Review Essay

The prison setting as a place of enforced residence, its mental health effects, and the mental healthcare implications

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A B S T R A C T

The subject of place is salient certainly when deliberating the health of prisoners as a social group. This paper provides an overview and assessment of health and place in relation to mental health and the prison locale. Particular attention is devoted to prison culture, both staff and inmate. The incarceration experience (i.e. the nature of enforced residence in the prison environment) can affect negatively prisoners' mental health. The mental health of the prison population is poor, and mental health services in the prison setting have need of further improvement. However, the provision of mental healthcare and the pursuit of good mental health in the prison milieu are challenging. The prison-based—exceedingly complex—three-way relationship between culture–mental and health–mental healthcare is debated.

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1. Introduction

This paper focuses on the mental health of adult male prisoners and the National Health Service (NHS) mental healthcare provided in Her Majesty's Prison Service (HMPS), United Kingdom (UK). To generalise, the prison population represents a social group that experiences poor mental health in relation to that of the general population. The nature of health and healthcare in prison is markedly dissimilar to the nature of health and healthcare in wider society for myriad reasons (e.g. access process to services, patient group social/health profile, etc.). In order to consider aptly issues that concern the mental health of prisoners (i.e. aetiology, prevalence, severity, interventions, and outcomes), the prison setting as a social and structural place requires attention; mental health determinants in the environment are poignant, as ‘custody can exacerbate mental ill health, heighten vulnerability and increase the risk of self-harm and suicide’ (Department of Health (DH), 2009, p. 7). The cultural nature and the institutional regime in the prison setting can affect both prisoner mental health and the provision of mental healthcare: ‘context is crucial’ (Jordan, 2010, p. 26).

What follows is a review that commences by outlining the status of the current prison system in the UK (including the prison population's broader health and social issues as these have an impact on the provision of health services in the prison setting). Attention is then devoted to the NHS mental health policy and practice context in HMPS. Prison culture literature and the therapeutic environment initiatives are then utilised to debate the nature of health and place specifically. Subsequently, resultant mental healthcare implications are discussed. Finally, the paper concludes with a critical consideration of the prison-based—exceedingly complex—three-way relationship between culture–mental and health–mental healthcare.

2. Review

2.1. Imprisonment in the UK: HMPS

The aims of imprisonment could be typified as punishment, deterrence, reform, and public protection (Coyle, 2005). The objectives of HMPS are ‘to protect the public and provide what commissioners want to purchase by holding prisoners securely; reducing the risk of prisoners re-offending; providing safe and well-ordered establishments in which we treat prisoners humanely, decently and lawfully’ (www.hmprisonservice.gov.uk, last accessed 4.5.11). The 2007–2008 Annual Report from Her Majesty's Chief Inspector of Prisons for England and Wales (2009) argues that ‘prisons are, in general, undoubtedly better-run with record numbers in prison’ (p. 5) and noted that lessons ‘need to be learnt if prisons are to be safe and effective’ (p. 5). Security, resources, conditions, control of prisoners, feelings of injustice amongst inmates, and staff unrest are reportedly the main issues, after overcrowding.

Notably, incarceration is not an inexpensive venture, as each inmate costs UK taxpayers around £35 000 a year (Coyle, 2005). Imprisonment is intended to provide public protection by housing inmates humanely and securely, while working towards reducing
re-offending and rehabilitation. However, ‘imprisonment spectacu-
larly and persistently fails to achieve one of its primary avowed aims,
which is to reduce the level of re-offending by those who have
been punished in this way’ (Cavadino and Dignan, 2007, p. 192). The
Social Exclusion Unit (SEU) highlights that ‘people who have been in
prison account for one in five of all crimes; nearly three in five prisoners
are re-convicted within two years of leaving prison; offending by ex-
prisoners costs society at least £11 billion a year’ (p. 5).

fective Punishment, Rehabilitation and Sentencing of Offenders
prioritises the need for the UK to address its cycle of crime
issue (via the provision of effective rehabilitation in prison,
resulting in a reduction in re-offending). ‘Despite record spending
and the highest ever prison population we are not delivering what
really matters: improved public safety through more effective
punishments that reduce the prospect of criminals re-offending
time and time again’ (p. 5). HMPS is considered in need of
transformation, and plans for fundamental changes are proposed.
A future firm focuses on reform and rehabilitation is suggested.
‘The criminal justice system cannot remain an expensive way of
giving the public a break from offenders, before they return to
commit more crimes’ (p. 1). In relation to managing offenders with
mental health problems, the Green Paper highlights Lord Bradley’s
review (DH, 2009) and the concept of diversion, but also stresses
the need for increased care capacity for patients/prisoners with
personality disorders. The Green Paper’s spotlight on rehabilita-
tion (that includes inherently good mental health) is welcome.

