



Caulfield, L.S. (2016) 'Counterintuitive findings from a qualitative study of mental health in English women's prisons.' *International Journal of Prisoner Health*, 12 (4): 216-229.

Official URL: <http://dx.doi.org/10.1108/IJPH-05-2016-0013>

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Counterintuitive findings from a qualitative study of mental health in English womens' prisons

Abstract

Purpose

Large numbers of women in prison report significant emotional and mental health problems, and there is evidence to suggest that the prison environment may exacerbate the incidence and severity of these issues (Armour, 2012). However, there has been limited exploration of the extent to which women's mental health problems exist prior to incarceration, whether symptoms first occur in incarceration, and how incarceration affects this.

Design/Methodology

In-depth interviews were conducted with 43 women incarcerated in three English prisons and a thematic analysis of the data was conducted. Review of official prison records provided a form of data triangulation.

Findings

Analysis of the data revealed that while many women who experienced mental health issues in prison had experienced these issues in the past, a number of women reported first experiencing mental health and emotional problems only after entering prison. Although these problems often recede, this demonstrates the significant impact that entering prison can have upon the mental health of women. Unusually, the data highlighted many positive experiences of support within prison. However, there was some lack of consistency in the treatment and support offered to women.

Originality/Value

The data presented here is in many ways more positive than previous research and – as opposed to much of the existing literature that simply states the prevalence womens' issues in prison - provides insight into the lived experiences of women in prison. This paper documents how prison can present an opportunity for women to engage with treatment, but there is a need for a clearer understanding of women's needs and consistent and appropriate support.

Introduction

Women in contact with the criminal justice system have particularly high-levels of need. In 2009 analysis of the Offender Assessment System¹ (OASys) data of almost 12,000 women under the supervision of probation in England and Wales showed that 89 percent of women had at least one area of need, with significant proportions having multiple needs (Social Exclusion Task Force, 2009). However, there remains a “relative lack of evidence about women’s offending-related needs” (Hedderman, Gunby, & Shelton, 2011, p. 16). The lack of detailed knowledge about the needs and experiences of women in contact with the criminal justice system has clear implications for prison regimes and interventions for women, and how women are treated in prison.

Mental health problems are a known criminogenic need (i.e. a factor associated with increased risk of criminal behaviours: Andrews & Bonta, 1995) and large numbers of women in contact with the criminal justice system present significant emotional, personal, and mental health issues. Indeed, previous research has demonstrated that female prisoners have a greater incidence of mental health problems than male prisoners (Palmer, Jinks, & Hatcher, 2010; Shaw, 2001; Teplin et al., 1996). A survey of psychiatric morbidity among prisoners in England and Wales conducted by the Office for National Statistics (ONS, 1998) showed that 40 percent of women had sought help or treatment for either a mental or emotional problem in the twelve months prior to entering prison, compared with around 20 percent of men. In 2009 the Ministry of Justice reported that approximately 26 percent of women in prison had been treated for a mental health or emotional problem in the year before custody. This is compared with 16 percent of men (Ministry of Justice, 2009). The Social Exclusion Task Force (2009) report that 60 percent of women under probation supervision, compared with 36 percent of men, are recorded in OASys as having emotional well-being needs. However, official figures are inherently problematic in this situation as many individuals who are not aware of their condition, or have never received treatment, are overlooked; thus figures may not represent actual prevalence rates.

Previous research has identified that women’s mental health problems rarely occur in isolation. For example, Singer, Bussey, Song, and Lunghofer (1995) reported that over half the respondents in their sample of incarcerated females indicated the co-occurrence of substance misuse and mental health problems. The mental health problems experienced by women in the prison system are different from those experienced by men (Shearer, 2003) and Young (1998) suggests that this may be in part due to the high percentage of incarcerated women who report physical and sexual victimisation as children & adults, often in intimate relationships (cf. McClellan, Farabee, & Crouch, 1997; Ministry of Justice, 2009), potentially leading to mental, emotional and physical health problems. It should also be noted here that many women in prison are mothers, and that mother-child separation has been identified as a primary source of distress for incarcerated women (Shaw, Rodgers, Blanchette, Hattem, Seto-Thomas, & Tamarack, 1990). With estimates that around two-thirds have children under 16 and are often the primary care-giver prior to incarceration (Prison Reform Trust, 2005), feelings of guilt, shame, despair, frustration, and depression at having

