

Mental Health in Prison: A Trauma Perspective on Importation and Deprivation

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Abstract

Prison is primarily intended as a punishment for criminal acts. It is an establishment which aims to punish those who commit crime, protect the public from crime and criminals, and reform criminals into law abiding citizens, thus reduce re-offending. It has however, been reported that imprisonment increases vulnerabilities and heightens mental ill health. Studies across a variety of counties have reported that the prevalence of mental illness in prison far exceeds that of the general population. Several studies have suggested that prisoners experience a number of pre-prison adversities which contribute to subsequent mental ill health. However, there are additional reports that prisoners develop mental illness due to the prison environment. This debate is rooted within a theoretical framework which considers importation and deprivation models (i.e., do prisoners take mental illness with them when they are imprisoned or do factors associated with being imprisoned cause mental illness to develop?). This current paper discusses how this theoretical framework may be placed within a trauma context. Many studies report that trauma precipitates the development of mental illness. Trauma is often prevalent for individuals prior to imprisonment and often experienced during imprisonment. Thus, it is suggested that the adverse effects of trauma are cumulative and thus likely to precipitate severe mental illness suggesting that mental illness in prison is attributable to both importation and deprivation perspectives.

Introduction

The world prison population is steadily on the increase. Indeed, successive editions of the World Prison Population list, produced by Walmsley (2006; 2008; 2011), which is based on between 214 and 218 countries, has reported that the number of prisoners worldwide has risen from over 9.25 million in 2006, through to over 9.8 million in 2008 and most recently to over 10.1 million in 2011. Notably, the highest prison population rate per 100,000 of the national population has rested with the USA. In 2006 the USA's prison population rate was 738 per 100,000, rising to 756 per 100,000 in 2008, and slightly decreasing to 743 per 100,000 in 2011. Comparably speaking, the prison population rate for England and Wales is far lower at 148, 153, and 153 per 100,000 in 2006, 2008, and 2011 respectively. However,

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the prison population in England and Wales is still substantial, equating to 84,883 prisoners in April 2011 (Walmsley 2011). Furthermore, it has been estimated that this rate will increase to an excess of 100,000 prisoners by 2014 (Carter 2007).

The Intended and Unintended Consequences of Imprisonment

Prison is primarily intended as a punishment for criminal acts. Indeed, Coyle (2005) highlighted that prison is an establishment which aims to punish those who commit crime, protect the public from crime and criminals, thus act as a deterrent to those contemplating committing crimes, and reform criminals into law abiding citizens, thus reduce re-offending. All of which occurs at great expense to the UK tax payer, with estimated costs of £35,000 per annum, per prisoner (Coyle 2005). Despite these aims and the associated expenses, researchers and practitioners alike have stated that imprisonment repeatedly fails to achieve its objectives. For example, rates of re-offending are high. Indeed, a report titled 'Reducing Reoffending by Ex-Prisoners' published by the Social Exclusion Unit (2002) highlighted that almost 60% of ex-prisoners re-offend and are placed back in prison within two years of their release and that ex-prisoners are responsible for 20% of all crimes. Thus, the intended consequences of imprisonment are rarely met. Moreover, imprisonment is associated with a myriad of unintended consequences, such as increased drug abuse, the deterioration of physical and mental health, and increased rates of prisoner suicide (Dye 2010). Indeed, the Sainsbury Centre for Mental Health (2008) reported that prison may "...cause a person's mental and physical health to deteriorate further, that life and thinking skills will be eroded, and that prisoners will be introduced, or have greater access to drugs" (p. 14). The focus of this review will be on prisoner mental health as an unintended consequence of imprisonment.

The Prevalence of Mental Illness in the Prison Population

The Department of Health (2009) reported that imprisonment increases vulnerabilities and heightens mental ill health, in addition to increasing the risk of suicide. Therefore, it is unsurprising that the prevalence of mental illness in prison is high. Indeed, several studies across a variety of counties have reported that the prevalence of mental illness in prison far exceeds that of the general population (Brinded et al. 2001; Corrado et al. 2000; Diamond et al. 2001). Singleton et al. (1998) reported that almost 90% of the prison population has a mental health issue, broken down Singleton et al. (1998) reported that 66% of prisoners in England and Wales have a personality disorder, 45% experience depression or anxiety disorders and 8% experience psychosis. When compared to prevalence estimates of mental illness in an epidemiological survey of the general population of England and Wales, these rates are high. For example, 5.3% of the general population were reported as having a personality disorder, 13.8% were reported as having experienced depression or anxiety disorders and 0.5% experienced psychosis (Singleton et al. 2000). Further to this, an international meta-analytical review of mental illness in prisons, which reviewed 62 surveys and thus 23,000 prisoners, concluded that major depression, psychosis, and antisocial personality disorders were far more prevalent in the prison population compared to the US and UK general population (Fazel & Danesh 2002).