2.2. HMPS NHS mental health policy and practice

DH and HMPS (2001) Changing the outlook: a strategy for
modemising mental health services in prisons officially introduces
the principle of equivalence to prison NHS mental healthcare. The
equivalence strategy calls for prison mental health services and
treatments to be in-line with the range of NHS community-based
mental healthcare available beyond the prison setting. To high-
light the continuing dominance of the equivalence aim, the DH
(2005) Offender mental healthcare pathway commences by reiter-
ating the ideal. NHS prison in-reach healthcare teams are
intended to provide the specialist mental health services to
persons in prison that are provided by community-based mental
health teams to the wider population.

The quality of NHS healthcare in prisons is measured by Prison
Health Performance Indicators (PHPI); this is a ‘traffic light’
performance rating system submitted to the Strategic Health
Authority (SHA). DH (2008) Guidance Notes: Prison Health Per-
f ormance and Quality Indicators details forty-three distinct areas
for assessment (e.g. Suicide Prevention, Primary Care Mental Health,
etc.). These measurements assess numerous aspects of prison
healthcare, not just mental health services. The DH & MoJ East
Midlands SHA PHPI Performance Report (2009) details the ‘traffic light’
quality indicators for seventeen of the UK’s HMPS prisons. The
Healthcare Environment section receives two red lights and
five amber lights, with the remaining ten lights showing green.
Furthermore, the Access To Specialist Mental Health Services section
receives one red, nine amber, and seven green lights.

The 2008–2009 Annual Report from Her Majesty’s Chief
Inspector of Prisons for England and Wales (2010) argues that
‘the prison system is struggling with the twin pressures of
increased population and decreasing resources’ (p. 5–6). Sixty-
four self-inflicted deaths occurred in prison custody in the
Inspectorate’s reporting year; importantly, ‘most local prisons
were not monitoring near-fatal incidents in order to learn lessons’
(p. 22). In addition, prisoners in receipt of self-harm and/or
suicide monitoring services are still, sometimes, ‘placed on the
basic regime, without consideration of its effect on their care
arrangements’ (p. 22). In-reach teams reportedly ‘often under-
resources, with staff carrying a heavy caseload’ (p. 29–30). The
majority of nursing staff in Powell et al’s (2010) recent multi-site
prison research reportedly ‘cited mental health problems as being
a substantial issue among prisoners’ (p. 1261).

In March 2011 the Offender Health Research Network (OHRN)
(2009) submitted their 2009 evaluation report concerning the
nation’s prison in-reach services to the National Institute of
Health Research. The majority of in-reach team leaders state their
teams are too small in size/staffing levels to aptly ‘meet the needs
of prisoners’ (p. 7). The bureaucracy in the prison system is
highlighted as an ongoing barrier, and working with HMPS in
terms of suicide/self-harm prevention and management (Assess-
ment, Care in Custody and Teamwork procedures) is variable, and
involvement and responsibilities are confused. Overall, however,
in-reach team leaders highly value the service, and consider the
concept of in-reach in the prison environment to be ‘an excellent
idea’ (p. 8). In-reach teams report ‘the impact of historical,
organisation, and physical factors upon the everyday delivery of
care’ (p. 8) in ‘an institutional setting with well established
procedures, relationships and cultural norms’ (p. 8). The provision
of healthcare is here linked to the social and institutional nature
of place (i.e. the prison milieu).

