Title: Irish ex-prisoner reflections on their psychological wellbeing whilst in prison in England and Wales.

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Abstract

Over the past 25 years the prison population of England and Wales has doubled and this has resulted in a significant proportion of the prisoner population suffering from mental ill-health. This paper considers the position of an under-researched group within the prison population in England and Wales, that of the Irish prisoner population. 37 semi-structured interviews were undertaken with recently released (within 2 years) Irish prisoners in England and Wales who were asked to reflect on their experiences of incarceration. It considers how themes of depression, paranoia and fear, and loneliness and isolation, all of which were identified as major factors within their experience of imprisonment in England and Wales, relate to the overall experience of incarceration.

Introduction

The term crisis is synonymous with the prison system in England and Wales, and has been common currency in both media and academic accounts of the prison system for decades (Loader, 2013; King and MacDermott, 1989; Bottoms and Preston, 1980; Sparks, 1971). Such crises have included the high prison population, overcrowding, bad conditions, understaffing and staff unrest, poor security, and the 'toxic mix' of long-term and life sentence prisoners and those experiencing mental ill-health (Cavadino et al, 2013). Prisons throughout England and Wales are overpopulated with people experiencing mental ill-health (National Audit Office, 2017a; Her Majesty's Inspectorate for Prisons, 2007; Fraser et al, 2009), and in the vast majority of cases, prison is not the appropriate setting in which to receive treatment (Department of Health, 2001; Salize et al, 2007). Those who go through the criminal justice system are more likely to suffer from depression, personality disorder and substance abuse problems, and pose a much higher risk of self-harm and suicide than the general population (Liebling, 1993, 1995; Singleton et al, 1998; Singleton et al, 2001; Fazel and Danseh, 2002). This paper uses the mental health crisis in English and Welsh prisons as a contextual backdrop in providing a reflective account from a small sample of Irish ex-prisoners on their experiences of depression, paranoia, fear, loneliness and isolation, while in prison. The findings in this paper are taken from the author's doctoral research which examined the lived experiences of Irish prisoners in England and Wales in the context of their mental health, and was the first ever study to specifically examine the mental health of this population of prisoners.

Irish prisoners are perhaps the oldest minority group likely to be found in the prison system in England and Wales (Borland et al, 1995) and they are now the third most represented foreign nationality in the prison system after Romanians and Poles (Allen and Watson, 2017; Ministry of Justice, 2019). On 31 December 2019 the prison population in England and Wales stood at 82,868. Of this figure there were 721 prisoners whose nationality was recorded as Irish (Ministry of Justice, 2019). Irish prisoners represent approximately 0.9% of the total prison population and 7.8% of the foreign national prisoner population, however this is likely to be an underestimate. There are also at least 1,500 Irish Travelers in prison in England and Wales. Irish Travelers are a community of people who have been a part of both Irish and British society for centuries and in the UK they are recognized as being a distinct ethnic group under the Race Relations Act 1976 (as amended in 2000), the Human Rights Act 1998 and the Equality Act 2010. Irish Travelers suffer from social exclusion, racism and discrimination based on their ethnicity, and Traveler life is associated with many risk factors, including substance

abuse, mental ill-health, unemployment, racism and a lack of education. All of these factors relate closely to the additional risk of an individual being involved, at some level, with the criminal justice system, "and it can be argued they contribute to the over-representation of Travelers in the criminal justice system, both in Ireland and in England and Wales" (Gavin, 2019, 138). The Irish population in Britain have, historically, been rendered as an invisible group in the context of being an ethnic minority, and have all too often been "neglected in consideration of race and cultural diversity" (Parekh, 2000, 31). Irish prisoners in Britain have also been ignored in the context of studies of ethnic minorities and the criminal justice system (Cheney, 1993; Hickman and Walter, 1997) and have been described as the invisible minority (Murphy, 1994). The aim of this paper is, therefore, to shine a light on some of the experiences of this invisible group in the prison system.

Mental health in prison in England and Wales

The over-representation of mental health problems amongst prisoner populations is well established internationally. Studies from Australia (Australian Institute of Health and Welfare, 2015), New Zealand (Brinded et al, 2001), the United States (Corrado et al, 2000; Schnitker et al, 2001; Steadman et al, 2009) and Canada (Simpson et al, 2013) have all confirmed this. European countries are facing an increase in the population of prisoners with mental health problems (Blaauw et al, 2000; Human Rights Watch, 2015; Lehmann, 2012; Salize et al, 2007). It is estimated that there are approximately two million prisoners in Europe and at least 25% of them suffer from a significant mental disorder (Fraser et al, 2009). Salize et al (2007) found there to be shortages in the area of prison mental healthcare throughout European countries. In England and Wales they found there to be insufficient and inadequate psychiatric services to diagnose illness, long referral delays due to shortage of psychiatric beds in the National Health Service (NHS), an absence of treatment for minor mental disorders, and a wholly inadequate aftercare system. Fazel and Danesh's (2002) examination of serious mental disorder from a sample of 23,000 prisoners from 12 countries (Australia, Canada, Denmark, Finland, Ireland, the Netherlands, New Zealand, Norway, Spain, Sweden, the United Kingdom and the United States) found that 4% of male and female prisoners had psychotic illnesses, 10% of male and 12% of female prisoners had major depression, and 65% of male and 42% of female prisoners had a personality disorder.

The composition of prisons in England and Wales does not reflect a cross section of society, and the most consistent factor of the typical prisoner is "unambiguously one of relatively severe

personal and social disadvantage" (Kirwan, 2013, 41). These disadvantages can be linked to the following factors that impact on the likelihood of both offending and reoffending: education, employment, drug and alcohol abuse, mental and physical health, attitudes and self-control, institutionalization and life skills, housing, financial support and debt and family networks (Social Exclusion Unit, 2002). When compared with the general population, it is apparent that the vast majority of prisoners have experienced a lifetime of social exclusion, and are over-represented in terms of negative experience of these nine factors. For example, levels of drug and alcohol abuse are significantly higher for the prison population and there are far higher levels of mental ill-health in the prison population than in the general population. 72% of male and 70% of female sentenced prisoners suffer from two or more mental disorders, compared with only 5% of males and 2% of females in the general population (Social Exclusion Unit, 2002).