Prevalence studies are useful in attempting to quantify the levels of mental illness within the prison population however, some considerations must be made. Firstly, given that screening of both physical and psychological ailments on entry to prison is often conducted by staff with no prior mental health training (Edgar & Rickford 2009), thus by staff who may be inefficient at identifying all mental health cases, combined with the fact that prisoners

mental health records are rarely transferred alongside prisoners from prison to prison (Durcan 2008), suggests that the true prevalence of mental illness in prisons may be greatly underestimated. Secondly, many prevalence studies are cross-sectional in nature, taking a snapshot of prevalence at a particular point in time. Other factors should be considered such as length of imprisonment, number of times imprisoned, type of facility, and potentially type of offender i.e., what type of crime they have been convicted off (Edwards & Potter 2004).

Pre-prison: Prisoner Adversities and Characteristics

The Social Exclusion Unit (2002) details a number of socially exclusive characteristics of prisoners prior to imprisonment. For example, half of the prison population have reading skills which are comparable or at a lower standard than that of the average eleven year old. A substantial proportion also struggle with writing and numeracy skills. In a related vein, over half (52%) of the prison population have failed to gain a formal qualification. Moreover, almost half (47%) absconded from their childhood homes suggesting difficult childhood home environments and experiences. Further childhood adversities such as exclusion from school and living away from biological parents are common and far more likely to be reported by the prison population than the general population. Furthermore, there are high reported rates of homelessness (32%) prior to imprisonment. Most notably, the Social Exclusion Unit (2002) reported that 50% of all prisoners were not registered with a general practitioner prior to their imprisonment, notable given the high prevalence of mental illness in this group and thus the obvious failure of individuals to engage with health services and to engage in help-seeking behaviours. In addition, traumatic and abusive experiences amongst prisoners are common (Durcan 2008). Such pre-prison adversities are often linked to subsequent mental health issues. Indeed, a lack of educational qualifications has been associated with an increased risk of developing mental health issues such as depression, Post-traumatic Stress Disorder (PTSD) and psychosis (Brewin, Andrews, & Valentine 2000; Rosenman 2002; Shevlin, Dorahy, & Adamson 2007; van Os, Hannssen, Bijl, & Ravelli 2000). Furthermore, there is a wealth of research supporting a link between childhood adversities such as abuse and mental health issues such as PTSD, Depression, and Psychosis (e.g., Kessler, Sonnega, Bromet, Hughes, & Nelson 1995; Norris 1992; Read, Perry, Moskowitz, & Connolly 2001). In addition, McNeil, Binder and Robinson (2005) concluded that a substantial proportion of the prison population who were deemed to have a mental health issue were homeless prior to imprisonment.

Prison Factors which Contribute to Poor Prisoner Mental Health

Although social exclusion, disadvantage, and traumatic adversities prior to imprisonment, which have the potential to precipitate mental illness, are high in prison populations it is also notable that many factors related to the prison environment can, and most likely do, contribute to poor prisoner mental health. Indeed, the World Health Organisation (WHO) reported that "...mental disorders may...develop during imprisonment itself as a consequence of prevailing conditions..." (WHO/ICRC 2005 p. 1). The WHO highlighted several factors which have the potential to contribute to poor prisoner mental health. These factors included overcrowding, prison violence, isolation from previous social contacts, insecurities surrounding employment and relationship opportunities on release from prison, poor health and mental health service provision during imprisonment, and a general lack of privacy or forced solitary confinement. Indeed, Durcan (2008) and Edgar and Rickford (2009) both highlighted that it is normal prison protocol to remove prisoners with serious mental health

issues from the stressful prison environment into segregation units. However, extreme segregation in the form of solitary confinement has been shown to have detrimental effects on prisoner mental health (Metzer & Fellner 2010).

