Towards mental health promotion in prisons: the role of screening for emotional distress

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Abstract

Prisoners who are at risk of mental illness and self-harm or suicide can be easily missed by existing prison screening procedures. More proactive measures are needed. One possible way is to ‘screen’ prisoners in the first week in custody. Self-report measures offer a better alternative to lengthy clinical interviews given the large number of prisoners. With a sample of 400 newly incarcerated male prisoners, this study aimed at establishing the construct validity, internal consistency and clinical utility of the GHQ-12 through a psychological screening programme. One factor with an eigen value of 5.94 explained almost 50% of the variance in the items on the GHQ-12. This questionnaire was also internally consistent. Using the same questionnaire, 59% of prisoners were emotionally distressed using the recommended cut-off-point for the prison population (score ≥5). These prisoners were referred to a variety of services including both voluntary and non-voluntary services and for 14% of those prisoners an ACCT plan was initiated. The prisoners appeared to welcome a programme of psychological screening. This screening may complement existing screening and suicide prevention procedures at the point of arrival to prison. The findings are discussed in terms of their implications for future research and the study’s limitations.

Keywords: Prisoners, GHQ-12, HADS, psychological screening, mental health promotion

1. Introduction

Studies have shown that as high as 90% of the prison population has some kind of mental disorder and that 92% of all suicides in prison are carried out by male prisoners (Shaw, Baker, Hunt, Moloney, & Appleby, 2004). Overall, the rates of mental illness and suicide in prison have been higher than those in the community (Fremouw, de Perczel, & Ellis, 1990; Singleton, Meltzer, Gatward, Coid, & Deasy, 1998). The high incidence of mental health problems among the prison population relates to a range of factors. Pre-existing mental illness can deteriorate and can be worsened by the prison environment and the prison environment itself may increase existing risk of suicide.
(Liebling, 1994). Alternatively, mental illness can develop as a result of the psychological effects of being incarcerated (William & Edwards, 2004).

A number of procedures (such as the Assessment, Care in Custody, and Teamwork; ACCT) are put in place to detect prisoners with mental health problems and to help address their needs. These are based on the notion that the prevention of emotional distress in general, and of self-harm and suicide in particular, should be multi-agency and multi-disciplinary and should not fall automatically within the remit of mental health services such as applied psychology and psychiatry. However, there is a growing population of mentally ill prisoners being insufficiently detected (Andersen, 2004). These findings suggest that the prisoners who are at risk of mental illness and self-harm or suicide but do not show obvious signs of distress can be easily missed by these procedures and should therefore be identified by more proactive measures. One possible proactive way is to screen prisoners during their first week in custody. This screening can assist in identifying those who are already suffering from a mental illness but also those who are experiencing higher levels of emotional distress and who may be at risk of becoming mentally ill. In this respect, this can contribute towards mental health promotion. One of the widely used screening measures in the general population is the General Health Questionnaire-12 (GHQ-12) (Goldberg & Hillier, 1979).

Therefore, the aims of the present study were: 1) to establish the construct validity of the GHQ-12 and its internal consistency; and 2) to show the clinical utility of the GHQ-12 by undertaking a psychological screening programme among newly incarcerated prisoners, and referring those in need to relevant services.

2. Method

2.1 Sample

This study was undertaken as part of routine applied psychology practice and induction procedures in one of largest male prisons in London, UK. Out of 526 prisoners in their first week in custody approached, 400 (76%) participated in the screening. The mean age was 33.5 years (SD= 9.14). The exclusion criteria was the presence of severe mental and/or physical illness preventing participation.

2.2 Instruments

The screening measure, the GHQ-12 (Goldberg & Hillier, 1979) was developed for use in community samples to detect clinically significant emotional distress. For each of the 12 items, prisoners were asked to select one of four possible answers to indicate how they felt. These were scored using the GHQ method (0, 0, 1,1). Smith & Borland (1999) showed that the GHQ-12 could be used in the prison setting as a screening measure with the threshold of 5 and over indicating clinically significant distress.

2.3 Procedure

During routine induction procedures to the prison, the prisoners were given brief information on the aims of the screening and were invited to participate. The prisoners were told that their participation was voluntary. A member of the applied psychology team administered the screening measure in the induction room to those who agreed to participate and gave verbal consent. Then, prisoners scoring 5 and over on the GHQ-12 were approached 2-4 days post-incarceration by either a chartered psychologist or a trainee psychologist to carry out an interview to identify need. During these interviews participants were also asked questions about intent and/or attempts of suicide or self-harm in the past and while they had been in the prison.