The aforementioned OHRN (2011) report provides updated
mental health prevalence statistics: severe and enduring mental
illness (SMI) is present in 23% of the prison population; major
depression is present in 19% of the prison population; psychosis is
present in 4% of the prison population; dual diagnosis is present
in 18% of the prison population; and substance misuse is present
in 66% of the prison population. Overall, 71% of the prison
population has a SMI, substance misuse problem, or both. This
OHRN report recommends that mental health in UK prisons
should be an issue for the entire HMPS (and not just the NHS
healthcare centres); increased resources are required to meet
clinical need; personality disorder and dual diagnosis clinical
skills and services require development; and continued research
and investment in prison mental healthcare are necessitated.

The World Health Organisation (WHO) (2007) highlights their
healthy prison concept to be a recognition that the health of
prisoners is not the responsibility of the healthcare clinicians
alone, but it is instead also dependent on the ethos and regime
created in the penal setting. The WHO’s Health in Prisons Project
and their report Health in prisons: a WHO guide to the essentials
in prison health (2007) acknowledge that prisoners’ individual
healthcare needs are important; however, the promotion of a
whole-prison (i.e. HMPS and the NHS working together in the UK
context) approach to health (e.g. promotion, prevention, services,
and treatment) is considered crucial for apt development of
healthy prisons, which provide appropriate care for those in
custody.

2.3. The broader health and social profile of prisoners

The SEU (2002) demonstrates that preceding imprisonment
47% of male prisoners ran away from home as a child, compared to
11% of the general population; 52% of male prisoners have no
qualifications, compared to 15% of the general population; and
32% of male prisoners were homeless prior to imprisonment,
compared to 0.09% of the wider population. In contrast to the
general public, prisoners are thirteen times as likely to have been
in care as a child; thirteen times as likely to be unemployed;
twenty times more likely to have been excluded from school;
two-thirds of prisoners were using drugs before imprisonment
(yet 80% have never had any contact with drug treatment
services); half of prisoners had no General Practitioner before
they came into custody; four in five have the writing skills,
two-thirds the numeracy skills, and half the reading skills at or below the level of an 11-year-old (SEU, 2002).

The social exclusion issues faced by this social group are overwhelming. These broader health determinants are crucial to this debate, as the health of the population that prisons receive has direct ramifications on the health services that are required in the prison setting. In relation to mental healthcare, these health and social profile issues provide the service with a population chock-a-block with potentiality for mental distress. Accordingly, psychiatric morbidity and comorbidity (i.e. a complex mix of several mental health issues and/or other health issues including substance and/or alcohol misuse) are prevalent. Nurse et al. (2003) record that suicide rates in prisons are six times higher than in the general population. The Revolving Doors Agency (2007) argues that HMPS has become a social dumping ground for people with mental illness; our prisons ‘carry a great burden of mental disability from major conditions…to lesser forms’ (Fraser et al., 2009, p. 410).

Additionally, while incarcerated, one-third of inmates lose their home, two-thirds lose their previous employment placements, over a fifth develop further financial problems, and over two-fifths lose contact with their family (SCMTH, 2008). ‘There are real dangers that prison will 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’ (SCMTH, 2008, p. 14). Prisoners misuse drugs for psychiatric, psychological, biological, pharmacological, and socio-economic reasons (Wheatley, 2007). Nurse et al. (2003) record that inmates often resort to drug misuse to relieve the tedium of incarceration, the feelings of isolation, and the lack of mental stimulus. Accordingly, Sifunda et al. (2006) report the ‘monotony of prison life’ (p. 2307). Moreover, ‘prescription drug dealing is common in prisons’ (Feron et al., 2008, p. 151), presenting problems for prison mental health services in relation to prisoners’ possession of prescription medication. Once again, this highlights the interrelated nature of health (i.e. the drug treatment) and place (i.e. the prison wing).

Both prisoner and staff culture are now considered in turn, as the links between the social environment, the mental health of the prisoner population, and the provision of mental healthcare are crucial.

2.4. The incarceration experience: prison culture

At this juncture, it is important to note that a large proportion of the prison culture literature originates from the United States (US). Admittedly, US and UK prisons are innately dissimilar; however, so are individual prisons and individual inmates’ subjective experiences of incarceration. Therefore, the body of US-origin knowledge is suitable for inclusion in a UK-based discussion providing its source is recognised and it is utilised appropriately.