The impact of imprisonment on mental health is not positive and prisoners are particularly vulnerable to developing mental health problems (Birmingham, 2001, 2003; Durcan, 2008; Bradley, 2009). This is significant since people with pre-existing mental health problems are more vulnerable to custody, as diversion initiatives are not always successful (Birmingham, 2001). There are many factors in prison which can contribute to mental ill-health, including overcrowding, violence, solitude, lack of privacy, lack of activity, isolation, insecurity, inadequate health service provision and the availability of drugs (Fraser et al, 2009). Durcan (2008) also referred to these, but also identified other factors including bullying by other inmates, concerns about family, having little meaningful activity, substance misuse; incompatibility with cell mates; poor diet; limited access to physical activity; unresolved past life traumas, and difficulty in accessing, healthcare and counselling services. There are also specific concerns and management needs associated with prisoners who are subject to Indeterminate Sentences for Public Protection (IPP). Examination of the mental health of prisoners who were subject to such sentences found that out of 2,204 prisoners assessed, 18% had received psychiatric treatment in the past, compared with 9% of the general prison population, and 21% were receiving medication for mental health problems. Furthermore, 66% required a clinical assessment for personality disorder, compared with 34% of the general population. Prisoners interviewed spoke of occasions when they heard voices, as well as experiencing mental health conditions such as bi-polar disorder and schizophrenia. (Sainsbury Centre for Mental Health, 2008) and research has found that prisoners in England and Wales are over-represented when compared with the general population in terms of suffering from

schizophrenia, psychosis, delusional disorder, personality disorder, drug dependency and alcohol dependency (Singleton et al.,1998; Singleton et al., 2001). Furthermore, in England and Wales it is estimated that up to 30% of all prisoners have engaged in deliberate acts of self-harm at some point during their incarceration (Brooker et al, 2002; Borrill et al, 2003), and many do so for the first time in prison. During the period September 2017 - September 2018 there were 52,814 incidents of self-harm, a 23% increase from the previous year, and a new record high. During the period December 2017- December 2018 there were 92 deaths by suicide, up from 70 in the previous 12 month period (Ministry of Justice, 2019). Death by suicide often reflects "a crisis of desperation" (Rickford and Edgar, 2005, 73), and in 2016 the Prisons and Probation Ombudsman noted that suicide in prison is typically the result of a "culmination of personal crises in individual lives" (House of Commons Justice Committee, 2016, 19). Suicide is "the most tragic consequence of mental illness" (Gunnell et al 2011, 343) and it can be argued that this crisis is present beyond the individual, but is also present in the prison as an institution and throughout society as a whole.

Since 2003 the provision of healthcare in British prisons has rested with the NHS. Healthcare professionals in prison are now employed by the NHS and are commissioned by the local Primary Care Trust (Durcan, 2008). The NHS has been in sole charge of commissioning and delivering mental health services in prisons since 2013 (NHS Commissioning Board, 2013) and it aims to deliver healthcare in prisons based on the principle of Equivalence of Care, as per the recommendation made by Her Majesty' Inspectorate of Prisons (1996), whereby prisoners are to receive the same standard of healthcare as those in the community. This principle is a well-documented right and is recognized by both the United Nations Mandela Rules (2015) (Rule 24) and the Council of Europe (2006). While a period in prison "should present an opportunity to detect, diagnose and treat mental illness, in a population often hard to engage with NHS services" (Reed and Lynne, 2000, 1031), the reality is quite different. For example, large numbers of prisoners are entering prisons with pre-existing mental health conditions, and these are not being identified upon arrival at prison reception (Brooker and Ullman, 2008; Offender Health Research Network, 2008**;** Birmingham, 2003). This was recently highlighted in evidence submitted to the Public Accounts Committee, where it was stated that 75% of the prisoners with mental health problems are not being detected through prison reception screening (Public Accounts Committee, 2017). This results in many prisoners serving their sentence while experiencing mental ill-health and not receiving the level of treatment that they need.

Many mental health issues often go undetected and untreated in prison (Offender Health Research Network, 2009) and it is well documented that the prevalence of psychiatric morbidity in the prison population is much higher than in the general population (Singleton et al, 1998; Fazel and Danesh, 2002; Grubin, 2010). Furthermore, some prisoners may have mental health problems which require them to be transferred to a secure hospital away from the prison. The Department of Health recommends that this process should take no longer than two weeks: prisoners should receive their first assessment within two days of a mental health problem being identified, their second assessment within nine days, and the Secretary of State should be able to sign the warrant for their transfer within 14 days. The reality is somewhat different. The National Audit Office (2017a) reported that of all prisoners transferred in 2016-17, only 34% were transferred within the 14-day period, and 7% had to wait for more than 140 days. It found that in 2016 "prisoners had waited an average of 47 days for their first assessment, a further 36 days for their second assessment and a further 13 days for the Secretary of State to sign the warrant for them to move to a secure hospital" (46). One of the reasons why such delays occur was touched upon by the National Audit Office (2017a) report, which stated that there were "examples of patients receiving multiple assessments from different hospitals without being able to secure a bed" (46) which suggests a lack of coordination between prison health services and the NHS provider as well as a lack of capacity for mental health patients in the overall health service. The National Audit Office (2017a) has been highly critical of the provision of mental healthcare in the prison estate. It found there to be a lack of clarity over how mental healthcare was to be provided, a lack of data on mental healthcare in prisons, and it referred to a prison system under considerable pressure due to drastic spending and staff cuts. The report admitted that the Government simply does not know how many people in prison have a mental illness, how much it is spending on mental health in prisons or whether it is achieving its objectives (National Audit Office, 2017b). In 2017 there were 31,328 people in prison who reported having mental health issues at any one time. 7,917 people were recorded by the NHS as receiving treatment for mental health illnesses in prison in England and Wales in March 2017. This equates to a treatment rate of 25%. Furthermore, 40% of prisons did not provide refresher mental health awareness training to prison staff (National Audit Office, 2017a). The overall lack of data on mental health in the prison system demonstrates the importance of research in this area. This study identifies issues relevant to a small, yet significant proportion of the prisoner

population in England and Wales, one that is hiding in plain sight, that of the Irish prisoner population.

This study

Since qualitative research is focused on the world of lived experience (Denzin and Lincoln, 2011), this research considers the term mental health as well as related themes identified, in the context of participants' subjective understanding of these terms, thus adopting a social constructionist stance. 37 semi-structured interviews were undertaken with recently released (within two years) prisoners in England and Wales as a part of the author's doctoral research. The overall research sample (*n*=37) was 92% male and 8% female. Ages ranged from 18 to over 50, the majority (57 %) being aged between 24 and 40. Interviews were conducted over a 12-month period, from March 2014 to March 2015. It should be noted at this point that there are limitations on this study. For example, it is not reasonable to assume that this small sample and the findings ascribed to it are representative of the entire Irish prisoner population in England and Wales. Furthermore, while eight Irish Travelers did agree to participate in aspects of the wider research project, they were very reluctant to discuss aspects of their mental health. This must also be noted as a limitation on the findings of this paper.