Following these interviews, participants were referred to different agencies depending on their needs. If participants answered the questions related to suicide and self-harm positively, ACCT plan was also initiated for them. The prison safer custody records for all participants were checked for a year following screening to examine whether there were any incidents of self-harm and attempts of suicide.
2.4 Statistical analyses

The construct validity of the GHQ-12 was established by examining its structure. The structure of the questionnaire was assessed by principal components analysis. The number of components to retain was decided with the help of a scree test before varimax rotation. The criterion for significant loadings was > 0.50. The reliability of the GHQ-12 was also established by Cronbach’s alpha coefficient, a coefficient of 0.91 being considered good.

3. Results

Out of 400 prisoners who took part in the screening, 395 prisoners (99%) fully completed the GHQ-12. The structure of the GHQ-12 is given in Table I. One component which had an eigen value of 5.94 explained 49.49% of the variance in the items. Cronbach's alpha coefficient was also satisfactory (0.91).

The level of emotional distress as measured by the GHQ-12 using the recommended threshold of ≥5 (Smith & Borland 1999) was 235 (59%) out of 395 prisoners. Out of these 235 prisoners, 25 (11%) were referred to voluntary counselling services, 110 (47%) were referred to applied psychology services, 46 (20%) to alcohol services, 18 prisoners (8%) to psychiatry, 18 (8%) primary care, 16 (7%) foreign national team, 12 (5%) to yoga, 10 (4%) acupuncture, 10 (4%) housing services, 7 (3%) forensic intervention programmes, 5 (2%) probation, 3 (1%) chaplaincy, 2 (0.9%) substance misuse and 1 (0.4%) to a parental awareness programme. Moreover, for 32 prisoners (14%), an ACCT plan was initiated. All of these prisoners were followed through the prison safer custody procedures for a year following their participation in the screening, none of these individuals had committed an act of self-harm or attempted suicide in that period of time.

Table I. The structure of the GHQ-12. Loadings > 0.50 are shown for 1 component that emerged from the principal components analyses.

<table>
<thead>
<tr>
<th>Item</th>
<th>Factor 1</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Been able to concentrate on whatever you are doing</td>
<td>0.73</td>
</tr>
<tr>
<td>2 Lost much sleep over worry</td>
<td>0.70</td>
</tr>
<tr>
<td>3 Felt that you are playing a useful part in things</td>
<td>0.64</td>
</tr>
<tr>
<td>4 Felt capable of making decisions about things</td>
<td>0.67</td>
</tr>
<tr>
<td>5 Felt constantly under strain</td>
<td>0.75</td>
</tr>
<tr>
<td>6 Felt you could not overcome your difficulties</td>
<td>0.68</td>
</tr>
<tr>
<td>7 Been able to enjoy your normal day-to-day activities</td>
<td>0.66</td>
</tr>
<tr>
<td>8 Been able to face up to your problems</td>
<td>0.73</td>
</tr>
<tr>
<td>9 Been feeling unhappy and depressed</td>
<td>0.76</td>
</tr>
<tr>
<td>10 Been losing confidence in yourself</td>
<td>0.74</td>
</tr>
<tr>
<td>11 Been thinking of yourself as a worthless person</td>
<td>0.65</td>
</tr>
<tr>
<td>12 Been feeling reasonably happy, all things considered</td>
<td>0.72</td>
</tr>
<tr>
<td>Eigenvalue</td>
<td>5.94</td>
</tr>
<tr>
<td>Percent of Variance</td>
<td>49.49</td>
</tr>
</tbody>
</table>

4. Discussion

The present study aimed at examining the construct validity of the GHQ-12 and its internal consistency and exploring the clinical utility of the GHQ-12 by undertaking a psychological screening programme among prisoners who were newly incarcerated, and referring those in need to relevant services.

The findings indicate that the GHQ-12 was internally consistent and that one factor explained almost 50% of the variance in the items. These findings suggest that the items on the GHQ-12 are relevant to the male prison population and support the unidimensional conceptualization of the GHQ-12.

