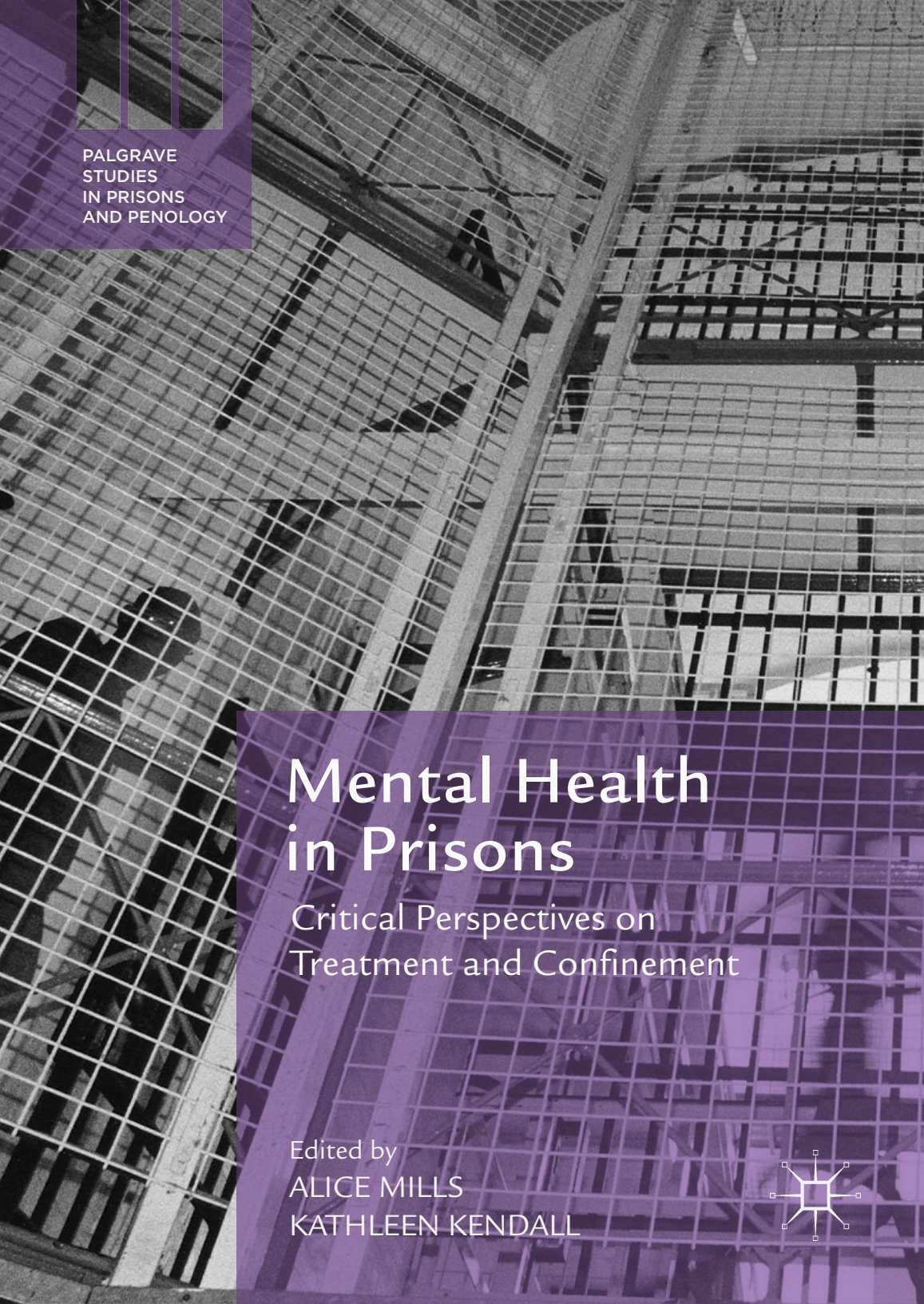
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Critical Perspectives on
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Editors

