

Version 2. 17th February 2004.

Study title; Follow up to Prison Mental Health Needs Assessment

Invitation

You are being invited to take part in a research study. Before you decide whether to participate, it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with colleagues or your manager if you wish. Ask Mr. N. Bowler if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part.
Thank you for reading this.

What is the purpose of the study?

This study involves comparing responses from professionals working in the fields of prison mental health or with mentally disordered offenders to data generated from the mental health needs assessment research in HMP Parc and HMP Swansea.

Objective –

- To ascertain whether mental health risk factors relevant to prisoners from previously collected data are recognised in the management of their mental health status.
- To develop consensus around priority service areas

Research Question - ***"Are factors identified within prison mental health needs assessment research, of significance to practitioners and others working in the field, in assessing and managing prisoners with mental health problems?"***

Why have I been chosen?
You are working in a capacity, which results in you coming into contact with mentally disordered prisoners whilst in prison or upon resettlement... or other mentally disordered offenders. Your view as to the relevant factors is therefore being sought.

Do I have to take part?
No. It is up to you to decide whether or not to take part. If you do decide to take part you will be given this information sheet to keep and be asked to sign a consent form. If you decide to take part you are still free to withdraw at any time and without giving a reason. This will not affect any aspect of your working role.

What will happen to me if I take part?
You will be asked to complete a number of questionnaires over a period of up to 3 months. The questionnaires will be modified forms of the 1st questionnaire, adapted in the light of feedback. During this time you will be kept informed of how the questionnaire has been developed and changed. It would be most helpful if you could consider and complete the various questionnaires as promptly as possible and see the project through to the end. However you will remain free to withdraw at any time.

Delphi Study.

The research will test the identified data against the opinions of expert stakeholders using a Delphi approach, requiring different groups of selected practitioners and others with an interest in the field to establish a consensus view as to service priorities.

What is being studied?

The opinions of people with experience of prisoner's mental health problems are being tested against available data from the Mental Health Needs Assessment research. The data has been analysed in order to

1. Identify relevant factors influencing prisoners' mental state
2. Identify potential areas for service development

What are the possible benefits of taking part?
We hope that the research will help to identify service priorities

What happens when the research study stops?

The research will be written up as part of a PhD thesis. The findings will be made available, if required, in anonymised format to the prisons and the Welsh Assembly prison in-reach coordinator. This will be done only to assist service development.

Complaint?
If you are unhappy with the way in which the study is conducted please raise your concerns in the first instance with one of the researchers. Failing that you may address complaints to Mr John Evans, Assistant Director, School of Health Science, University of Wales, Swansea. The normal University complaints mechanisms are available to you. This is a non/low risk, non-invasive, non-patient/prisoner contact study - covered under the University's public liability insurance

Will my taking part in this study be kept confidential?

All information, which is collected during the course of the research, will be anonymised and stored confidentially. It will not be accessible by anyone who is not part of the research team. Any information collected from you will have your name removed so that you cannot be recognised from it. The report of data in the thesis will not identify any individuals. You are asked to identify yourself on the questionnaire so that I can track responses from individuals, particularly in relation to parts C and D, which will need completion more than once. No individuals will be identified in the reporting of the data.

What will happen to the results of the research study?

Results will be incorporated into the PhD thesis. Results will also be shared with the prisons involved in the study and the Welsh Assembly prison in-reach collaborative.

Who is organising and funding the research?

The University of Wales, Swansea is funding and supporting this research.

Who has reviewed the study?

Swansea Local Research ethics Committee

Background. **This questionnaire relates to the mental health of offenders and prisoners and the services, which they receive. It consists of three parts. Two of the sections (parts C and D) are part of a 'Delphi' study, to be completed more than once on separate occasions to try and develop a consensus as to priorities for community and prison mental health services.** NOTE; **Parts C and D ask you to make judgments 'as if' new investment were available. This is a hypothetical statement and does not anticipate the availability of money for these specific purposes.**

Part A**. Asks for some information about your experience of working with mentally disordered persons**

Part B. **This part asks you to make judgements about experiences before and inside prison, which might impact upon prisoners' mental health. This is a 'once only' part. This will allow comparisons to be made between professionals' judgments and the data obtained during the previous prison mental health needs assessment.**

Part C. **This part asks you to prioritise functions of mental health care ranging from before prison (police and court diversion) through care experienced whilst imprisoned to care on release from prison.**

Part D. This part is trying to determine which client groups and problems are of the highest priority for prison mental healthcare. Again you are asked to make a judgement on the basis that new money was available for investment.