Out of 526 prisoners approached to participate in the screening, 400 prisoners (76%) took part in the screening. A substantial number of prisoners (59%) were emotionally distressed as measured by the GHQ-12 using the threshold of ≥5. This finding is consistent with the prevalence rates estimated by previous studies using the GHQ ranging from 44 to 68% (McGilloway & Donnelly, 2004).
As a result of this screening process, prisoners who reported emotional distress were referred to a variety of both statutory and voluntary services for support and for 14% of those prisoners an ACCT plan was initiated. The follow-up consisting of a review of the prison safer custody records for a year following the screening indicated that none of these individuals had committed an act of self-harm or attempted suicide. These results suggest that participation in the screening was moderately high and that prisoners welcomed such proactive approaches to their care in custody. This is pleasantly surprising given the fact that adherence to treatment among people with mental illness who are also incarcerated can be problematic and that alternative methods (such as outpatient commitment) have been suggested to improve treatment adherence (Fuller Torrey & Zdanowicz, 2001).

There are a number of limitations of the present study. Basic demographic data including age was not collected for the prisoners who did not take part in the screening. Therefore, it is not possible to ascertain whether or not the sample was biased.

For prisoners who did not have sufficient English, Language Line Services were used to administer the GHQ-12. Unfortunately, adapted versions of the questionnaires were not used because of linguistic diversity of the foreign nationals who took part in the study. This might have influenced the findings. Future screening studies should use adapted versions of the GHQ-12 and should examine the ways in which the findings converge or diverge.

The present study was undertaken in one of the major London prisons for males. This prison included prisoners from different cultures and ethnicity. However, the findings may not be generalised across the prison estate. It would be useful to undertake the same screening in comparable male prisons in other parts of Britain.

In addition, it is not possible to estimate how many of the newly incarcerated individuals would have been referred to relevant services in the absence of the screening. A controlled study could be useful. Nevertheless, the potential advantages of the screening in the first week of custody are still worth considering, given the hectic nature of the prison environment. Thus, the first week in custody could have been a potentially debilitating period for the prisoners. Furthermore, it is also encouraging to note that, as result of the screening, a number of potentially useful referrals to other care and support services available in the prison, including Chaplaincy and voluntary counselling services, were facilitated for some prisoners at the point of arrival to prison.

Keeping these pitfalls in mind, this type of screening may complement existing screening and suicide prevention procedures at the point of arrival to prison with the view of detecting not only obvious signs of mental illness or emotional distress but also more subtle and nonetheless debilitating levels of emotional distress that warrant care and support.

It is beyond the scope of the present study to ascertain the ways in which participation in the psychological screening might have been a helpful experience for prisoners. Nevertheless, one can hypothesise that the screening provided access to professional support and in turn, professional support provided opportunities for self-disclosure and positive interpersonal interaction and increased motivation for self-management. Thus, in doing so, professional support might have promoted perceived stability, predictability and control. Another mechanism might be that screening helped enhance prisoners’ sense of control (and/or reduce powerlessness) over one’s health and life in such a demanding and restricting environment. It remains for future qualitative or quantitative studies to examine potential mechanisms by which prisoners might have benefited from taking part in this type of screening.

The prison induction procedures provided a platform for psychologists to take a leading role in undertaking a psychological screening programme. The rate of participation and the number of referrals made and prisoners helped at least in terms of prevention of suicide and self-harm suggest that it may be feasible to undertake an additional mental health screening in prison during the first week of incarceration, a time when the prisoners are at most risk. Nevertheless, prisons are busy institutions and staff resources are usually overstretched. One could argue that it is unrealistic to expect another questionnaire to be administered and the findings acted upon. This is especially relevant when one considers the ways in which community mental health teams operate. These usually use certain thresholds for referral acceptance. Prison mental health services aim to operate in similar ways. As a result, prisoners who are emotionally distressed, in the absence of mental illness, would not normally be referred to these services. Therefore, the screening has substantial implications for existing services.

However, without this additional screening, prisoners who were at risk could have been easily missed at a high cost to mental health services and prison staff, especially in terms of attempts of self-harm and suicide or development of mental health problems requiring long-term care. It is premature to say that this screening should complement existing screening procedures. A controlled longitudinal study should be carried out before its value is dismissed.
This screening can be incorporated into existing induction procedures in ways similar to the present study. For example, prison officers responsible for the induction procedures can be trained in the administration and the interpretation of the GHQ-12, the identification of need and relevant referral making. The workings of the existing prison staff and existing support mechanisms such as the Insiders Scheme, the Listeners Scheme, voluntary counseling services and Chaplaincy can be reorganized to accommodate the new proactive procedure.

References