Mental Health in Prisons

Critical Perspectives on Treatment and Confinement

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Abbreviations

ABS	Australian Bureau of Statistics
ACCT	Assessment, Care in Custody and Teamwork
ADTP	Alcohol Dependency Treatment Programme
BHA	Boston Housing Authority
BJS	Bureau of Justice Statistics
CMCH	Corporate Manslaughter and Corporate Homicide Act 2007
CORI	Criminal Offender Record Information
CSC	Close Supervision Centre
DH/HMPS	Department of Health/HM Prison Service
DRWs	Drug Recovery Wings
DSM	Diagnostic and Statistical Manual of Mental Disorders
FPT	Forensic Prison Team
GLM	Good Lives Model
GP	General Practitioner
HMCIP	HM Chief Inspector of Prisons
HMIP	HM Inspectorate of Prisons
HMPPS	HM Prison and Probation Service
IAMHDCD	Indigenous Australians with Mental Health Disorders and Cognitive Disability in the Criminal Justice System Project
IEP	Incentive and Earned Privileges
IPA	Interpretative Phenomenological Analysis

IPP	Indeterminate Imprisonment for Public Protection
JCHR	Joint Committee on Human Rights
LBGTQ	Lesbian, Gay, Bisexual, Transgender and Queer
MDT	Mandatory Drug Testing
MFUs	Māori Focus Units
MHDCD	Mental Health Disorder and Cognitive Disability in the Criminal Justice System Project
MHIRT	Mental Health In-Reach Team
MHSU	Mental Health Screening Unit
MRC	Massachusetts Rehabilitation Commission
NAI	National Archives of Ireland
NAO	National Audit Office
NHS	National Health Service
NOMS	National Offender Management Service
NPS	New Psychoactive Substances
NSW	New South Wales
PHE	Public Health England
PIC	Prison Industrial Complex
PJ	Psychological Jurisprudence
PPO	Prisons and Probation Ombudsman
PSA	Psychoactive Substances Act 2016
PTSD	Post Traumatic Stress Disorder
RIDR	Report Illicit Drug Reaction
SC	Synthetic Cannabinoids
SDTP	Substance Dependence Treatment Programme
SLMC	See Life More Clearly
SMI	Serious Mental Illness
SSDI	Social Service Disability Insurance
SSI	Social Security Insurance
SUs	Service Users
THC	Tetrahydrocannabinol
VA	Veterans Administration
W2B	Walls to Bridges
WHO	World Health Organization
WSDTP	Women's Substance Dependence Treatment Programme

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1

Introduction

Alice Mills and Kathleen Kendall

People with mental health problems have long been present in both prisons and other places of confinement. Seddon notes that throughout the eighteenth century 'it was increasingly becoming the case that the "natural repository for the lunatic who had committed a felony […] was the local gaol or house of correction" (Walker and McCabe 1973, p. 1)' (Seddon 2007, p. 20, citation in original). Today, prison populations worldwide experience substantially higher levels of mental distress than the general population. In a systematic review of 81 studies from 24 countries, Fazel and Seewald (2012) found a prevalence of psychosis of 3.6% in male prisoners and 3.9% in females, with corresponding figures for major depression of 10.2 and 14.1%. In England and Wales, 90% of the prison population is said to experience one or more psychiatric

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disorders,[1] four times the corresponding rate in the wider community (Brooker et al. 2008). Women and young people in prison are particularly vulnerable to mental health problems (NHS Commissioning Board 2013; Fazel et al. 2008). In the US, the level of mental health problems in prisons is so high that carceral institutions have been seen as 'de facto' psychiatric hospitals (Daniel 2007). This can be at least partially attributed to the low tolerance shown towards disorderly public behaviour in the 1990s, which, as Young (2004) suggests, is likely to have been motivated by a desire to control people with mental health problems wandering the streets without proper facilities or treatment. Although in recent times various attempts have been made to divert or transfer those with mental health problems away from the prison system, such attempts have had a limited impact in practice. For Seddon (2007), this is because the very presence of those with mental health problems within prison is an intrinsic element of the whole confinement project. Institutional confinement is used as a method of punishment to exclude the 'deviant', the dangerous and the vulnerable and '[F]rom this perspective, the confinement of some of the mentally disordered within prisons is unsurprising' (Seddon 2007, p. 157).