Dye (2010) stated that a "...paramount component of the pains of imprisonment" (p. 789) is violence. Indeed, it has often been reported that inmate on inmate assaults are extremely common (Stephan & Karberg 2003) albeit that epidemiological and indeed phenomenological research related to the extent and context of prison violence is limited (Blitz, Wolff, & Shi 2008). Thus, reports of high levels of violence in prison, combined with research which has repeatedly reported that assaultive violence is one of the leading traumatic experiences which precipitate PTSD (Breslau, Davis, Andreski, & Peterson 1991; Breslau et al. 1998), suggests that perhaps the level of traumatising within prison is one of the main factors related to high rates of prisoner mental health issues. Indeed, Blitz et al. (2008) conducted a study which investigated physical victimization and mental illness in prison ($N = 7528$). The study concluded that prisoners who had received treatment for a range of mental health issues (PTSD, depression, anxiety, bipolar disorder, and schizophrenia) reported higher rates of physical victimization. More specifically, males with a mental disorder history were 1.6 times more likely to report experiencing physical victimization from other inmates compared to those without a mental disorder history. Similarly, females with a mental disorder history were 1.7 times more likely to report physical victimization. It could therefore be argued that many prison factors are traumatizing and, given the aforementioned links between trauma and mental illness, have the potential to contribute to prisoner's poor mental health.

Pre-prison Prisoner Adversities and Characteristics or Prison Factors?

Whether pre-prison, prisoner adversities and characteristics, or factors directly associated with imprisonment contribute equally or not to the development and thus high prevalence of mental illness in prisons can be rooted within a theoretical framework which considers importation and deprivation models. Essentially this theoretical framework asks the question, do prisoners take mental illness with them when they are imprisoned or do factors associated with being imprisoned cause mental illness to develop? (Edwards & Potter 2004). This theoretical framework, as we have previously touched upon, may also be placed within a trauma context.

The Importation and Deprivation Models of Mental Illness in Prisons

The importation model suggests that maladaptation such as poor mental health is imported into the prison environment (Carroll 1974). Importation theorists have suggested that mental health issues may be a common factor which leads to criminality and thus arrest and imprisonment (Edwards & Potter 2004). Ultimately suggesting that pre-prison, prisoner adversities and characteristics as discussed in section 4 of the current review best account for the high rates of mental illness in prison populations. In comparison, the deprivation model, thus deprivation theorists (Goffman 1961; Sykes 1958) propose that maladaptation, such as mental illness, is attributable to the 'pains of imprisonment' in the prison environment, as discussed in section 5 of the current review.

One major criticism of the deprivation model is that it fails to account for individuals who do not develop maladaptation, in this case mental illness, whereas others do (Dye 2010). If deprivation was the sole factor in maladaptation then all prisoners should have mental health problems, however as is seen by a number of prevalence studies this is not the case (Fazel &

Danesh 2002). A limitation of importation models is simply that they ignore the effects of deprivation (Dye 2010), suggesting that prisoners are not affected by the prison environment and associated occurrences such as assault. To borrow from the prison suicide literature, researchers have suggested that suicide (another form of maladaptation) is best explained by combination models (Dear 2006). Thus, suicide is explained by a combination of imported factors and deprivation factors during imprisonment. The same may hold true for mental illness. In other words, the 'pains of imprisonment' may further exacerbate pre-prison, prisoner characteristics and adversities. This may explain why the 'pains of imprisonment' may increase the likelihood of mental illness for some but not for all individuals.

A Trauma Perspective on Importation and Deprivation Models of Mental Health in Prisons

As aforementioned, existing trauma histories, including both traumatic and abusive experiences, are common amongst prisoners (Durcan 2008). Thus, prisoners import the negative and detrimental effect of traumatisation into prison. When imprisoned it is common for prisoners to experience additional traumas, such as assaultive violence and solitary confinement (Metzer & Fellner 2010; Stephan & Karberg 2003) to name only a few. Thus, similar to the deprivation theory, the prison environment itself creates further potential for the development of mental illness. Indeed, research in the trauma and mental health literature has suggested that the cumulative effect of trauma greatly increases the likelihood of individuals developing a mental illness, such as psychosis. Indeed, research has shown that when individuals experience more than one traumatizing event, the likelihood of experiencing psychosis increases in a dose response fashion, i.e., the likelihood of developing psychosis increases with each subsequent traumatic experience (Shevlin, Houston, Dorahy & Adamson 2008).