¹ The OASys is a need and risk assessment used by the prison and probation service in England and Wales. The OASys consists of 13 sections that assess offenders’ criminogenic needs, risk of harm, and likelihood of reconviction. In order to predict the likelihood of reconviction, sections one to twelve of the OASys examine offending history and current offence, social and economic factors, and personal factors. Data is collected from a range of sources, including the probation service, courts, and prison service.

'abandoned' her children (Watson, 1995; Jaffe, Pons, & Wicky, 1997) are common in the female prison population. The mental health of women in contact with the criminal justice system is typically characterised by high levels of depression and anxiety, substance abuse, personality disorders, and considerable amounts of self-harming behaviour (Gorsuch, 1998), and incarcerated women are more likely than incarcerated men to be diagnosed with severe mental illness (Teplin, Abram, & McClelland, 1996) or to have ever made a suicide attempt (Leigey & Reed, 2010).

Research also suggests clear links between histories of abuse and victimisation and mental health problems; and while researchers and practitioners are aware of these links, Fillmore & Dell (2000) report that a number of women also link their abuse experiences to their self-harming behaviour. Despite the documented levels of mental health and emotional need, it has been hypothesised that the stress of the confines of the prison environment may exacerbate the incidence and severity of mental health problems (Armour, 2012), and particularly so for substance abusing women (Staton, Leukefeld, & Webster, 2003). Indeed, in the absence of adequate mental health services within prison settings, there has been evidence for some time to suggest that women's mental health problems do not subside, but may in fact increase in severity during periods of incarceration (Byrne & Howells, 2002). A rise in the occurrence of mental health problems may become more apparent among substance abusing women as they enter prison and detoxify, thus the 'numbing' capabilities of the drugs disappear and problems must again be faced (DeCou, 2001).

Martin and Hessebrook's (2001) study of US women incarcerated in medium and maximum security revealed that women with the highest levels of mental health needs were the most likely to have experienced childhood violence, had the weakest social supports, and were highly likely to be involved in violent crime. They suggest that the relationships between women's background, criminal history, and mental health are complex and that too often their mental health problems are unrecognised, misdiagnosed, and inadequately treated. Indeed, Parsons, Walker, and Grubin (2001) propose that existing initial screening procedures in prison overlook the majority of cases of mental disorders, thus the numbers of women with mental health problems may be likely to be even higher than official figures show. Where mental health problems have been identified and procedures exist to tackle this, these are often seen as insufficient. In addition, female prisoners with psychiatric diagnoses have often proven difficult to place within the prison system, where placements in secure National Health Service (NHS) facilities have been hard to obtain, resulting in long periods of unsuitable prison placements (Gorsuch, 1998; Silvestri & Edisioni, 2013). Gorsuch's study of women in Holloway prison found that the most difficult of these women to place 'were significantly more likely than the comparison group to have suffered physical and/or sexual abuse in childhood; to have committed a variety of offences; to have committed crimes of serious violence and arson; to have spent time in a secure psychiatric facility in the past; to be considered a danger to themselves and a management problem in Holloway; to have a personality disorder diagnosis; and, eventually, to receive a prison sentence or community disposal rather than a hospital order.'(p. 556). Again, this research highlights the lack of provision, treatment, and services that have been available to deal with women's mental health problems, from anxiety disorders and depression through to more severe psychiatric diagnoses. The introduction of Psychologically Informed Planned Environments (PIPE) in a number of establishments in England has in part begun to address the needs of some vulnerable women and women diagnosed with Personality Disorders (Turley, Payne, & Webster, 2013), but still does not address the needs of the majority of women in prison.