Prior to the commencement of the research, ethical approval was sought and approved by the relevant ethics committees at the author's academic institution. Purposeful sampling was used to identify participants. This involves identifying and selecting participants who have good knowledge or understanding about an issue or who have experience with the issue being researched (Creswell and Plano-Clarke, 2011), in this case the knowledge and experience was of imprisonment. The format chosen for this research was that of semi-structured interviews with an informant led interview style, which are concerned with "the interviewee's perceptions with a particular situation or context" (Robson, 1995, 231). Non-directive probing questions were used to encourage and motivate participants to provide clarifying information without influencing their answers. Such an approach is designed to be neutral in order to avoid increasing the probability that any specific type of answer is encouraged or discouraged from respondents.

Thematic analysis was used to analyze interview notes (Braun and Clarke, 2006; Caulfield and Hill, 2014). This is a six-stage process consisting of the following: familiarization with data; generation of codes; searching for themes; reviewing themes; defining and naming themes and

producing the research report. Thematic analysis is generally considered to be suitable for analyzing any type of qualitative data (Caulfield and Hill, 2014). While the process broadly followed the six-stage process, it did not do so in a linear process. Fortunately, the six-stage process is flexible as there is no actual standardized approach to carrying out thematic analysis (Howitt and Cramer, 2008).

The first step was to familiarize myself with the data and this was done by reading and re-reading my interview notes. They were then typed up and again reviewed. Additional notes were also taken, as thoughts and ideas developed during the reviews. Coding is "the formal representation of analytic thinking" (Maxwell and Rossman, 1999, 155) and this research adopted a data and a theory led approach to coding. In order to search for and identify themes, a color coding system was used. Codes were ascribed for themes that were theory led and which were evident from reviewing the notes. These were essentially themes that participants were asked about based on the literature, for example, mental health, addiction, homelessness and education. Whenever a particular theme was referred to it was highlighted with its relevant color code. In order to search for data led themes, these themes were then grouped into coded data streams. These data streams were reviewed which allowed for more themes to be identified. For example, under the code for mental health, various themes emerged such as depression, paranoia and fear, and loneliness and isolation. These themes were ascribed their own new code and copied and pasted into a new document which was dedicated to that particular code and the identification of these themes form the basis of this paper.

Findings

(1) Depression

Depression can affect people in different ways and can cause a wide variety of symptoms. They range from lasting feelings of unhappiness and hopelessness, to losing interest in the things you used to enjoy and feeling very tearful. Many people with depression also have symptoms of anxiety. There can be physical symptoms, fatigue, poor sleep patterns, poor appetite, low libido, and various aches and pains. Symptoms of depression range from mild – perhaps feeling persistently low in spirit - to severe – which can make you feel suicidal. Most people experience feelings of stress, unhappiness or anxiety during difficult times. A low mood may improve after a short period of time, rather than being a sign of depression (NHS webpage on clinical depression, n/d).

Depression was a major concern for participants, both prior to and during imprisonment. Many noted that although they suffered from depression prior to imprisonment, in most cases, imprisonment made it worse, with one stating that he "*was not sure where the depression came from*" and that "t*he depression crept up on me bit by bit*" (Male, aged 35-39). This supports the contention that prison exacerbates mental ill-health. Some noted that although they may have suffered from depression prior to prison, it was not until they arrived in prison that it was diagnosed or they received treatment. One participant stated that while he "s*uffered from depression from my early teens and have had many very low points in my life... it wasn't until I came into prison that this was diagnosed*." (Male, aged 25 - 29). The nature and the environment of the prison itself were referred to as being depressing in itself. Several participants referred to the environment of prison – the physical place itself – as being depressing and having an effect on them. When discussing the relationship between the prison environment and depression one participant stated that "*you do get down in prison. The place just has that about it*" (Male, aged 35-39). One participant noted that depression was linked with the inherent nature of imprisonment itself, stating "*it's the nature of imprisonment. It's the environment. If you think about it too much it gets to you and you end up feeling shit about yourself*" (Male, aged 35-39), while another spoke of the surroundings, the place and the environment as being "*a depressing place*" (Male, aged 18-23). Depression often resulted in participants in this study engaging in acts of self-harm, or even attempting suicide, and the treatment available was considered to be inadequate. One participant spoke of the link between his depression and suicide attempt, stating, "*I had reached a stage where the depression had set in...There was no hope, no light at the end of the tunnel for me. So I decided that I had enough and that I was going to kill myself*" (Male, aged 50+).

(2) Paranoia and Fear

A person experiencing paranoia may exhibit certain features. These include thinking other people are lying to them or trying to manipulate them, feeling they cannot really trust their friends and associates, worrying that any confidential information shared with others will be used against them, thinking there are hidden meanings in remarks most would regard as innocent or worrying that their spouse or partner is unfaithful despite a lack of evidence. (NHS webpage on personality disorder, n/d).

Paranoia is characterized "by suspicion of others' motives and self-referent interpretation of other people's intentions and behavior" (Brotherton and Eser, 2015, 1). Paranoia was a concern

raised by several participants and it fed into the fear that some felt. Entering prison can be a daunting experience (Ratcliffe, 2005) and fear upon arrival into prison may be heightened for those who are experiencing it for the first time (Ratcliffe, 2005; Pogrebin and Dodge, 2001). For some who have been in prison previously, returning may not be such a fearful event (Ratcliffe, 2005; Pogrebin and Dodge, 2001). Some may have developed coping mechanisms, and to some extent, having been through it before, will know what to expect (Cooper and Livingston, 1995; Rocheleau, 2014). Knowing what to expect may, however, also strike fear into the hearts of those who have already been in prison. One participant stated that prison was a "*harsh environment and in a place where life is not worth much. It's a place of fear and paranoia*" (Male, aged 50+), while a female participant felt that experiencing paranoia was quite normal for prisoners: "*I suffered from paranoia for a while. Like people were out to get me. I think that's pretty normal in prison*" (Female, aged 30-34). Participants also linked paranoia with feelings of anger and frustration, especially when on lockdown. One participant stated that "*when you're on 23-hour lockdown you get paranoid. You get angry and frustrated"* (Male, aged 18-23). Paranoia was often related to fear of violence and death. One participant stated: "*I thought everyone had it in for me, that they were all talking about me. If I heard someone talking outside the door, I was sure that they were talking about me. There was a fear that I was going to be killed. I didn't know what was happening in my head at all*" (Male, aged 35-39).

Participants also spoke of the relationship between their paranoia and self- harming. In both of these cases participants were highly critical of the treatment that they received. One stated that the impact of his paranoia "w*as lethal. I just broke the bit off my zip, sharpened it and started poking my arms. They took me out, bandaged me up and just gave me an aspirin and sent me back*" (Male, aged 50+). Another participant spoke of a similar experience: "*I cut my hands really deep about five times. They put me into the hospital part of the prison, stitched me up and after a few days I was back on the wing. They said I was alright but I wasn't alright at all*" (Male, aged 35-39). Such poor treatment is not surprising as similar findings were recorded by Marzano et al (2012) who found that prisoners' experiences of prison staff responses to incidents of self-harm were generally negative.