Those with mental health issues are often criminalised, but imprisonment itself can create or exacerbate mental health problems. Prisons are hostile environments where people experience fear, intimidation, psychological and physical harm due to, amongst other issues, separation from family and friends, living at close quarters with other prisoners and a lack of constructive activity. The likelihood of self-inflicted death is 8.6 times greater in prison than in the community (Ministry of Justice 2017). This has been explicitly linked to the consequences of imprisonment including boredom, isolation, stressful events within prison such as intimidation and victimisation, and the increasing use of New Psychoactive Substances (NPS) (Dear 2008; National Audit Office [NAO] 2017).

The literature on mental health in prisons has grown exponentially in the last 20 years, and is currently somewhat dominated by mental health professionals, particularly from the 'psy' sciences (Mills and Kendall 2016), perhaps reflecting a substantial increase in the number of mental health staff working in prisons. More critical approaches such as those

from sociology, criminology and gender studies have been neglected and little attention has therefore been paid to the constraints and impositions of the prison environment and the exercise of penal power on mental health and mental health treatment (Mills and Kendall 2016). This book seeks to overcome this deficit by presenting a variety of critical perspectives on mental health in prison from academics, practitioners and those who have been involved with the criminal justice system. It examines how the environment, regime, architecture and culture of a place designed for punishment can affect mental health and determine the type, delivery and effectiveness of mental health services. A range of different jurisdictions is discussed in order to demonstrate how mental health in prisons is affected by wider socio-economic and cultural factors, and how in recent years neo-liberalism has abandoned, criminalised and contained large numbers of the world's most marginalised and vulnerable populations. These jurisdictions include Australia, New Zealand and Canada, where due to the ongoing effects of colonialism, indigenous groups are substantially over-represented in the prison population, in addition to England and Wales, Ireland, and the United States. All are neo-liberal societies which have seen increasing structural inequalities. This book is therefore missing other, especially non-Western perspectives in low-income and middle-income countries, which, we would argue, should be the subject of further research and discussion. Overall, this collection challenges the dominant narratives of individualism and pathology and many contributors focus instead on the relationship between structural inequalities, suffering, survival and punishment.

In doing so, this book uses a broader conceptualisation of mental health than other literature in this area. Psychiatric studies such as those cited at the beginning of this book reveal high levels of diagnosed mental illness in prison populations; however, it should be remembered that these levels will be shaped by the instruments used to diagnose and measure them, which in turn are underpinned by a bio-medical framework (Busfield 2011). Many prisoners experience mental health difficulties which do not come to the attention of treatment services or fulfil the criteria for mental illness set by diagnostic manuals. The World Health Organization (WHO) (2014) defines mental disorders as comprising 'a broad range of problems […] generally characterised by some

combination of abnormal thoughts, emotions, behaviour and relationships with others'. However, it is difficult to judge what might be considered 'abnormal' thoughts and behaviour in the abnormal environment of a prison, where mental and emotional distress may be considered intelligible responses to experiences of imprisonment, social exclusion and the histories of trauma, loss and abuse, which are considerably more likely to be present amongst incarcerated populations (Durcan 2006).

The terms 'mental illness', 'mental disorder' and 'mental health' are associated with narrow medicalised perspectives, limited in their ability to consider the causes of mental distress (Johnstone and Boyle 2018). Like Morrow and Malcoe (2017), we therefore also use terms such as 'mental distress', 'emotional distress' and 'psychological well-being', although the individual contributors to this volume may use the language of 'mental health' and 'mental illness' according to the aims of their work and their professional background.