As noted above, there remains a relative lack of detailed understanding about the specific needs of women in contact with the criminal justice system (Hedderman et al., 2011). Indeed, Palmer et al., (2010) suggest there is a need for robust qualitative data to add depth of understanding to much of the existing quantitative data reported in the literature. In particular there has been limited exploration of the relationship between women's experiences mental health problems exist prior to prison, and how prison may affect the mental health of women. The suggestion that the prison environment may exacerbate the incidence and severity of mental health issues (Armour, 2012; Staton et al., 2003), has to date not been fully explored with incarcerated women and so forms the basis of the research presented here.

Methods

Data collection

The information gleaned from interviews with those in contact with the criminal justice system can provide us with a wealth of information that is simply not available through official records (Sapsford & Jupp, 1996). However, the reliability of self-report data relies on the honesty of respondent's accounts, and there is always a risk that these accounts will provide 'an imaginative organization of experiences that imposes a distortion of truth...a mixture of fiction and non-fiction...about life and particular lived experiences (Denzin, 1989, p. 24). When interviewing prisoners these issues may be even greater, with "self-protection; overconfidence; and inaccuracies of memory to name just a few." (Nee, 2004). In an attempt to combat this, a 'triangulation' of data has typically been found to be the best approach to increase validity. Indeed, those experienced in prison-based research suggest that while all information should be taken seriously, researchers should check stories wherever possible (King & Liebling, 2008).

Here, semi-structured interviews with participants were complimented with data from the Offender Assessment System (OASys)² to cross-check some of the information provided during interview. The use of these records also allows for the collection of demographic and other data that does not require explanation by participants, allowing more time for discussion of more pertinent issues during valuable and often limited interview time.

A semi-structured interview schedule was designed and piloted with a small sample of female ex-prisoners in the community. Participants were asked questions about their experiences of mental health and emotional issues throughout their lives: any history of mental health problems (either diagnosed or self-report); the specific form these problems took; whether any specific life events may have contributed to their mental health problems; and the impact of prison on participant's mental health.

Interviews lasted an average of 53 minutes and were recorded using a digital voice recorder. Each participant was interviewed only once. Only the researcher and research participant were present during the interview. Once consent had been given, information from the OASys were accessed by the researcher.

² From a research perspective, the measure provides a useful tool from which to obtain demographic data collected about offenders and cross-check sections of interview data.

Participants

Following ethics approval from the applicable university and approval for access from HM Prison Service National Research Committee, three women's prisons in England agreed to take part in the research: one open; one semi-open; one closed. Using a range of recruitment strategies³ 43 women agreed to participate: 18 from the open prison, 13 from the semi-open prison and 12 from the closed prison (see table 1). The research followed the standards of informed consent set out by the British Psychological Society. Issues such as confidentiality and the right to withdraw were fully considered and explained both verbally and in writing in a participant information form. Each participant was given a written copy of the participant information form and consent form to keep.

The data below on age, ethnicity, age at first conviction, and offence type were taken from the women's OASys records. Unfortunately, the recordings of interviews with two women were too poor to transcribe, due to considerable noise outside the interview rooms. The women ranged in age from 18 to 59 years; the mean age was 34.38 years (SD=10.43). 80.95% of the women were classified as White, 7.14% Black Caribbean, 7.14% Black Caribbean and White, and 4.76% Indian. This compares to the following figures for the total prison population in England and Wales (aged 15+, March 2016): White 74%, Black Caribbean 12%, Asian 8%, mixed 4% (Allen & Dempsey, 2016). While the national figures present data for combined groups (e.g. 'Asian' & 'Mixed') and the prison population is variable, the sample here broadly represent the wider prison population in terms of ethnicity.

Table 1 about here

Table two presents information on the offences committed by the women in this sample, broken down by type of establishment. Unless otherwise stated, the offence listed is taken from the OASys record for each individual.

Table 2 about here

Data analysis

Interviews were audio recorded, transcribed, and coded. A highly structured thematic analysis approach was taken, aided by the qualitative data analysis software NVivo. NVivo software was chosen primarily to aid the organisational aspects of managing such a large amount of qualitative data. Analysis began with an in-depth coding process involving working line-by-line through the entire body of data, initially led by themes identified through the literature, noted by the researcher during interviews, when listening to recordings, in the transcription process, and reading transcripts.