(3) Loneliness and isolation

Loneliness can be defined as "distressful consciousness of an inner distance to other humans and thus as a desire for satisfying and meaningful relations" (Lamster et al, 2017, 51). It is a

subjective, emotional and cognitive appraisal of a person's environment. As with paranoia, loneliness and isolation were associated with periods of lockdown, which was identified as a dangerous time for those experiencing mental ill-health. One participant identified this relationship in the following terms:

"Isolation inside is a big problem. When you're locked up, alone with no company, sure it's no wonder that some lads who maybe aren't strong willed breakdown and end up talking to imaginary people. This is a very dangerous position to be in…I was on lockdown sometimes for 23 hours a day. That shit destroys a person's mind." (Male, aged 50+)

A female participant noted that being alone in prison is often followed by *"a lot of loneliness and hopelessness"* (Female, aged 30-34), while a male participant described being alone in prison, with little to do but reflect, can be dangerous. He stated that *"you can get caught up in negative thoughts and emotions and that can be a bad road to go down* (Male, aged 50+). The silence associated with isolation was referred to by another participant who also viewed any resulting descent into self-examination in a dangerous light. Again, lockdown was referred to as a contributing factor to deteriorating mental health:

"Sitting alone in your cell dwelling on the past can lead you down a bad road. When you're alone at night with your thoughts it's hard not to think of what you done or what was done to you, what you're missing, and what you lost. Thinking about it can get you in a lot of trouble. It can ruin your mind and you get obsessed with it…Some places have you on 23-hour lockdown and others have a bit more regular routine...the places on lockdown could drive fellas mad, being stuck in your cell all the time looking at the four walls. You'd go crazy after too long. It's inhumane to do this to anyone." (Male, aged 50+)

Discussion

Depression, paranoia, fear, and loneliness and isolation can all be viewed as a crisis for the individual who is experiencing them. Perhaps more important is how an individual deals with these factors – whether they can manage and cope and get through their crisis, or whether the crisis gets the better of the individual. When factors such as depression, paranoia, fear, and loneliness and isolation come to the fore, and when an individual cannot cope with them, this may result in a new crisis, where the individual engages in acts of self-harm or attempts to commit suicide.

Depression is one of the most common mental illnesses in prison and it is much more prevalent in the prisoner population than in the general population (Gusak, 2007; Leigh-Hunt and Perry, 2014). Light et al (2013) found that 65% of female and 37% of male prisoners suffered from depression (n = 1,435). Leigh-Hunt and Perry (2014) estimated that up to 75% of the entire prison population in England and Wales suffer from some level of depression, with higher rates in young women, the elderly and remand prisoners. Several participants in this study claimed that their depression was a direct contributing factor to committing acts of self-harm and attempting suicide. Participants in this study also linked depression with the prison environment, and research has found that "mental disorders may develop during imprisonment itself as a consequence of prevailing conditions" (World Health Organisation / International Committee of the Red Cross, 2005). These conditions "can, and most likely do, contribute to poor prisoner mental health" (Armour, 2012, 886). There are many reasons why the prison environment, with its rules and regimes, may have a detrimental impact on mental health (Birmingham, 2003). Imprisonment separates individuals from their families and friends and places them in an environment where stress, boredom and bullying are commonplace (Heidari et al, 2014; Offender Health Research Network, 2010; Pogrebin and Dodge, 2001). Research has found that long periods of isolation, such as being on lockdown, accompanied by minimal mental stimulus, contributed to poor mental health as well as feelings of intense anger, frustration and anxiety (Nurse et al, 2003). Overcrowding in prisons has been linked with psychological distress and has a significant negative impact on the provision of mental healthcare (Evans, 2003; Walmsley, 2005).

The degree of paranoia that was experienced by participants in this research ranged from being convinced that other people were talking about them, to a fear of being killed by other prisoners or by prison officers. Paranoia was highlighted in prison-based research as one of the greatest factors that affect prisoners – the other was boredom (MacGuinness, 2000). It was stated that both "breed frustration, and some sort of displacement is needed, if only to satisfy psychological needs" (MacGuinness, 2000, 95). Furthermore, this research found that the conditions of imprisonment, for example being on lockdown, were associated with a sense of paranoia. This should come as no surprise as Haney (2003) has noted that when prisoners are deprived of normal human interaction, many suffer from mental health problems including anxiety, panic, insomnia, paranoia, aggression and depression. Furthermore, inter-prisoner violence is not uncommon, and therefore being paranoid may in fact be a survival mechanism that some utilise, whereby a constant fear of violence might

ensure that they are vigilant and aware of their surroundings at all times. In England and Wales there were 22,374 prisoner-on-prisoner assaults in the 12 months to March 2018, up 16% from the previous year. Of these, 3,081 (14%) were serious assaults, an increase of 9% in the number of serious incidents from the previous year and both of these figures are record highs (Ministry of Justice, 2018). Paranoia may also be linked to a real issue such as being a victim of crime in the past.

Participants in this research cited fear as a major factor upon arrival into prison. This can be linked to the fact that prisoners are often at their most distressed on entry to prison, especially those who are experiencing prison for the first time (Liebling et al, 2005, as cited in Jacobsen et al, 2008). Paranoia has been also linked with fear (Binswanger et al., 2011) and vulnerability (Boyd and Gumley, 2007), both of which were reported by participants, and boredom, which has also been linked with paranoia (Brotherton and Eser, 2015). Von Gemmingan et al (2003) suggest that people who are easily bored have a greater predilection towards negative rather than positive effect. They argue that individuals who exhibit mild levels of paranoia are prone to experiencing boredom, and a bored mind has been found to be "the logical starting point in a pattern that predicted that individuals would be more apt to creating stimulating information, fixate on thoughts concerning the self, and be anxious about how they are viewed by others" (916). Paranoia has been found to be at its worst when those experiencing it are isolated, allowing their "imaginations to run riot" (Boyd and Gumley, 15). Research has shown that long isolative periods, such as that time prisoners referred to on lockdown, can negatively impact upon mental health, creating feelings of anger, frustration and stress (Goomany and Dickinson, 2015). De Veaux (2013, 257) noted that conditions in lockdown "can cause such symptoms as perceptual distortions and hallucinations, massive free-floating anxiety, acute confusional states, delusional ideas and violent or self-destructive outbursts, hyper-responsivity to external stimuli, difficulties with thinking, concentration and memory, overt paranoia and panic attacks." Several participants in this research highlighted the links between lockdown and paranoia.