Clemmer (1940) notes that prison culture includes the prisoner–staff–surroundings relationship in tandem with the traditions, habits, rules, attitudes, customs, and codes that govern the social organisation of the prison. Prisons are single sex institutions that operate repetitive and exceedingly disciplined daily routines. Coyle (2005) highlights that these two prevailing characteristics of prisons can be problematic for its population, since the bulk of prisoners are young men who are unused to a lifestyle dictated by daily schedules and authority. These inmates are then held in conditions of close confinement with very little private space. The potentiality for social tension and disagreements is, understandably, great.

Clemmer’s (1940) American penitentiary study, The prison community, aims to describe the culture of the investigated prison: its ‘penal milieu’ (p. 294). Clemmer (1940) highlights three fluid subgroups in his studied prison population; social classes are argued to exist. The elite class comprises of the most intelligent, sophisticated, and urbanised offenders who choose to overtly set themselves apart from the masses. The middle class is occupied by the vast majority of inmates and it is typified by its lack of unorthodox individuals and dislike for the third class, ‘the hoosiers’ (p. 108). The hoosiers are labelled so by the members of the other two social groups. This lowest class includes sexual offenders, ‘the feeble-minded’ (p. 108), those who lack physical courage, and ‘the backward’ (p. 108). The nature of mental health and place is evident clearly here, as those with overt mental health issues (as defined by the social group itself) are labelled negatively and placed at a cultural disadvantage in the social setting.

Sykes (1958) reported the utilisation of the labels below by prisoners in order to brand one another (pp. 84–108):

- merchant (a prisoner who sells what he should merely give),
- punk (a prisoner who submits to aggressive homosexuals),
- gorilla (a prisoner who takes what he wants from others by sheer force),
- rat (a prisoner who voluntarily communicates with the guards),
- fish (a prisoner who is newly arrived),
- fag (a prisoner classed as a passive, stereotypical homosexual),
- ball buster (a prisoner who perpetually defies the guards),
- wolf (a prisoner considered to be a dominant, forceful homosexual),
- tough (a prisoner labelled as aggressive and touchy),
- real man (a prisoner who endures the rigors of imprisonment with dignity).

Ireland and Qualter (2008) detail how contemporary forms of intragroup prison bullying via psychological/verbal victimisation often result in social and/or emotional loneliness. Prison culture is linked directly to prisoners’ wellbeing, once again highlighting the relationship between social place and resultant health-oriented experiences.

Sim (2006) claims the daily experiences of male prisoners are mediated by their relationships with, and expectations of, the other prisoners and their guards as men. Sim (2006) believes a culture of masculinity permeates prisons, often generating a hostile environment. De Viggiani’s (2003) UK-based prison ethnography reports that masculine ideology dominates the prison’s culture. Newton (1994) comprehensively explains how theories of masculinity can be effectively utilised to study men in prison: it is the unwritten codes in the patriarchy and the power relations of hegemonic masculinity, which are particularly pertinent in prison culture.

Bandyopadhyay’s (2006) Indian prison ethnography focuses on what happens to maleness and masculinities in the ‘chaotic, violent atmosphere’ (p. 195) during periods of incarceration; inmates’ struggles to reclaim agency (as a result of the divestiture of rights throughout imprisonment) and to assert a sense of self in the prison as an ‘overwhelmingly male space’ (p. 186) are explored. ‘The ideas of weak men, strong men, hardened men, and soft men are implicit in the hierarchies that prisoners construct’ (p. 190). Aggressive, violent men usually occupy the highest rungs of the prison hierarchy. Status is also dependent upon money, political connections, length of sentence, relations with influential staff members, personal appearance, and crime committed. For example, inmates who conducted crimes that were regarded as intelligent were honoured; whereas, ‘rapists were universally hated’ (p. 190). Acts of violence and threats of violence are often utilised in an attempt to maintain and control the social structure. Prisoners’ presentation of self is characterised as ‘a performance
of a certain image’ (p. 196) where speech, body language, dress style, etc. all have cultural ramifications.