Themes of This Book: Critical Approaches to Treatment in Confinement

This book aims primarily to (re)introduce a range of critical perspectives to scholarly work on mental health and penal institutions. Although each of the chapter authors brings their own unique critical approach to this topic, reflecting their varying focuses, academic and professional backgrounds and personal experiences, broadly, this volume is based upon four key themes which run throughout the chapters. Firstly, this collection acknowledges that prison is an unsuitable environment for those with mental health problems (Mills and Kendall 2016; Seddon 2007),[2] particularly as imprisonment, the prison environment, architecture and regime may create and/or exacerbate mental distress. Despite widespread recognition of this, the use of imprisonment for those with mental health issues persists. Although in England and Wales the 2010 Bradley report recommended the extension of police and court diversion services to direct those with serious mental disorder away from the criminal justice system, such schemes remain patchy, and only a small

percentage of prisoners with mental health problems are transferred from prisons to outside psychiatric facilities. In the absence of alternative provision, many with mental health problems end up in prison as the 'default' institution (see McCausland et al., this volume) or a place of last resort, particularly if there is seemingly nowhere else for them to go.

In recent times, prison mental health has become a topic of heightened public interest due to the increasing incidence of suicide and self-harm in prisons. In England and Wales, incidents of self-harm increased by 73% between 2012 and 2016 and there were 120 self-inflicted deaths in prisons in 2016, the highest figure since records began (NAO 2017). As noted above, previous research into suicide and self-harm has demonstrated that whilst the prison population contains a high degree of 'imported vulnerability' to suicide and self-harm, the fear, boredom, isolation and other frustrations created by the prison environment strongly contribute to the risk of self-harming behaviours (Dear 2008; Liebling and Krarup 1993; Liebling 1992), alongside the continual failure of the state to learn the lessons from previous deaths in custody (Sim, this volume). The pains of imprisonment have been considerably extended since Sykes's seminal study (see, for example, Crewe 2011). Nevertheless, the deprivations of liberty, goods and services, heterosexual relationships,[3] autonomy and security remain salient as the basic premise, purpose and form of imprisonment endure. For Sykes (1958, p. 79), these pains represented considerable sources of frustration, boredom, discomfort and isolation but together also embody 'a set of threats or attacks which are directed against the very foundations of the prisoner's being'. Imprisonment therefore acts as an assault on the prisoner's sense of self, threatening their ontological security in addition to their physical safety. Moreover, the ability to take measures to ameliorate mental health difficulties, that might be recommended outside of carceral environments, such as constructive activity, support from family and friends, a healthy diet and exercise is highly limited by the prison environment and regime. In these circumstances, it is perhaps foreseeable that expressions of mental distress such as suicide and self-harm are likely to increase, particularly in the context of recent cuts to prison budgets such as in England and Wales.

Secondly, we explore the interface between correctional and psychiatric treatment and the tension between the competing priorities of care and custody. In prison, many mental health problems go undetected and untreated, even at the more serious end of the scale (Senior et al. 2013). In a US study, only one in three state prisoners and one in six jail inmates with a mental health problem received treatment in prison (James and Glaze 2006). Prisoners may not admit to having mental health problems at reception screening due to the shock of imprisonment (Sim 2002) or fear of being viewed as weak and/or vulnerable, and symptoms of mental distress may go ignored on prison wings (Birmingham 2003).

Even when prisoners do receive treatment, its value is likely to be limited by the fact of imprisonment, the priorities of treatment services and available resources. The extent and form of treatment, and quality of care may also be influenced by the degree to which treatment agencies and healthcare staff are bound to the prison authorities and their priorities of security and control. Psychiatric services may be provided by the prison itself, outside of the health departments responsible for public healthcare standards, such as in Belgium and Lithuania. In such instances, mental health services may be more concerned with control and custody, leading to substandard care and human rights violations (WHO/International Committee of the Red Cross 2005). For example, when the Prison Medical Service in England and Wales was responsible for the provision of mental health care, psychotropic medicine was administered to control recalcitrant prisoners and prisoners were thought to have been used as 'guinea pigs' for new forms of medication (Sim 1990, 2002; Woolf 1991; Coggan and Walker 1982). Healthcare professionals working in prison may be seen as part of the disciplinary structure of the prison, potentially constructing prisoners as 'less eligible subjects', undeserving of anything but poorer standards of care than non-prisoners (Sim 2002, p. 300).