³ Letters, posters, peer recruiters, prison officer recruiters, a prison television interview.

Subsequent to this a data led approach was applied to the transcripts. The initial themes acted as a basis for coding, supplemented by new themes emerging during the in-depth coding process.

Next, the list of codes was reviewed in order to search for themes. This involved a process of assessing whether there were any commonalities between codes. Themes therefore represent a coding of the initial coding (Howitt & Cramer, 2008). Once an initial broad list of themes was highlighted, these were reviewed. At this stage it was important to consider whether there was sufficient evidence in the data to support each of the themes that had emerged. Some themes emerged as key themes, with substantial incidences of the codes from numerous participants. Other groups of codes emerged as sub-themes, relevant to the over-arching themes.

Once the write-up of the analysis of interviews was complete, this data was systematically cross-checked against the data collected from OASys records. Data from OASys records was manually entered into SPSS.

Results

Presented below are the results of the thematic analysis, detailing the voice and experience of the women in this sample, and documenting how they themselves view their experiences of mental health and emotional problems throughout their lives, both prior to and in prison. Thirty-three of the women discussed having experienced mental health and/or emotional issues at some point during their lives. Experience of mental health and emotional issues is taken from the women's descriptions, definitions, and where relevant formal medical diagnosis. These experiences varied in longevity, aetiology, and seriousness. Understanding the effect of imprisonment on these women allows for consideration and exploration of what has been offered by way of support and help while in prison and the data presented here focuses primarily on participants' experiences of mental health problems and treatment while incarcerated. First, however, a brief overview of participants' histories of mental health problems and treatment engagement is provided.

Twenty-seven women explained that they had experienced mental health and emotional issues prior to their current sentence, whether formally diagnosed or not. These ranged from Post-Traumatic Stress Disorder, to Depression, to Anxiety, often with evidence of co-morbidity, including self-harming behaviours and suicidal ideation. Depression was by far the most prevalent mental health issue, reported by 23 of 27 of participants. The interviews explored whether treatment had been offered or made available to these women when experiencing mental health problems prior to prison, and – where treatment had been offered - explored treatment engagement. Twenty women had some experience of treatment. The reasons reported for past lack of treatment engagement ranged from chaotic lifestyles, to inaccurate diagnosis, to feeling the treatment offered unhelpful, to a refusal to seek help. Many of the women spoke at length about their experiences of mental health problems and experiences of treatment: this has been summarised below in table three to provide an accessible and succinct overview of this data.

Insert table three about here

The remainder of this section presents details of: the effect of prison on women with previous mental health and emotional issues; the effect of prison on the mental health and emotional well-being of women with no prior issues in this area; and the support provided for women's mental health and emotional issues during this current sentence. The women are referred to by unique research identification numbers. Women at the closed prison are CXX, at the semi-open prison SOXX, and at the open prison OXX. The OASys record of SO11 was unavailable, and interview transcripts of C5 and SO6 unavailable. However, SO11's interview data has been included where relevant. The findings are presented under the thematic headings identified from the data analysis, with reference made to data from OASys reports where relevant.

Effects of prison on women with a history of mental health and emotional issues

Twelve women – all of whom had described previous mental health issues - spoke specifically about the mental and emotional impact of entering prison. For SO2, the primary impact of incarceration upon her mental health was an inability to sleep. While this is not an unusual response to the anxiety and stress that entering prison is likely to cause, she also explained how she was diagnosed with another episode of depression by the prison medical team. However, she dismissed this diagnosis, reporting that she felt 'quite lively'. SO11 and SO10 also described experiencing insomnia on entering prison, and the effect this had on them. SO11 felt that this was due to a mix of entering rehabilitation, worrying about her children, and the guilt that surfaced each time she attempted to give up substance use. However, after some months in prison she managed to begin sleeping a little more. For SO10 the insomnia was primarily attributed to concern over being separated from her child, but she also explained that she suffered anxiety and paranoia and was placed on suicide watch.