For some, depression and paranoia may have been pre-existing conditions which were not identified at prison reception, and for others, they may have developed these conditions for the first time after entering prison. This may be linked to the isolation that participants referred to experiencing while in prison. Participants linked depression and paranoia with incidents of attempted suicide and self-harm. Research on prison suicide has described the hopelessness

often caused by depression as being the "single most important predisposing variable in prisons/clinical and community samples" (Palmer and Connelly, 2005, 165). When an individual loses control over their environment such as during prison lockdown, this can often result in feelings of hopelessness, which may result in incidents of suicide and self-harm (Palmer and Connelly, 2005). Participants also spoke of the poor treatment they felt they received after an incident of self-harm, with several claiming that they were bandaged up and returned to their cells. This bears resonance with findings from earlier research where one participant stated: "I get no help whatsoever...they bandage me up and put me back in my cell" **(**Marzano et al 2012, 6). Self-harming and suicide (as well as attempted suicide) can often relate to a person feeling socially alienated (Furnivall, 2013; van Orden et al, 2010) and these links are well established. Foucault (1988) noted the links between imprisonment and alienation stating that "confinement causes alienation" (227).

One female participant in this research spoke of medicalized prescription based treatment being the limit of what was available, and claimed that talking therapies would have been more beneficial but were never offered:

"*There's no interest in talking therapy, trying to get to the root of a person's problem. Medication is what they do...All they want to do is keep you medicated instead of looking into someone's problems*" (Female, aged 30-34).

Feelings of loneliness and paranoia are closely related, and research has found that a reduction in feelings of loneliness can reduce paranoid thoughts (Gooymany and Dickinson, 2015). Lamster et al (2017) have found loneliness to be a potential cause of paranoia, and isolation and loneliness have also been linked with depression in prison in several studies (Chamberlain, 2015; DeVeaux, 2013; Harris et al, 2006). Recalling his experience of imprisonment DeVeaux (2013, 267) stated that "Isolation did not help my mental state. More than anything else, I recall feeling sad and depressed. I felt caged, alone and helpless." Foucault (1977) noted that isolation was one of the very first principles of imprisonment, whereby prisoners were to be isolated from the external world, from the motivations of their offence and from other prisoners. Thus "not only must the penalty be individual, but it must also be individualizing" (Foucault, 1977, 238). Such individualizing was expected to have a transformative effect on the prisoner:

"Alone in his cell, the convict is handed over to himself; in the silence of his passion and of the world that surrounds him, he descends into his conscience, he questions it and feels awakening

within the moral feeling that never entirely perishes in the heart of man…the walls are the punishment of the crime; the cell confronts the convict with himself; he is forced to listen to his conscience" (Foucault, 1977, 238-239).

However participants in this research questioned the value of such reflection, with several using the term "*bad road*" to describe the emotional and mental journey that such introspection can lead a person on.

Conclusion

This paper has attempted to shine a light on the experiences of a small, yet significant proportion, of the prison population in England and Wales: the Irish prisoner. Anecdotal evidence suggests that there may be over 1,000 Irish prisoners in England and Wales and yet research on this group is negligible. Coupled with at least 1,500 Irish Travellers, the over number of Irish prisoners in England and Wales is likely to be approximately 2,500. This would make them the largest foreign national group within the prison system by far. This research identified themes of depression, paranoia and fear, and isolation and loneliness as impacting upon Irish prisoners in England and Wales. Depression in the prison population is common and it may often be related to feelings of paranoia, fear, loneliness and isolation. On its own, it might be easy to dismiss levels of depression in the prisoner population as everyone gets a bit down sometimes, especially in prison, given the environmental factors which were referred to in this paper. However, if depression is combined with feelings of paranoia and isolation, as discussed by participants, then this may result in a situation where a person's view of their future is one of hopelessness, and this is a major concern when it comes to self-harming and suicide, both of which are increasing in at record levels in prisons across England and Wales. All prisoners, irrespective of their nationality, are impacted upon by this. There is, however, no reason to suggest that Irish prisoners in England and Wales suffer disproportionately from depression, paranoia and fear, and isolation and loneliness, when compared with the general prisoner population. However, the lack of data in this paper from Irish Travelers again needs to be acknowledged. Gavin (2019) has found that Irish Travelers suffer from racism, bullying and discrimination in the prison system in England and Wales, and such mistreatment is likely to have an impact on their mental health. An examination of the mental health of this group would be merited in the future.

While Irish prisoners do make up a significant percentage of the overall foreign national prisoners population, they do, by in large, remain a somewhat invisible group within the

prisoner population for several reasons. Typical concerns for foreign nationals include language, family contact and immigration (Richards et al, 1995). Irish prisoners do not suffer to the same extent as other foreign nationals, as there is no language barrier and Irish nationals are considered for deportation only in the most exceptional circumstances, and are typically treated as a special case in order to reflect the close "historical, community and political ties between the United Kingdom and Ireland, and the existence of the common travel area" (Harvey, 2007, 209). Maintenance of family ties is a concern for all prisoners, not just foreign nationals. Maintaining family contact is a concern for all prisoners, not just foreign nationals. It is not unreasonable to assume that if a prisoner's family is in a foreign country it is more difficult to keep in contact with them, than if they are in the same country. On that note, it can be said that Irish prisoners whose family are in Ireland do share a common experience with foreign national prisoners. It should, however, be noted that there is probably a large percentage of Irish prisoners whose families are also living in England and Wales and therefore family contact is less of an issue in certain cases.

Moving forward, more needs to be done for all prisoners with mental health problems, and there are various ways in which this could be done. Prisoners who are serving Indeterminate Sentences for Public Protection are a group which experiences high levels of anxiety, depression and who are at a high risk of self-harming. Approximately 2,100 of these prisoners are still serving an indeterminate prison sentence, despite their tariff already having expired. They should be released immediately as this could free up mental health resources in the prison system which are needed elsewhere. Participants in this research were critical of staff responses to mental health issues as well as the availability of treatment. While prison officers receive basic training on mental health when hired, recent research has shown that 40% of prisons do not offer a refresher mental health training to staff (National Audit Office, 2017a). This should be rectified and staff should be continually trained and upskilled in this area. Furthermore, since May 2017 all new prison officers receive a four hour training session entitled "Introduction to mental health". More than four hours training may prove useful.

There is also a growing Mindfulness movement developing worldwide. A study of a modified Mindfulness program offered to 2,000 prisoners in Massachusetts found that 1,350 completed the program and reported less hostility, improved self-esteem and better emotional control (Samuelson et al, 2007). A similar program was launched on a pilot basis in England and Wales using yoga. Participants reported increased positive emotions and reduced stress (Bilderbeck et al, 2013). This is something that could be rolled out nationally.