Alternatively, mental health treatment in prison may be provided by external services including community mental health services, through commissioning either by the prison administration or justice department, such as in New Zealand (Wakem and McGee 2012), or by national or local health authorities, such as in England and Wales,

France, Italy, and most Nordic countries (Brooker and Webster 2017; Dressing and Salize 2009). In the case of the former, decisions regarding treatment may still be made in the interests of the institution and healthcare budgets may be used to supplement over-committed custody budgets (Wakem and McGee 2012). One example of the latter model are prison mental health in-reach teams (MHIRTs) introduced in Anglo-Welsh prisons in 2002. These multi-disciplinary teams, commissioned by local healthcare agencies, were designed to provide an equivalent range and quality of care to patients with severe mental illness in prison as they would receive in the community. Despite their relative independence from the prison authorities, their aim of providing equivalent mental health care can still be substantially hampered by the prison setting, the emphasis on punishment and security rather than well-being, and the sheer weight and complexity of demand for mental health services (Mills and Kendall 2016, this volume; Harvey and Smedley 2010). Mental health professionals may also be burdened with tasks associated with minimising harm to the institution rather than relieving the distress of the prisoner patient (see Cox and Marland, this volume), including assessing prisoners' suitability for administrative or punitive segregation and managing suicide and self-harm (Mills and Kendall 2010, this volume). The tendency to focus on managing risk and maintaining the public image of the prison, rather than providing appropriate care, was recently highlighted by the Ombudsman in New Zealand who examined several cases of prisoners accommodated in 'at risk units' due to self-harming behaviour. These units contain sparsely furnished isolation cells with no television or reading material and very little opportunity for contact with others. Prisoners kept there were subject to the use of tie down beds and waist restraints,[4] justified by the Department of Corrections as a legitimate response to the perceived risk of self-harm (Stanley 2017). In one case, a prisoner spent 37 nights on a tie-down bed from 4 p.m. to 8.30 a.m. ostensibly to prevent him from self-harming, a practice which the Ombudsman declared amounted to 'cruel, inhuman or degrading treatment or punishment for the purposes of Article 16 of the [UN] Convention against Torture' (Office of the Ombudsman 2017, p. 5).

Mental health services in prison have overwhelmingly focused on psychiatric treatment for prisoners with diagnosed serious mental illness, particularly medication, even though many prisoners have expressed an interest in wanting help with deep-rooted personal problems (Mills and Kendall 2010; Crewe 2009). Psychological treatment at least in UK prisons has become 'synonymous with reducing criminality' (Harvey and Smedley 2010, p. 10) through offending behaviour programmes rather than relieving emotional and mental distress, and psychologists may hold considerable power over prisoners, given their input into risk and security classifications and parole decisions (Crewe 2009), eroding the likelihood of a trusted therapeutic relationship.

Both the focus of mental health services in prisons and the punitive management of self-harm demonstrate how prisons tend to individualise and pathologise mental health problems rather than viewing them as a response to imprisonment, the prison environment, and structural violence outside the prison. In 1990 the then Chief Inspector of Prisons, Stephen Tumin, noted the danger of viewing suicide and self-harm in prison primarily as medical problems, as it may lead to the view 'that all the answers lie with the doctors' (HM Chief Inspector of Prisons 1990, p. 7). To counter this pathologising discourse, in this collection we also focus on non-medical approaches to alleviating mental and emotional distress. These include the use of peer supporters (see chapters by Moyes and Perrin, this volume), which may have substantial benefits for both peer supporters themselves and those whom they seek to help, and prison education programmes (Pollack and Edwards, this volume). Such approaches offer the possibility of inclusive transformative practice and support in prisons for all prisoners regardless of the level of symptoms or sources of their distress.