Female Prisoner's Mental Health: A Special Trauma Case?

Thus far, the current review has presented research predominately, if not exclusively, based on male prisoners. However, women represent a small proportion of the total prison population. Interestingly the proportion of women prisoners is rising, more so than the rise in the rate of male prisoners (Fawcett 2004). Similar to male prisoners, female prisoners constitute some of the most socially and economically disadvantaged individuals in society. Levels of education are low and unemployment is high (Corston 2007; Coll, Millar, Fields, & Mathews 1997). For women, social and economic disadvantage can go hand in hand with traumatic experiences, including, emotional, physical and sexual abuse as well as subsequent domestic violence. Indeed, female prisoners are more likely to have experienced physical and sexual abuse compared to their males prisoner counterparts (Wolf, Silvia, Knight, & Javdani 2007). In one study it was reported that 9% of female prisoners had experienced childhood sexual abuse, of which 41% experienced penetration. Furthermore, 70% reported the experience of severe levels of physical violence. Seventy-five percent experienced extreme domestic violence (Browne, Millar, & Maguin 1999). Green, Miranda, Daroowalla, and Siddique (2005) reported that 98% of the female prison population disclosed trauma histories. Furthermore, Lawrie (2003) reported that 98% of female prisoners with histories of childhood abuse also had comorbid drug and alcohol disorders, which they directly blamed for their offending. Thus, from a trauma importation model perspective females import a great deal into the prison environment.

From a trauma deprivation (or exacerbation) model perspective, prison itself can have severe detrimental effects on women's mental health. Indeed, traumas in prison such as physical internal searches, privacy invasion, and verbal emotional abuse can further exacerbate mental illness (Moloney, van den Bergh, & Moller 2009). This suggests that combined models of importation and deprivation from a trauma perspective may be best suited to explain the high prevalence of female mental illness in prison. Indeed, Moloney and Moller (2009) reported that the Kyiv Declaration recommended that trauma disorders should be a focus when addressing the mental health needs of women prisoners.

Conclusion

Imprisonment has many unintended consequences one of which is a high prevalence of mental illness (Fazel & Danesh 2002). Researchers have debated whether the high prevalence of mental illness is imported into the prison system or if the prison environment itself causes mental illness. These debates have been rooted in the wider theoretical framework of importation and deprivation models, which debate various forms of maladaptation. Although less research has been conducted specifically in relation to mental health, research from other domains such as prison suicide has concluded that a combination of importation and deprivation models best explain maladaptation (Dye 2010). This may hold true for prison mental health. However, as the literature in relation to mental health in prison is littered with reference to traumatic experiences, the current review proposed a trauma perspective on importation and deprivation (or perhaps better termed exacerbation) models. In other words, pre-existing traumatic experiences are common in both male and female prisoners which are further exacerbated by traumas experienced within prison. This is supported by literature suggesting that the cumulative effect of trauma is likely to precipitate severe mental illness such as PTSD and psychosis (Shevlin et al. 2008). It is notable, however, that prison mental health is multifactorial and is often intertwined with high rates of drug and alcohol disorders (Moloney & Moller 2009; Moloney et al. 2009). Unfortunately, a discussion of this was beyond the scope of the current review.

References

- Andersen, HS. (2004) 'Mental health in prison populations. A review — with special emphasis on a study of Danish prisoners on remand.' *Acta Psychiatrica Scandinavica*, 110 (Suppl. 424), 5–59.
- Arboleda-Florez, J. (2009) 'Mental patients in prisons' *World Psychiatry*, 8, 187–189.
- Breslau, N., Davis, GC., Andreski, P., & Peterson, E. (1991) 'Traumatic events and PTSD in an urban population of young adults' *Archives of General Psychiatry*, 48, 216–222.
- Breslau, N., Kessler, RC., Chilcoat, HC., Schultz, LR., Davis, GC., & Andreski, P (1998) 'Trauma and Posttraumatic Stress Disorder in the Community: The 1996 Detroit Area Survey of Trauma' *Archives of General Psychiatry*, 55, 626–632.
- Brewin, CR., Andrews, B., & Valentine, JD. (2000) 'Meta-analysis of risk factors for posttraumatic stress disorder in trauma-exposed adults' *Journal of Consulting and Clinical Psychology*, 68, 748–766.
- Blitz, CL, Wolff, N, & Shi, J. (2008) 'Physical victimization in prison: The role of mental illness', *International Journal of Law and Psychiatry*, 31, 385–393.