Bandyopadhyay (2006) labours the point that ‘the idea of a changing persona is significant in understanding the issue of competing masculinities in prison’ (p. 197). It is important to remember that ‘hardness and softness are not fixed attributes inscribed onto maleness, but notions that circulate in prison and vary with circumstances’ (p. 191); the prison environment is significantly complex, and inmates’ construction of self in the institution, and place in the prison hierarchy are fluid. An inmate’s personality is not a static construct throughout their period of imprisonment. Prison mental health services need to reflect appropriately the exceedingly convoluted nature of inmates’ experiences of incarceration and consider whether the nature of health provision (e.g. the help-seeking process in the establishment) is compatible with the prison social environment. For example, in relation to health behaviour, as a result of hypermasculinity, male prisoners tend to under-report emotional difficulties and often help is sought only when the condition has severely deteriorated (Kupers, 2005).

It is now generally accepted that positive social interaction can improve mental health by fulfilling both emotional and material human needs. However, ‘social integration may play a different role for persons incarcerated in total institutions than among the human needs. However, ‘social integration may play a different role for persons incarcerated in total institutions than among the personal development, a more positive psychological and physical wellbeing issues (i.e. aspects of health) are associated with assimilation into the prison social environment (i.e. the place under discussion here).

Common to all cultures is the characteristic of flux. A society’s culture, or more often its array of cultures, is continually changing to some degree; culture is not a static social phenomena. The promotion of a new cultural model is perhaps a possible project for HMPS. It is theoretically feasible to alter the social dynamics in prisons. Arguably, an ideological shift towards viewing incarceration primarily as a period of time in which to develop inmates’ preparation for release (via addressing social exclusion issues, literacy and numeracy skills, and the promotion good mental health, as examples) is worthy of consideration. The creation of prison establishments where containment is considered secondary to the positive development and rehabilitation of prisoners is a valuable suggestion. Arguably, if prisoners perceived, and experienced, their prison stay as an opportunity for beneficial personal development, a more positive psychological and physical approach to imprisonment could be fashioned.

2.5. The social world of prison staff

‘In order to understand how prisoners function, it is essential to know something about the kind of people who work in prisons and what they do’ (Coyle, 2005, p. 83). It should be remembered that many members of prison staff spend more time in prison during their lives than the majority of prisoners. Crawley and Crawley (2008) report that ‘prison officers see themselves as part of an unvalued, unappreciated occupational group. Their understanding is that they are regarded by the public as unintelligent, insensitive and sometimes brutal, and that their work is perceived as entailing no more than the containment of society’s deviants and misfits’ (p. 134). Resultant occupational norms and values are important to this healthcare debate that addresses links between mental health and place.

Cynicism, suspiciousness, group solidarity, conservatism, and machismo are characteristics often attributed to prison officer culture. Interestingly, feelings of social isolation and an emphasis on physical courage often typify prison officer culture (Crawley and Crawley, 2008); this also characterises some inmate cultures. Additionally, the pressure to conform to the occupational culture is reportedly strong, bullying behaviour exists, and experiences of the environment are often branded stressful (Crawley and Crawley, 2008); this also echoes prisoners’ experiences of the prison social environment. A prison staff’s ‘circle of stress’ (Nurse et al., 2003, p. 480), as a result of high levels of staff sickness and absence, and poor job satisfaction seem to persist. Congruently, MacDonald and Fallon (2008) report that it is these two aspects that prison healthcare staff also cite as their main issues. Therefore, it would appear that some of the problematic aspects of the prison environment are shared between its members, both staff (with differing roles) and inmates. The apparent similarities arguably suggest that future improvements are somewhat simpler than if disparate issues affected dissimilar social groups.

Tait (2008) argues that a radical reassessment of the role of the prison officer is required. The idea of prison officers as ‘turnkeys’ (p. 3) must be supplanted; instead, ‘the care of and contact with the inmates in his or her charge’ (p. 3, italics not in original) should be the primary occupation of prison officers. Care and contact are crucial. Tait argues that developing caring inmate–officer relationships often helps inmates manage their period of imprisonment, increases prison officer job satisfaction, and develops prison officer career aspirations. Such relationships require prison officers to listen, understand, and respond to inmates’ needs. Tait’s caring interactions are ‘founded on relationships characterised by respect, fairness and sociability’ (p. 5). Wheatley (2007) has perhaps hit-the-nail-on-the-head with his appeal to embark upon ‘staff training, promoting a supportive, helpful culture that aims for fairness and respect’ (p. 415), as fairness and respect (or, more precisely, the subjectively experienced lack of) are issues frequently raised by prisoners in their prison narratives.