Contact for further information

Mr. N. Bowler.
Lecturer in Mental Health Nursing,
University of Wales,
Swansea
SA2 8PP
01792 518571
e-mail. N.J.Bowler@Swan.ac.uk

You will be given a copy of the information sheet and a signed consent form to keep.

CONSENT FORM
VERSION NO. 2.2
DATE ; 17th February 2004

Centre number .....
Study number .....
Respondent identification number for this study..... *N.B.* Two copies should be made for (1) subject (2) researcher

☐

Title of project ; Follow up to Prison Mental Health Needs Assessment

1. I confirm that I have read and understood the information sheet] for the above study and have had the opportunity to ask questions.

2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason.

I agree to take part in the above study

Name of Participant DATE

Signature

Name of Person taking consent DATE

Signature

Researcher DATE

Signature

Appendix j

Staff Survey Questionnaire (2004)

Follow up Questionnaire to Prison Mental Health Needs Assessment

Part A. About you

NAME;

Role;

Location **(where are you working now or where you gained your experience of working with this client group?)**

Experience **(years and type of experience of working with mentally disordered offenders and/or prisoners)**

Part B; Prisoners mental health

This part of the questionnaire is a *'once only'* judgement of the impact of prisoners' experiences upon their mental health. You are asked to tick how positively or negatively in your judgement a wide range of social and prison experiences would impact upon the prisoner's mental health using one of the 5 descriptors ranging from 'extremely positive' to 'extremely negative.' This data will allow a comparison to be made between respondents' judgements and data previously collected.

Instructions

Please tick one of the boxes to indicate what impact, if any, you judge these factors to have upon prisoners' mental health?

10. **Poor educational attainment**

Extremely positive	*Positive*	*Neither positive or negative*	*Negative*	*Extremely negative*

11. **Have been 'in care' in the past**

Extremely positive	*Positive*	*Neither positive or negative*	*Negative*	*Extremely negative*

12. **No previous prison sentence**

Extremely positive	*Positive*	*Neither positive or negative*	*Negative*	*Extremely negative*

13. **Working in paid employment before prison,**

Extremely positive	*Positive*	*Neither positive or negative*	*Negative*	*Extremely negative*

14. History of taking illegal drugs

Extremely positive	*Positive*	*Neither positive or negative*	*Negative*	*Extremely negative*

15. **Have currently been in prison for less than a month**

Extremely positive	*Positive*	*Neither positive or negative*	*Negative*	*Extremely negative*

16. **Currently on remand**

Extremely positive	*Positive*	*Neither positive or negative*	*Negative*	*Extremely negative*

17. **Conviction for a sex offence**

Extremely positive	*Positive*	*Neither positive or negative*	*Negative*	*Extremely negative*

18. Showing remorse

Extremely positive	*Positive*	*Neither positive or negative*	*Negative*	*Extremely negative*

19. **Anti-social personality** (those describing themselves as 'Loners', 'Not trusting', Unable to get on with others, 'Impulsive')

Extremely positive	*Positive*	*Neither positive or negative*	*Negative*	*Extremely negative*

20. Locked in cell for 20 hours a day or more

Extremely positive	*Positive*	*Neither positive or negative*	*Negative*	*Extremely negative*

21. Experience of intimidation

Extremely positive	*Positive*	*Neither positive or negative*	*Negative*	*Extremely negative*

22. Not engaged in working, educational or rehabilitation regime in prison

Extremely positive	*Positive*	*Neither positive or negative*	*Negative*	*Extremely negative*

Part C; Prison Management of mental health problems.

This part of the questionnaire is trying to identify the areas of mental healthcare, which could make the biggest difference to mentally disordered prisoners. You are asked to consider the respective investment priority of different functions of the care process, as if new money was available for service development. These functions follow the whole range of interventions for mentally disordered offenders/prisoners from arrest and court appearance to imprisonment and release. The range of priority goes from 'urgent' as the highest priority to 'area for disinvestment' for areas you may consider to be of no worth. It may be that you will be asked to complete this section (and section C) more than once in order to try and develop a consensus as to what the priorities are.

Instructions

Please tick these items to indicate their investment priority for prison mental health care for prisoners.