Finally, at the time of writing (March 2020) all prisons in England and Wales have gone into a state of lockdown as a result of the COVID-19 pandemic. Prisons pose an acute risk of the virus spreading at a particularly fast rate, in a process referred to as cluster amplification. COVID-19 has been detected in the prison population in England and Wales. Two prisoners have died, at least 13 prisoners have tested positive for the virus and 4,000 prison staff are now self-isolating (Grierson et al, 2020). The spread of the virus and the reduction in staff numbers has resulted in social distancing measures being introduced, the cancellation of association, the cancellation of educational and training programs, and a general position of prisoners spending a lot more time in their cells. This will surely have an impact on the mental health of the prison population. As well as releasing all prisoners who are serving an IPP sentence post-tariff, consideration should be given to releasing all prisoners who are serving a prison sentence of up to 12 months for non-violent and non-sexual offences as well as older prisoners who pose no risk to themselves or others. There are currently over 5,000 prisoners over the age of 60 and releasing them would free up a significant amount of space in the prison system and could ease the potential spread of COVID-19 throughout the prison estate.

Bibliography

Allen, G. and Watson, C. (2017). *UK Prison Population Statistics: Briefing Paper Number SN/SG/04334.* House of Commons, London.

Armour, C. (2012). Mental Health in Prison: A Trauma Perspective on Importation and Deprivation. *International Journal of Criminology and Sociological Theory,* 5 (2), 886-894.

Australian Institute of Health and Welfare (2015) *The health of Australia's prisoners 2015*, Australian Institute of Health and Welfare, Canberra.

Bilderbeck, A.C., Farias, M., Brazil, I.A., Jakobowitz, S. and Wikholm, C. (2013). Participation in a 10-week course of yoga improves behavioural control and decreases psychological distress in a prison population. *Journal of Psychiatric Research,* 47 (1), 1438-1445.

Bingswater, I., Nowels, C., Corsi, K., Long, J. Booth, R., Kutner, J. and Steiner, J. (2011). "From the prison door right to the sidewalk, everything went downhill," A qualitative study of the health experiences of recently released inmates. *International Journal of Law and Psychiatry,* 34 (4), 249-255.

Birmingham, L. (2001). Diversion from custody. *Advances in Psychiatric Treatment,* 7 (3), 198-207

Birmingham, L. (2003). The mental health of prisoners. *Advances in Psychiatric Treatment,* 9 (3), 191-199.

Blaauw, E., Roesch, R. and Kerkhof, A. (2000). Mental disorders in European prison systems. Arrangements for mentally disordered prisoners in the prison systems of 13 European countries. *International Journal of Law and Psychiatry,* 23(5), 649-663.

Borland, J., King, R. and McDermott (1995). The Irish in Prison: A Tighter Nick for the Micks? *British Journal of Sociology,* 46 (3), 371-394.

Borrill, J., Burnett, R., Atkins, R., Miller, S., Briggs, D., Weaver, T. and Maden, A. (2003). Patterns of self-harm and attempted suicide among white and black/mixed race female prisoners. *Criminal Behaviour and Mental Health,* 13 (4), 229-240.

Bottoms, A. and Preston, R. (1980). *The Coming Penal Crisis: A Criminological and Theological Exploration.* Scottish Academic Press, Edinburgh.

Boyd, T. and Gumley, A. (2007). An experiential perspective on persecutory paranoia: A grounded theory construction. *Psychology and Psychotherapy: Theory, Research and Practice,* 80 (1), 1-22.

Bradley, K. (2009) *The Bradley Report: Lord Bradley's review of people with mental health problems or learning disabilities in the criminal justice system*. Department of Health, London.

Braun, V. and Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, 3 (2), 77-101.

Brinded, P., Simpson, A., Laidlaw, T., Fairley, N. and Malcolm, F. (2001). Prevalence of psychiatric disorders in New Zealand prisons: a national study. *Australian and New Zealand Journal of Psychiatry*, 35 (2), 166-173.

Brooker, C., Repper, J., Beverley, C., Ferriter, M. and Brewer, N. (2002). *Mental Health Services and Prisoners: A Review*. University of Sheffield, Sheffield.

Brooker, C. and Ullman, B. (2008). *Out of Sight, Out of Mind. The State of Mental Healthcare in Prison.* Policy Exchange, London.

Brotherton, R. and Eser, S. (2015). Bored to fears: Boredom proneness, paranoia, and conspiracy theories. *Personality and Individual Differences,* 80 (1), 1-5.

Caulfield, L. and Hill, J. (2014). *Criminological Research for Beginners: A Students Guide.* Routledge, Oxon.

Cavadino, M., Dignan, J. and Mair, G. (2013). *The Penal System: An Introduction (5th ed.).*Sage, London.

Chamberlain, A. (2015). Embodying prison pain: Women's experiences of self-injury in prison and the emotions of punishment. *Theoretical Criminology,* 20 (2), 205-219.

Cheney, D. (1993). *Into the Dark Tunnel: Foreign prisoners in the British Prison System*. Prison Reform Trust, London.

Cooper, C. and Livingstone, M. (1992). Depression and coping mechanisms in prisoners. *Work and Stress,* 5 (2), 149-154.

Corrado, R., Cohen, I., Hart, S. and 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 (5), 633-647.

Council of Europe (2006). *Recommendation (2006) 2 of the Committee of Ministers to member states on the European Prison Rules (Adopted by the Committee of Ministers on 11 January 2006 at the 952nd meeting of the Ministers' Deputies).* Available at < https://www.refworld.org/docid/43f3134810.html > Accessed 12 August, 2019.

Creswell, J. and Plano Clarke, V. (2011). *Designing and Conducting Mixed Methods Research (2nd ed.).* Sage, Thousand Oaks, California.

Denzin, N. and Lincoln, Y. (2011). Introduction: The Discipline and Practice of Qualitative Research. In N. Denzin and Y. Lincoln (Eds.) *The Sage Handbook of Qualitative Research (3rd ed.).* Sage, Thousand Oaks, California.

Department of Health (2001). *Changing the Outlook: A Strategy for Developing and Modernising Mental Health Services in Prisons*. Department of Health, London.

De Veaux, M. (2013). The Trauma of the Incarceration Experience. *Harvard Civil Rights – Civil Liberties Law Review,* 48, 257-277.

Durcan, G. (2008). *From the Inside: Experiences of Prison Mental Healthcare*. Sainsbury Centre for Mental Health, London.

Evans, G. (2003). The built environment and mental health. *Journal of Urban Health,* 80 (4), 536-555.