2.6. Health and place: therapeutic environments

In relation to therapeutic environments, Collins and Munroe (2004) state ‘the environment can be thought of as the interplay of four main factors, each of which has varying degrees of influence: the patients; the staff; the ‘care context’;... external constraints and influence’ (p. 132). Therapeutic communities are places where the social relationships and structure of the day are designed to aid health and wellbeing. Treatment environments are influenced by an array of factors including the institutional framework (i.e. the aims of the institution), the physical set-up of the care centre, organisational factors (e.g. management set-up, level of patient involvement, etc.), and ‘suprapersonal factors’ (i.e. the sum of involved social actors’ characteristics: gender split, average age, social role mix, faith variance) (Timko and Moos, 2004, p. 144). Therapeutic community principles, which are ‘based on the premise that just as a disordered personality may be produced by a pathological social environment, so a beneficial environment may remove such disorder’ (Manning, 1979, p. 303), were developed in the UK throughout the Second World War and were embraced by the social psychiatry movement in the 1950s (Manning, 1979a).
In 1962 Her Majesty's Prison (HMP) Grendon opened as the first 'Psychiatric Prison' (Parker, 1970, p. xi), this 'means that the total organisation in which the patient is involved forms part of the therapeutic regime' (Parker, 1970, p. xi) where 'the aim is to produce a supportive and permissive environment in which the inmate is encouraged to express his inner feelings, his doubts and difficulties, without fear of retaliation from others' (Parker, 1970, p. xii). In 1970 Parker predicted that 'Grendon's greatest contribution will most certainly be the example it sets as a very human, and humane, institution' (p. xiii). Accordingly, Genders and Player's 1995 study of HMP Grendon, which explores factors that shape the structure and culture of the prison, recorded that 94% of the interviewed men understood themselves to be benefitting from the therapeutic regime (p. 113). At HMP Grendon, rules and regulations are kept to a minimum, democracy and group-based decision-making is promoted, and communalism (i.e. community-constructed boundaries and conditions) is idealised (Genders and Player, 1995, as adapted from p. 83). Genders and Player (1995) argue that the existence of mutually supportive relationships between inmates, and between inmates and staff, are crucial to the therapeutic environment, and that the conventional prison culture and prisoner code of conduct is dismantled at HMP Grendon with positive ramifications.

Campign et al. (2004) argue that we are all constructions of our environment and of each other, developing our identities, learning patterns of communicating and our social responses in the context of our social environment. 'The quality of our physical environment can be health giving or health destroying' (Howard, 2004, p. 105). Howard notes that differences, including personal space, access to diversional activities, and shared philosophy of care are given experience issues with overcrowding, a lack of mental/physical stimulation, and trouble balancing the 'patient care' versus 'prisoner containment' attitudes, responsibilities, etc. Arguably, the mental health of prisoners could be positively developed via a conscious effort on the part of the UK's prisons to fabricate some form of a more therapeutic social milieu.

2.7. Enabling environments initiative

Johnson and Haigh (2011) review the Royal College of Psychiatrists’ latest initiative, the Enabling Environments (EE) project (a development of the preceding therapeutic environment methodology). The EE system intentionally identifies features in any given setting that foster a sense of connected belonging for the involved social actors ‘and suggests a process by which these principles can then be customised for specific settings’ (Johnson and Haigh, 2011, p. 17). Two new concepts from the EE initiative are noteworthy here: the psychologically informed environment (PIE), and the psychologically informed planned environment (PIPE). To summarise, both of these approaches strive for greater psychological awareness of a setting, humane, and enlightened treatment, enhanced wellbeing for all involved, plus reflective practices and shared action learning in the staff team (Johnson and Haigh, 2011). The PIPE scheme is designed for high security and/or high risk settings (e.g. HMPS).