23. **Alternatives to prison for mentally disordered offenders.** (Increased use of diversion at point of arrest or before court, increased specialist psychiatric provision (such as low/medium secure provision) and non-custodial alternatives to prison)

Urgent priority	High priority	Low priority	Status quo	Area for disinvestment

24. **Improved screening, assessment and diagnosis of mental health problems to ensure that no mentally disordered prisoners remain hidden from healthcare services in prison.** (Opportunities may exist at reception or during other health consultations to identify mental health problems. Prison specific screening tools for assessment could be introduced)

Urgent priority	High priority	Low priority	Status quo	Area for disinvestment

25. **Better prison healthcare management of mental disorder and adoption of the Care Programme Approach** (Improved detection and diagnosis, care planning and monitoring of mental health problems whilst in prison)

Urgent priority	High priority	Low priority	Status quo	Area for disinvestment

26. Prisoner-centred healthcare. (A change in the culture of prison healthcare to allow greater prisoner participation in health care, wing based care, a focus upon health promotion and self-management, increased self-help and 'Listener' type schemes)

Urgent priority	High priority	Low priority	Status quo	Area for disinvestment

27. **Stronger focus upon multi-agency working and sharing of information.** (Earlier consideration of setting up aftercare and involvement of external agencies to achieve this. Better use of information including court reports and existing GP/mental health records on reception to prison and more sophisticated IT systems in prison for holding and sharing information with other agencies)

Urgent priority	High priority	Low priority	Status quo	Area for disinvestment

28. **Increased training and support** (Increased opportunities for clinical staff in prison to professionally update and receive clinical supervision and training for custody officers in signs and symptoms of mental disorder)

Urgent priority	High priority	Low priority	Status quo	Area for disinvestment

29. **More creative regimes and therapeutic activity**. (Improved provision of psychological therapies and constructive daily activity for mentally disordered prisoners)

Urgent priority	High priority	Low priority	Status quo	Area for disinvestment

30. **NHS transfer and clinical support** (Easier transfer to NHS for prisoners under the 1983 Mental Health Act and when individuals become severely disturbed and greater involvement of expert practitioners to support care in prison)

Urgent priority	High priority	Low priority	Status quo	Area for disinvestment

31. **Better functioning across prison departments.** (Improved working between prison departments to enable coordinated response to multiple mental/physical health, educational and social needs.)

Urgent priority	High priority	Low priority	Status quo	Area for disinvestment

32. **Development of in/outreach** (Development of flexible medical, nursing and other professional roles, which can move between prison and the community to follow-up prisoners after discharge)

Urgent priority	High priority	Low priority	Status quo	Area for disinvestment

Section D. Prioritisation of client groups

This section is trying to determine which client groups and problems are of the highest priority for prison mental healthcare. Again you are asked to make a judgement 'as if' new money was available for investment.

Instructions
Please tick these items according to their investment priority

33. **Substance misuse**

Urgent priority	High priority	Low priority	Status quo	Area for disinvestment

34. **Unresolved psychological trauma and post-traumatic stress**

Urgent priority	High priority	Low priority	Status quo	Area for disinvestment

35. **Psychotic illness**

Urgent priority	High priority	Low priority	Status quo	Area for disinvestment

36. Dual diagnosis (Serious mental illness and drug problem)

Urgent priority	High priority	Low priority	Status quo	Area for disinvestment

37. Self-harm and suicide

Urgent priority	High priority	Low priority	Status quo	Area for disinvestment

38. Dangerous behaviour

Urgent priority	High priority	Low priority	Status quo	Area for disinvestment

39. **Anxiety, depression, phobic and other neurotic disorders**

Urgent priority	High priority	Low priority	Status quo	Area for disinvestment

40. Social problems – including relationship problems, debt, homelessness

Urgent priority	High priority	Low priority	Status quo	Area for disinvestment

41. **Prisoners vulnerable to abuse**

Urgent priority	High priority	Low priority	Status quo	Area for disinvestment

42. Complex and multiple mental health and social needs

Urgent priority	High priority	Low priority	Status quo	Area for disinvestment

Appendix k

HM Prison Service First Reception Health Screen as used in HMP Audit (2005)

FIRST RECEPTION HEALTH SCREEN

HM PRISON SERVICE
HEALTH CARE

Prison No .....
Surname .....
Forename(s) .....
D.O.B. .....

Name of GP .....
Address .....
.....
.....