- Brinded, PMJ., Simpson, AIF., Laidlaw, TM., Fairley, N., & Malcolm, F., (2001) 'Prevalence of psychiatric disorders in New Zealand prisons: A national survey.' *Australian and New Zealand Journal of Psychiatry*, 35, 166–173.
- Browne, A., Miller, B, Maguin, E. (1999) 'Prevalence and severity of lifetime physical and sexual victimization among incarcerated women.' *International Journal of Law and Psychiatry*, 22, 301-322.
- Carter of Coles, Lord (2007) *Securing the future: Proposals for the efficient and sustainable use of custody in England and Wales*. London: Ministry of Justice.
- Carrol, L. (1974) *Hack, blacks and cons*. Lexington, MA: Lexington Books.
- Coll CG, Miller JB, Fields JP, & Mathews B. (1997) 'The experiences of women in prison: implications for services and prevention'. *Women Therapy*, 20, 11–28.
- Corrado, RR., Cohen, I., Hart, S., & Roesch, R., (2000) 'Comparative examination of the prevalence of mental disorders among jailed inmates in Canada and the United States'. *International Journal of Law and Psychiatry* 23, 633–647.
- Corston, J (2007) *The Corston report: A review of women with particular vulnerabilities within the criminal justice system*. London: Home Office.
- Coyle, A (2005) *Understanding Prisons*. Berkshire: Open University Press.
- Dear, G. (2006) *Preventing suicide and other self-harm in prison*. Basingstoke; Palgrave Macmillan.
- Diamond, PM., Wang, EW., Holzer, CE., Thomas, C., & Cruser, A., (2001) 'The prevalence of mental illness in prison'. *Administration and Policy in Mental Health*, 29, 21–40.
- Durcan, G. (2008) *From the inside: Experiences of prison mental health care*. London: Sainsbury Centre for Mental Health.
- Dye, MH (2010) 'Deprivation, importation, and prison suicide: Combined effects of institutional conditions and inmate composition', *Journal of Criminal Justice*, 38, 796-806.
- Eden, JF., Peters, RH., & Hills, HA. (1997) 'Treating prison inmates with co-occurring disorders: An integrative review of existing programs'. *Behavioural Sciences & the Law*, 15, 439–457.
- Edgar K., & Rickford, D. (2009) *Too little, too late: An independent review of unmet mental health need in prison*: Prison Reform Trust.
- Edwards WT., & Potter, RH. (2004) 'Psychological Distress, Prisoner Characteristics, and System Experience in a Prison Population'. *Journal of Correctional Health Care*, 10, 129 – 149.
- Fazel, S., Bains, P., & Doll, H. (2006) 'Substance abuse and dependence in prisoners: A systematic review'. *Addiction*, 101, 181–191.
- Fazel, S., & Danesh, J. (2002) 'Serious mental disorders in 23000 prisoners: A systematic review of 62 surveys'. *Lancet*, 359, 545–550.
- Fazel, S., & Lubbe, S. (2005) 'Prevalence and characteristics of mental disorders in jails and prisons'. *Current Opinion in Psychiatry*, 18, 550–554.
- Fawcett Society (2004) *Women and the criminal justice system: a report of the Fawcett Society's Commission on Women and the Criminal Justice System*. London: Commission on Women and the Criminal Justice System
- Green, BL, Miranda, J, Daroowalla, A & Siddique, J. (2005) 'Trauma exposure, mental health functioning, a programme need of women in jail'. *Crime Delinquency*, 51, 133-151.
- Goffman, E. (1961) *Asylums*. Garden city, NY: Anchor Double Day.
- HMIP (2009) *HM Chief Inspector of Prisons for England and Wales Annual Report 2007-08*. London: The Stationary Office.