Fazel, S. and Danesh, J. (2002). Serious mental disorder in 23,000 prisoners: a systematic review of 62 surveys. *The Lancet,* 359 (9306), 545-550.

Foucault, M. (1988). *Madness and Civilization: A History of Insanity in the Age of Reason.* Random House, New York.

Foucault, M. (1977). *Discipline and Punish: The Birth of the Prison*. Penguin, London.

Fraser, A., Gatherer, A. and Hayton, P. (2009). Mental health in prison: great difficulties but are there opportunities? *Public Health,* 123 (6), 410-414.

Furnivall, J. (2013). *Understanding suicide and self-harm amongst children in care and care leavers*. Institute for Research and Innovation in Social Sciences, Glasgow.

Gavin, P. (2019). 'Prison is the worst place a Traveller could be': The Experiences of Irish Travellers in Prison in England and Wales. *Irish Probation Journal,* 16, 135-152.

Goomany, A. and Dickinson, T. (2015). The influence of prison climate on the mental health of adult prisoners: A literature review. *Journal of Psychiatric and Mental Health Nursing,* 22, 413-422.

Grubin, D. (2010). Health Screening in Prisons. In S. Wilson and I. Cumming (Eds.) *Psychiatry in Prisons: A Comprehensive Handbook*. Jessica Kingsley, London.

Gunnell, D., Hawton, K. and Kapur, N. (2011). Coroners' verdicts and suicide statistics in England and Wales. *British Medical Journal,* 343, d6030.

Grierson, J., Taylor, D. and Halliday, J. (2020). Fears over coronavirus risk in prisons as first UK inmate case confirmed. *The Guardian*, 19/3/2020. Available at https://www.theguardian.com/world/2020/mar/18/first-uk-prisoner-with-covid-19-confirmed-at-strangeways-manchester > Accessed 21 March 2020.

Gusak, D. (2007). Effectiveness of art therapy in reducing depression in prison populations. *International Journal of Offender Therapy and Comparative Criminology,* 51 (4), 444-460.

Haney, C. (2003) Mental Health Issues in Long-Term Solitary and "Supermax" Confinement. *Crime and Delinquency,* 49 (1), 124-156.

Harris, F., Hek, G. & Condon, L. (2006). Health needs of prisoners in England and Wales: the implications for prison healthcare of gender, age and ethnicity. *Health and Social Care in the Community*, 15 (1), 56-66.

Harvey, A. (2007). Expulsion and exclusion. *Journal of Immigration, Asylum and Nationality Law*, 22 (3), 202-209.

Heidari, E., Dickinson, C. and Newton, T. (2014). An overview of the prison population and the general health status of prisoners. *British Dental Journal*, 217 (1), 15-19.

Her Majesty's Inspectorate of Prisons. (1996). *Patient or Prisoner*? Her Majesty's Inspectorate of Prisons, London.

Her Majesty's Inspectorate of Prisons. (2007). *The mental health of prisoners.* Her Majesty's Inspectorate of Prisons, London.

Hickman, M. and Walter, B. (1997). *Discrimination and the Irish Community in Britain*. Commission for Racial Equality, London.

House of Commons Justice Committee. (2016). *Prison safety: Sixth report of session*. House of Commons, London.

Howitt, D. & Cramer, D. (2008). *Introduction to Research Methods in Psychology*. Pearson, Harlow.

Human Rights Watch. (2015). *Double Punishment: Inadequate Conditions for Prisoners with Psychosocial Disabilities in France*. Human Rights Watch, Paris.

King, R. and McDermott, K. (1989).British prisons 1970-1987: The ever-deepening crisis. *British Journal of Criminology*, 29 (2), 107-128.

Kirwan, S. (2013). Encouraging the Development of Prisoner Re-Integration in Irish Penal Policy: Financing Social Re-Integration Alternatives. *Cork Online Law Review* 12 (1) 37-58.

Lamster, F., Nittel, C., Rief, W., Mehl, S. and Lincoln, T. (2017). The impact of loneliness on paranoia: An experimental approach. *Journal of Behaviour Therapy and Experimental Psychiatry*, 54 (1), 51-57.

Lehmann, M. (2012). Psychiatric care in the German prison system. *International Journal of Prisoner Health*, 8 (4-3), 131-140.

Leigh-Hunt, N. and Perry, A. (2014). A systematic review of interventions for anxiety, depression, and PTSD in adult offenders. *International Journal of Offender Therapy and Comparative Criminology*, 59 (7), 701-725.

Liebling, A. (1993). Chaplaincy life: Suicide and suicide attempts in prison. *New Life*, 10 (1), 76-81.

Liebling, A. (1995). Vulnerability and prison suicide. *British Journal of Criminology* 35 (2) 173- 187.

Liebling, A., Tait, S., Durie, L., Stiles, A. and Harvey, J. (2005). Safer local evaluation. *Prison Service Journal* 162. Cited in E. Jacobsen and N. Loucks (2008). *There when you need them most: PACT's first night in custody services.* Prison Reform Trust, London. Available at <http://www.prisonreformtrust.org.uk/Portals/0/Documents/there%20when%20you%20need%20them%20most%20a%20review%20of%20pact's%20first%20night%20in%20custody%20services.pdf > Accessed 12 August, 2019.

Light, M., Grant, E. and Hopkins, K. (2013). *Gender differences in substance misuse and mental health amongst prisoner: Results from the Surveying Prisoner Crime Reduction (SPCR) longitudinal cohort study of prisoners*. Ministry of Justice, London.

Loader, I. (2013). Introduction: Mapping the penal landscape of England and Wales. In A. Dockley and I. Loader (Eds.) *The Penal Landscape: The Howard League guide to criminal justice in England and Wales*, Routledge, Oxon.

MacGuinness, P. (2000). Dealing With Time: Factors that Influence Prisoners to Participate in Prison Education. In D. Wilson and A. Reuss (Eds.) *Prison(er) education: Stories of change and transformation.* Waterside Press, Winchester.

Marshall, C. & Rossman, G. (1999). *Designing Qualitative Research (3rd ed.).* Sage, London.

Marzano, L., Ciclitira, K. and Adler, J. (2012). The impact of prison staff responses on self-harming behaviours: Staff experiences, reactions, and concerns. *British Journal of Clinical Psychology*, 51 (1), 4-18.

Ministry of Justice (2017). O*ffender Management Statistic Bulletin, England and Wales Quarterly October to December 2016: Annual 2016: Prison populations 31 March, 2017.* Ministry of Justice, London.

Ministry of Justice (2018). *Safety in Custody Statistics, England and Wales: Deaths in Prison Custody to June 2018 Assaults and Self-harm to March 2018.* Available at <https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/729496/safety-in-custody-bulletin-2018-Q1.pdf > Accessed 12 August, 2019.