For C4 the tension headaches she experienced outside prison became much more serious on entering prison, but, like the women who experienced sleep problems, these did subside with time as she became used to the prison environment.

'I had a lot of problems with stress and tension headaches. When I was on C wing I was getting them every week, fairly regularly, where now I get them once every two to three months. It could be because I've settled down now.'

What about the worrying things in general, do you feel that has subsided?

Yes it has. I think because I've got into a routine and I know that the kids are okay. I still get worried about them, especially now my eldest is 15 and going through his teenage years but in general it's not too bad.

Did you speak to the doctors at that time?

I did about my headaches. My headaches were more of migraine, they were that bad that I'd be crying my eyes out or I'd want to bang my head against the wall, they were

really severe. But I was talking to the doctors here and they said it sounded more like stress tension headaches.'

(C4 and interviewer)

SO3 explained how difficult she found entering prison, suffering significant anxiety and worry. However, she did not have a recurrence of depression and expressed some relief at having been sentenced after a two year wait for her court case. Similarly, SO8 also expressed how she experienced worry and anxiety in prison.

'It's when I'm worrying and have things on my mind, I sit there and I do cry sometimes.'

(SO8)

The depression she had experienced outside of prison persisted, and she was in contact with the prison counsellor.

Notably, a number of women expressed the positive impact that entering prison had on their mental and emotional wellbeing. For example, C7 explained how helpful and supportive the prison health team had been, while for O6 this was the first time she had regularly taken her antidepressant medication.

'So it wasn't until I actually got to prison and I was forced to take my pills that things started to look good. And I thought, oh no, if I'd have done this years ago I wouldn't be here now.'

(O6)

Additionally, through attending the Offending Behaviour Programmes that were part of her sentence plan, O6 decided that counselling might be beneficial for her. After years of failing to engage in talking therapies for more than a few sessions, at the time of interview she had been in contact with a counsellor for six months and reported finding it 'really useful'. For O3, it was the courses that she had done in prison that she felt had helped her to most address her past. SO13 had a similar story to tell. While she had failed to engage with counselling in the past outside of prison, in prison she had made full use of these services.

'But now, I'm a great believer in counselling and psychology and that's because it's helped me so much.'

(SO13)

For O1, it was the routine of working outside that she felt had a very positive effect on her. She was employed in the prison gardens and found that this tired her out so much she slept well and also reported a decrease in her depressive symptoms. However, she did report that at the start of her current sentence sleep and coping were problems for her, but perhaps more significantly she had not felt she was offered the support she needed.

'I asked if I could see a counsellor and they said that I couldn't have one, cos they didn't see it as an issue. You know it was for people to solve like their problems, obviously the heroin.'

So you weren't given any access to anyone...?

I did 19 months in prison and they never once addressed my offence or nobody asked me.'

(O1 and interviewer)

She also explained that after periods of home leave she experienced an increase in symptoms of depression.

'When I went on my first home leave in July I felt really depressed when I come back, for about a week. And I've never ever felt so low, because I do...It feels...it feels like being sentenced all over again, cause you've gone right back from coming so far to going straight back to square one.'

(O1)

Similarly, SO5 reported that she had not received support during her previous prison sentence. Specifically, she felt that if she had been able to attend the Enhanced Thinking Skills (ETS) course during her last sentence this would have been very beneficial.

Effects of prison on women with no history of mental health and emotional issues

Six women, who had not reported a history of significant mental health or emotional issues prior to incarceration, talked of the specific emotional and mental health impact of entering prison. Shortly after being arrested and placed on remand, C3 was referred to a psychologist a prescribed antidepressant medication.

'I was on depression tablets and I actually saw a psychologist not that I was mad but someone to help me. They put me in anot because I would harm myself but because of the state I was in they were very concerned about me. I wouldn't eat – you know all of a sudden your life is going well and then you're in prison. I was taken away from my child who I was always with, it was difficult.'