The EE vocabulary of shared values is the basis for the practical application of the EE approach; this is problematic in the prison setting as the underlying goals of the NHS and HMPS are, at present, dissimilar (i.e. care versus containment). As prison life is associated with discipline and control, the environment alone can be considered anti-therapeutic (Hughes, 2000). The prison-based nursing staff in Powell et al.'s (2010) study ‘acknowledge the conflict between the custody regime and healthcare delivery’ (p. 1257), and reportedly experience this tension acutely. Sifunda et al. (2006) also document the divergence between health needs of prisoners and safety protocols in the prison. Evidently, the relationship between health and place in the prison setting is problematic.

3. Implications for mental healthcare in the prison environment

'The delivery of mental healthcare within the prison system is a complex process' (Brooker and Birmingham, 2009, p. 1). This is arguably because 'the prison milieu is not always conducive to good mental health and is not often a useful catalyst for mental healthcare' (Jordan, 2010, p. 26). Implications for mental healthcare policy and practice are convoluted, as it is evident that the issue of place is salient when considering the mental health of prisoners; therefore, HMPS, the MoJ, the DH, and the NHS could explore future commissioning strategies and service provision approaches that assess aptly the notion that the nature of the penal milieu affects both the mental health of its inhabitants and the supply of mental healthcare in the setting. The cultural environment in the UK's prison system ought to be addressed for future mental healthcare policy and practice developments to produce wholly positive ramifications.

Development of prison mental healthcare represents an important, but considerable, challenge for prisons. It should be recognised that it is not the case that HMPS and the NHS are set as an easy task, which they fail to complete. Rather, the UK’s publicly financed prison service and its healthcare centres are set an exceedingly difficult task, as aims are often conflicting (punishment versus rehabilitation; prisoner versus patient); the population is exceptionally needy, resources are tight, and political/public opinion is volatile. King (2007) highlights that 'it is very difficult indeed to run prisons which are more or less escape proof, orderly and safe, which provide programmes aimed at changing offending behaviour and offering prospects of rehabilitation, and which respect the human rights of staff and prisoners' (p. 329). Frequent reminders of the complexity of the prison setting are apt; solutions to problems may not be simple. Simplicit research conclusions and undemanding policy/practice responses arguably miscalculate and undervalue the complexity of human social life. As Kupers (2005) quite rightly points out, ‘every generalisation has many exceptions’ (p. 714); therefore, it must be remembered that ‘it is not at all the case that all prisoners fit a mould’ (p. 714). ‘Every prison is different in population, culture, organisation, and practice and the availability of appropriate NHS beds/services varies between regions’ (Brooker et al., 2009, p. 110). Further to this, an assumption that the context of study (i.e. the prison as an institution/organisation/setting) is a stable research site in numerous respects (e.g. its culture, working practices, and how it’s experienced by inhabitants) arguably underestimates the inherent fluidity and infinite complexity of social settings. It is crucial to recognise that ‘all prisons differ, and what works in one prison may not be effective—or even feasible—in another’ (Brooker et al., 2009, p. 117).

At present, HMPS arguably prioritises the secure containment of offenders above apt preparation for release (e.g. good mental health). However, rehabilitation and reducing re-offending services and interventions (e.g. reading and writing skills, and preventative and curative health services) ought to be extended. The SEU (2002) argues that efforts to effectively rehabilitate prisoners into society require drastic improvement and expansion. Good mental health is surely a prerequisite for apt reform and positive integration into and involvement in society post-release. Future prison-based mental healthcare research and service improvement is consequently both necessary and apt.
Evidently, ‘prison settings are a challenging environment in which to manage and deliver healthcare’ (Powell et al., 2010, p. 1263). Despite this, Sifunda et al. (2006) ‘found strong evidence of prison being a strategic point to increase access to health services for offenders’ (p. 2301) (i.e. a prison stay represents a useful point of access to address this social population’s—many—health issues). A prison sentence should be regarded as a temporal entity that permits the devotion of time and attention to appropriate preparation for release (including good mental health). The myriad issues pertaining to health and place in the UK’s prisons are well worthy of continued research attention and resultant policy and practice development (both NHS and HMPS).

To conclude, the prison-based—exceedingly complex—relationship between culture—mental and health—mental healthcare requires further attention, research, and development, as a positive cultural shift in the prison system (i.e. the nature of the penal milieu) may benefit prisoners’ mental health, the staff and inmate social environments, and the provision of prison mental healthcare.

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