Ministry of Justice (2019). *Safety in Custody Statistics, England and Wales: Deaths in Prison Custody to June 2019 Assaults and Self-harm to March 2019.* Available at <https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/820627/safety-in-custody-q1-2019.pdf >Accessed 11February, 2020.

Murphy, P. (1994). The Invisible Minority: Irish Offenders and the English Criminal Justice System. *The Probation Journal,* 41, 2-8.

National Audit Office. (2017a). *Mental Health in Prison*. National Audit Office, London.

National Audit Office. (2017b). *Mental Health in Prison*. Available at <https://www.nao.org.uk/press-release/mental-health-in-prisons/ > Accessed 1 July, 2019.

NHS Commissioning Board. (2013). *Securing Excellence in Commissioning for Offender Health.* Available at < https://www.england.nhs.uk/wp-content/uploads/2013/03/offender-commissioning.pdf> Accessed 12 August, 2019.

NHS Webpage on Clinical Depression. (n/d). Available at < http://www.nhs.uk/conditions/depression/Pages/Introduction.aspx > accessed 11 February, 2020.

NHS webpage on Personality Disorder. (n/d). Available at < http://www.nhs.uk/Conditions/Personality-disorder/Pages/Symptoms.aspx > accessed 11 February, 2020.

Nurse, J., Woodcock, P. and Ormsby, J. (2003). Influence of environmental factors on mental health within prisons: focus group study. *British Medical Journal* 327, 480.

Offender Health Research Network. (2009). *A National Evaluation of Prison Mental Health In-Reach Services.* Offender Health Research Network, Manchester.

Offender Health Research Network. (2008). *Evaluation of the reception screening process used within prisons in England and Wales.* Offender Health Research Network, Manchester.

Offender Health Research Network. (2010). *The pathway of prisoners with mental health problems through prison health services and the effect of the prison environment on the mental health of prisoners*. Offender Health Research Network, Manchester.

Palmer, E. and Connelly, R. (2005). Depression, hopelessness and suicide ideation among vulnerable prisoners. *Criminal Behaviour and Mental Health*, 15(3), 164-170.

Parekh, B. (2000). *Commission on the Future of Multi-Ethnic Britain*. Runnymeade Trust, London.

Pogrebin, M. and Dodge, M. (2001). Women's accounts of their prison experiences: A retrospective view of their subjective realities. *Journal of Criminal Justice*, 29 (6), 31-541.

Public Accounts Committee oral evidence: Mental Health in Prisons, HC 400, Monday 23 October 2017. Available at <http://data.parliament.uk/writtenevidence/committeeevidence.svc/evidencedocument/public-accounts-committee/mental-health-in-prisons/oral/71919.pdf > Accessed 1 July, 2019.

Ratcliffe, M. (2005). *Safer Custody Detoxification Treatment and Therapeutic Programme*, Centre for Crime and Justice Studies, London.

Reed, J. and Lyne, M. (2000). Inpatient care of mentally ill people in prison: results of a year's programme of semi-structured inspections. *British Medical Journal,* 320, 1031.

Richards, M., McWilliams, B., Batten, N., Cameron, C. and Cutler, J. (1995). Foreign nationals in English prisons 1: Family ties and their maintenance. *The Howard Journal of Crime and Justice,* 34 (2), 158-175.

Rickford, D. and Edgar, K. (2005). *Troubled inside: Responding to the mental health needs of men in prison*. Prison Reform Trust, London.

Robson, C. (1995). *Real World Research*. Blackwell, Oxon.

Rocheleau, A.M. (2014). Prisoners' Coping Skills and Involvement in Serious Prison Misconduct. *Victims and Offenders,* 9 (2), 149-177.

Rosen, G. (1968). *Madness in Society: Chapters in the Historical Sociology of Mental Illness*. University of Chicago Press, Chicago.

Sainsbury Centre for Mental Health. (2008). *In the dark: the mental health implications of Imprisonment for Public Protection.* Sainsbury Centre for Mental Health, London.

Salize, H.J., Dreßing, H. and Kief, C. *Mentally Disordered Persons in European Prison Systems - Needs, Programmes and Outcome (EUPRIS) Final Report* – October 31, 2007. Available at
< http://www.antoniocasella.eu/archipsy/Salize_EU_psy-prisons_31oct2007.pdf > Accessed 17 December, 2018.

Samuelson, M., Carmody, J., Kabat-Zinn, J. and Bratt, M. (2007). Mindfulness-based stress reduction in Massachusetts Correctional Facilities. *The Prison Journal,* 87, 254.

Schnittker, J., Massoglia, M. and Uggen, C. (2012). Out and Down: Incarceration and Psychiatric Disorders. *Journal of Health and Social Behaviour,* 53 (4), 448-464.

Simpson, A., McMaster, J. and Cohen, S. (2001). Challenges for Canada in meeting the needs of persons with serious mental illness in prison. *Journal of the American Academy of Psychiatry and the Law,* 41 (4), 501-509.

Singleton, N., Meltzer, H. and Gatward, R. (1998). *Psychiatric Morbidity Among Prisoners in England and Wale*s. Office of National Statistics, London.

Singleton, N., Bumpstead, R., O'Brien, M., Lee, A. & Meltzer, H. (2001). *Psychiatric morbidity among adults living in private households, 2000.* Office of National Statistics, London.

Social Exclusion Unit. (2002). *Reducing Reoffending by Ex-prisoners*. Cabinet Office, London.

Sparks, R. (1971). *Local Prison: The Crisis in the English Penal System.* Heinemann Educational Books, Winterton.

Steadman, H., Osher, F., Robbins, P., Case, P. and Samuels, S. (2009). Prevalence of serious mental illness among jail inmates. *Psychiatry Online,* 60 (6), 761-765.

United Nations. *United Nations Standard Minimum Rules for the Treatment of Prisoners (the Nelson Mandela Rules).* Available at< https://undocs.org/A/RES/70/175 > Accessed 8 July, 2019.

van Orden, K., Witte, T., Cukrowicz, K., Braithwaite, S., Selby, E. and Joiner, T. (2010). The Interpersonal Theory of Suicide. *Psychological Review,* 117 (2), 575-600.

von Gemmingen, M., Sullivan, B. and Pomerantz, A.(2003). Investigating the relationships between boredom proneness, paranoia, and self-consciousness. *Personality and Individual Differences,* 34 (6), 907-919.

Walmsely, R. (2005). Prison healthcare and the extent of prison overcrowding. *International Journal of Prisoner Health,* 1 (1), 3-12.

World Health Organisation / International Committee of the Red Cross. (2005). *Information sheet on prisons and mental health.* Available at < http://www.who.int/mental_health/policy/mh_in_prison.pdf > Accessed 2 May, 2019.