(C3)

She reported that she had now adjusted to prison and no longer needed support or medication. O16, SO12, and O9 also reported developing depressive symptoms and suffering significant stress on entering prison. O9 explained how she had been referred to a psychiatrist after experiencing physical symptoms that her doctor felt were related to stress and depression. She also reported that at the time she felt strongly that this was not the case.

'I was being in denial about that. "I'm not stressed...I'm not stressed." I kept telling the doctor, "I'm not stressed. Okay, why do you think I'm stressed? I'm getting all these aches and pains, there's something wrong with me." And it was stress obviously...and I was at breaking point.'

(O9)

Subsequently she was prescribed antidepressant medication and was being monitored by a psychiatrist. O16 had also been prescribed antidepressant medication, but had stopped taking them, and felt this was mistake as her symptoms quickly returned. At this point she had asked for a counsellor, and at the time of interview was waiting to see one, although her doctor felt medication was the best option for her.

'I asked to have a counsellor, but the doctor said that the anti-depressants would help me, cos I'd been on them before when I first came into prison.'

(O16)

SO12 explained that she began suffering with depression shortly after entering prison. She had been prescribed antidepressants and felt these were helpful, but had not been offered any counselling.

As noted earlier in this article, when discussing diagnosis and causes, O17 struggled a great deal with entering prison for the first time and suggested this had caused the second breakdown in her life. However, she explained that the counselling she received helped her cope and subsequently she felt comfortable asking for counselling when she felt it would be useful.

'My mum died January and I automatically asked for counselling.'

(O17)

O19 had initially been imprisoned abroad and reported experiencing no mental health or emotional issues until she was transferred to an English prison.

'The only time I took antidepressants was when I came back into this country, I started to have panic attacks when I went to [...], and they put me on antidepressants to calm me down. Claustrophobia, can't handle being in closed spaces.'

(O19)

Shortly after entering an English prison she learnt that her mother was terminally ill but that she was not able to visit her in hospital. She reported struggling to cope with this, but that seeing a counsellor for two months helped her.

Support in prison

In total 27 women spoke about their experiences of treatment and support for mental health and emotional issues in prison. In order to provide a full picture of the range of support experienced, this section provides details of support for women with previous mental health problems and also those discussed in the section directly above.

13 women were, or had been, taking prescribed medication in prison for their mental health issues. C8, SO11, C12, and O20 had all been taking long-term antidepressant medication, although O20 reported having recently stopped taking this and her sleeping medication. SO2 was prescribed sleeping tablets and SO12 was prescribed antidepressant medication in prison. C4 was simply prescribed pain medication to cope with her tension headaches. However, the majority of women who had received support for their mental health or emotional problems in prison had been provided with some form of counselling or psychiatric support. O9 had been placed on antidepressants but was also being monitored by a psychiatrist. C3 had received counselling for three months while on remand and was also prescribed antidepressant medication. She now reported coping fine without either form of treatment. C11, while still on medication, had stopped contact with counselling and other mental health personnel as they felt she had reached a point where she no longer needed the support. She reported having found the sessions helpful, although she did find talking about her past difficult. O19 was prescribed antidepressants and referred for counselling when she moved from a foreign prison to an English prison, and in particular felt that the counselling had been good for her. O14 was referred for counselling as part of her sentence plan, in addition to the antidepressant medication that she had been taking for approximately ten

years. She had never received counselling before, and while she had only been in counselling for two weeks at the time of interview, she was hopeful it would be beneficial.

SO8 was currently having weekly counselling sessions and reported finding this helpful, and both she and the counsellor felt she did not require medication. O8 explained that she was currently receiving counselling because of her cannabis use, and for O17 the counselling she received had helped her cope with coming to prison. Indeed, she reported finding it helpful and when during her sentence when her mother died, she 'automatically asked for counselling'. SO10 also needed support in order to cope with entering prison, having been referred for psychiatric support, although she only saw the psychiatrist on one occasion. O13 began counselling on entering prison in an attempt to tackle her PTSD and was still receiving counselling at the time of interview. O2 reported having seen a counsellor at various time points throughout her prison sentence, but only in English prisons, rather than the foreign prison she had spent part of her sentence in. She explained that this process had been very helpful to her and she now felt she could recognise if she needed counselling again and would feel confident to ask for this.