- Kessler, RC., Sonnega, A., Bromet, E., Hughes, M., Nelson, CB. (1995) 'Posttraumatic stress disorder in the National Comorbidity Survey'. *Archives of General Psychiatry*, 52, 1048-1060.
- Lawrie R. (2003) *Speak out, speak strong*. Sydney: Australian indigenous law reporter.
- McNeil, DE., Binder, RL., & Robinson, JC. (2005) 'Incarceration Associated With Homelessness, Mental Disorder, and Co-occurring Substance Abuse'. *Psychiatric Services*, 56, 840-846.
- Metzer, JL., & Fellner, JF. (2010) 'Solitary confinement and Mental Illness in US Prisons: A Challenge for Medical Ethics'. *The Journal of the American Academy of Science and Law*, 38, 104-108.
- Moloney KP., & Moller, LF. (2009) 'Good practices for mental health programming for women in prison: Reframing the parameters'. *Public Health*, 123, 431-433.
- Moloney, KP., van den Bergh, BJ., & Moller, LF. (2009) 'Women in prison: The central issues of gender characteristics and trauma history'. *Public Health*, 123, 426-430.
- Norris, FH. (1992) 'Epidemiology of Trauma: Frequency and Impact of Different Potentially Traumatic Events on Different Demographic Groups'. *Journal of Consulting and Clinical Psychology*, 60, 409-418.
- Read, J., Perry, BD., Moskowitz, A., & Connolly, J. (2001) 'The contribution of early traumatic events to schizophrenia in some patients: a traumagenic neurodevelopmental model'. *Psychiatry*, 64, 319-345.
- Rosenman, S. (2002) 'Trauma and posttraumatic stress disorder in Australia: findings in the population sample of the Australian National Survey of Mental Health and Wellbeing. Australian and New Zealand'. *Journal of Psychiatry*, 36, 515-520.
- Sainsbury Centre for Mental Health (2008) *In the DARK: The Mental Health Implications of Imprisonments for Public Protection*. Sainsbury Centre for Mental Health: London.
- Shevlin, M., Dorahy, M., & Adamson, G. (2007) 'Childhood Traumas and Hallucinations: An Analysis of the National Comorbidity Survey'. *Journal of Psychiatric Research*, 41, 222-228.
- Shevlin, M., Houston, JE., Dorahy, MJ., & Adamson, G. (2008) 'Cumulative traumas and psychosis: An analysis of the national comorbidity survey and the British Psychiatric Morbidity Survey'. *Schizophrenia Bulletin*, 34, 193-199.
- Singleton, N., Bumpstead, R., O'Brien, M., Lee, A. & Meltzer, H. (2000) *Psychiatric morbidity among adults living in private households*. London: Office for National Statistics.
- Singleton, N., Meltzer, H. & Gatward, R. (1998) *Psychiatric morbidity among prisoners in England and Wales*. London: Office for National Statistics.
- Social Exclusion Unit (2002) *Reducing Re-offending by Ex-Prisoners*. Social Exclusion Unit: London.
- Stephan, JJ., & Karberg, JC. (2003) *Census of state and federal correctional facilities 2000*. Washington, D.C.: Bureau of Justice Statistics, U.S. Department of Justice.
- Sykes, G. (1958) *The society of captives*. Princeton, NJ: Princeton University Press.
- Walmsley, R (2006) *World Prison Population List*. 7th Ed. London: Home Office Research, Development and Statistics Directorate.
- Van Os, J., Hannssen, M., Bijl, RB., & Ravelli, A. (2000) 'Strauss (1969) revisited: a psychosis continuum in the general population?' *Schizophrenia Research*, 45, 1-2.
- Walmsley (2008) *World Prison Population List*. 8th Ed. London: Home Office Research, Development and Statistics Directorate.
- Walmsley (2011) *World Prison Population List*. 9th Ed. London: Home Office Research, Development and Statistics Directorate.

- WHO/ICRC (2005) *Information sheet on prisons and mental health*. Geneva: WHO. Available at http://www.euro.who.int/_data/assets/pdf_file/0007/98989/WHO_ICRC_InfoSht_MNH_Prisons.pdf (accessed 11 Nov 2011).
- Wolf, A. Silvia, F. Knight, K. & Javdani, S. (2007) 'Responding to the health needs of female offenders'. In Rosemary Sheelen, Ed. *What works with women offenders*. Devon: Willan Publishing.