Thirdly, we argue that despite the individualising and pathologising discourses of much of the current policy and literature around mental health in prisons, mental health issues are likely to be strongly affected, if not created, by wider structural issues. As Johnstone and Boyle (2018, p. 8) assert, '[h]umans are fundamentally social beings whose experiences of distress and troubled or troubling behaviour are inseparable from their material, social, environmental, socioeconomic and cultural contexts'. In this regard, there is a well-established and growing body of scholarship

demonstrating that poor mental health is more prevalent among individuals who are socially marginalised due to socio-economic disadvantage, gender, ethnicity, racialisation, colonialism, nationality, gender identity, sexual orientation, disability and age; and that persons who occupy several marginalised positions have an even greater likelihood of experiencing mental health problems (Macintyre et al. 2018; Silva et al. 2016; Rosenfield 2012). This is unsurprising since marginalisation is concomitant with numerous harms likely to cause mental and emotional distress including neglect, inequality, subordination, discrimination, oppression and violence (Pickett and Wilkinson 2010; Johnstone and Boyle 2018). Unfortunately, a diagnosis or label of mental illness can often lead to further marginalisation and harm (Pūras 2017).

This situation highlights the need to adopt policies and practices targeting social inequities and injustices. Yet, the current political and economic climates in the jurisdictions covered by this book are dominated by neoliberalism, which despite being diverse, complex and evolving, is fundamentally 'associated with increased inequality in income, power, and access to resources within countries and a dismantling of universal welfare provision' (Collins et al. 2016, p. 135). Under such a regime, marginalised individuals become even more vulnerable and are held entirely responsible for their circumstances. Rather than preventing and addressing the harms associated with inequalities through the establishment of fairer and caring communities, governments have instead embraced punitive responses through the expansion of prisons, community-based punishments and other spaces of confinement including immigration detention centres. Following their examination of imprisonment in ten nations across all five continents, Jacobson et al. (2017, p. vii) note that with well over 10 million people incarcerated worldwide, there has been a rapid and unrelenting growth in imprisonment, disproportionately harming marginalised groups. Thus, as many authors in this collection illustrate, socially excluded individuals are more likely to experience mental health problems, imprisonment or both (see, for example, chapters by McCausland et al.; Cavney and Friedman; Sim; Norton-Hawk and Sered, this volume). In such a way, imprisonment and patterns of mental health problems both serve as indices of inequality (Whitlock 2016).

Finally, given the above arguments, several contributors take an abolitionist stance, arguing that due to the punishing and debilitating effects of imprisonment, there is an urgent need to consider alternatives. Regardless of healthcare and other reforms that seek to humanise prisons or make them places of rehabilitation and/or treatment, prisons have failed to reduce crime and will only ever be likely to further damage mental health. Several jurisdictions such as England and Wales, Australia and New Zealand aim to provide health care to prisoners which is of a standard equivalent to that provided in the community (Mills and Kendall 2016). This is likely to be unrealistic and unachievable in an 'anti-therapeutic' environment designed for punishment and confinement where health care is not seen as a core business activity (Mills and Kendall 2010), and may be implicated in punishment and control (Seddon 2007). Additionally, if the presence of people with mental health problems in prison is an intrinsic element in the use of institutional confinement as punishment, as Seddon (2007) suggests, no matter how radically mental health care is improved, it will not address the problem. Seddon therefore urges 'a radical re-think of the whole confinement project' (2007, p. 166). Prisons remain expressions of state power which emphasise collective and individual punishment over collective support and empathy (Sim 2009). Security and control requirements will always be prioritised over therapeutic needs (Seddon 2007; Carlen and Tombs 2006) and the informal power held by unaccountable prison staff continually undermines more enlightened policies and practices (Ryan and Sim 2016).

Furthermore, given the socially excluded backgrounds of most prisoners, it is difficult to see how prison could be seen as rehabilitative (Carlen and Tombs 2006), particularly because as state institutions, prisons are 'intimately connected with the reproduction of an unequal and unjust social order divided by the social lacerations of class, gender, 'race', age and sexuality' (Sim 2009, p. 8; see also Ryan and Sim 2016). Despite criticisms of the abolitionist movement as unrealistic and idealistic, abolitionist campaigners in England and Wales have claimed success in abolishing the Prison Medical Service in the early 1990s, and the closure of the mentally torturous Control Units in the mid-1970s (Sim 2009). Resources that are used to provide ostensibly rehabilitative