EXPLAIN TO THE PRISONER THAT THE PURPOSE OF THIS INTERVIEW IS TO GAIN A BRIEF CONFIDENTIAL MEDICAL AND PSYCHIATRIC HISTORY

PHYSICAL HEALTH

Have you seen your GP recently? **YES / NO**

Complaint

Have you ever had, or suffered from, any serious illness? **YES / NO**

Illness

Are you receiving any form of treatment? **YES / NO**

Medication

Have you had any serious injuries? **YES / NO**

What and when

Have you had any operations? **YES / NO**

Operation type, where and when

Are you HIV positive or worried about having contracted the HIV or Aids virus? **YES / NO**

Are you allergic to anything? **YES / NO**

What (in red)

Have you been immunised against the following? **YES / NO**

Tetanus: *Polio:* *Hepatitis B:*

Have you any worries regarding your general health? **YES / NO**

What are they?

Has your family any history of medical problems? **YES / NO**

What are they?

Is your eyesight good? **YES / NO**

Is your hearing good? **YES / NO**

Well man / woman observations (within 24 hours)

BP.....P.....R.....T.....

Peak flow ..... Height .....

Weight ..... Urine .....

Name of last hospitals attended

1 .....
Address .....
.....
.....

2 .....
Address .....
.....
.....

DRUG / ALCOHOL HISTORY

Tick box if 'YES'

Have you ever used drugs? **YES / NO**

Type, amount, method

Are you using drugs at present? **YES / NO**

Type, amount, method

Have you ever shared needles? **YES / NO**

How much alcohol do you drink daily?

Quantity

Do you think you drink excessively? **YES / NO**

Do you smoke tobacco? **YES / NO**

Quantity

GYNAECOLOGY

Date of Last Menstrual Period (LMP)?

Do you have any gynaecological problems? **YES / NO**

If yes, brief details

Have you ever had any gynaecological operations at any time? **YES / NO**

If yes, when?

Have you ever had a smear test? **YES / NO**

If yes, when

Do you know the results?

Do you suffer from:

(a) Bleeding between periods **YES / NO**

(b) Vaginal discharge **YES / NO**

Are you on any form of contraceptive? Pill / IUD / or any other?

OBSTETRICS

Have you ever been pregnant? **YES / NO**

If yes, was the delivery FTND / LSCS / Forceps?

Any miscarriages or terminations?

If yes, when

Brief details

Any reason to believe you are pregnant? **YES** ◯ **NO** ◯

Do you wish to have a pregnancy test? **YES** ◯ **NO** ◯

MENTAL HEALTH

Tick box if 'YES' or where indicated

Have you suffered from any psychiatric illness in the past? **YES / NO** ☐

What illness, where and when?

Have you ever deliberately harmed yourself? **YES / NO** ☐

How and when?

Have you ever attempted suicide? **YES / NO** ☐

Method tried

Has any close relative or friend ever attempted suicide? **YES / NO** ☐

Are you or have you been prescribed any psychiatric medication / medicine for your "nerves"? **YES / NO** ☐

Details

Is this your first time in prison? **YES / NO** ☐

Were you expecting to be sent to prison? **YES / NO** *(tick if "No")* ☐

Have you received a larger sentence than you were expecting? **YES / NO** ☐

Does anyone else know you're in prison? **YES / NO** *(tick if "No")* ☐

Are you expecting contact with your family and friends? **YES / NO** *(tick if "No")* ☐

Do you use drugs or alcohol? **YES / NO** ☐

Do you feel like hurting yourself at the moment? **YES / NO** ☐

Are you feeling suicidal? **YES / NO** ☐

To be considered by screener

Does the prisoner seem excessively withdrawn or depressed? **YES / NO** ☐

Does the prisoner seem excessively anxious? **YES / NO** ☐

Is the prisoner charged / convicted of sexual offences / offences against a child? **YES / NO** ☐

Is the prisoner charged with murder / manslaughter? **YES / NO** ☐

Is the prisoner charged / convicted of an offence against a relative / partner? **YES / NO** ☐

Has concern been expressed by the police, probation or any other agancy? **YES / NO** ☐

RAISE A F2052SH IF PRISONER TALKS ABOUT FEELING SUICIDAL OR IF OTHERWISE INDICATED

Name and address of latest psychiatric hospital / psychiatrist / community psychiatric nurse

.....

.....

.....

.....

Any other information we should know?

This form has been completed during a private interview with the prisoner who is fully aware of the nature of responses contained in it.

CO / Nurse *Signature* ..... *Print* ..... *Date* .....

MEDICAL IN CONFIDENCE

ADDITIONAL INFORMATION