For O10, O15, and SO7 the counselling and/or psychiatric support was almost a continuation of the support they had been receiving prior to prison. O10 began counselling while awaiting trial and O15 had received counselling for two and a half years prior to sentencing to help her come to terms with the abuse she had suffered. SO7 had a history of psychiatric contact prior to prison and described the support in prison as 'extremely brilliant'. While O6 had been to counselling sessions in the past, she explained that prison was the first time she had ever continued with counselling for more than a few sessions. At the time of interview she had been attending counselling sessions for several months and the counsellor felt she had 'broken a barrier'. Furthermore, as discussed previously, it was also the first time she had taken her antidepressant medication appropriately.

'So it wasn't until I actually got to prison and I was forced to take my pills that things started to look good. And I thought, oh no, if I'd have done this years ago I wouldn't be here now.'

(O6)

SO13 reported that prison was the first time she had been 'allowed' to engage with counselling, after previously being prevented by her ex-partner. She had received both counselling and psychotherapy and felt strongly that these had been beneficial for her. O16 was awaiting her first counselling session at the time of interview, while C7 explained how the health team in general had been 'fantastic, extremely brilliant'. O3 had been offered counselling in prison but refused, instead citing that she had found the courses she had attended most helpful in dealing with her past. Similarly, SO5 reported finding the Enhanced Thinking Skills course helpful emotionally.

A further five women were not receiving support. As discussed earlier, O1 felt that the routine of working outside had helped her psychologically, although she did report that she had needed support during her last prison sentence and this was not made available to her. SO3 had received counselling and psychiatric support during her trial, but was not interested in continuing this in prison. C10 explained that her mental health problems were in the past and she had no current need for support. SO4 reported never having sought help and SO1 had a history of refusing support prior to prison.

Discussion of findings

The prevalence and type of mental health issues reported by the women here are in line with previous findings in this area (cf. Lindquist 2000; Social Exclusion Task Force, 2009), suggesting these findings may be applicable to women in prison more broadly.

The finding that for some women prison regimes may initially exacerbate existing mental health problems supports previous literature (Nacro, 2009; Sered & Norton-Hawk, 2008) and many of the factors specific to women in prison may exacerbate mental health issues. For example, the relatively small number of women's prisons means that women are often placed a long way from home, and thus often a long way from any support networks. For many women this means being far away from the children for whom they are often the primary carer. While not discussed in this paper, of note is that in the sample here 19 of 43 (44%) women had children under 18. 14 of these 19 women (33%) were the primary carer for their children prior to going to prison. All of these factors mean that prison takes a high emotional toll on many women, with feelings of guilt and remorse being common (Allen, Flaherty, & Ely, 2010).

An area lacking in the research literature is the extent to which women's mental health problems exist prior to prison or whether symptoms occur as a result of incarceration. Consequently, the finding that six women in this sample reported first experiencing mental health and emotional problems only after entering prison is an important one. All six of these women were diagnosed with depression in prison and prescribed antidepressant medication. Four of these women were also given either counselling or psychiatric support, and one further woman was waiting to see a counsellor. While this demonstrates the significant negative impact that prison can have upon the mental health of women, this finding also highlights the positive way in which most of these women were supported. In general they were offered support quickly and found it helpful in working to overcome their problems and cope with prison. However, Douglas, Plugge & Fitzpatrick (2009) note that for women who are not suffering from significant mental health problems, but do require some support in emotionally adjusting to prison, often this support is lacking.

It is also notable that a further four women experienced mental health and emotional problems in response to their offence, specifically when waiting for their court hearing. This suggests a potential need for support for women's well-being not only in prison, but throughout their experiences of the criminal justice system. In terms of mental health support once they reached prison, two of these women were provided with support, although for one the support was reported to be very limited. The other two women did not report access to any mental health support on entering prison.

A minority of prisoners with very severe mental health problems are placed within forensic secure units. Many others are supported within prison by in-reach teams, run by the NHS, who liaise with community support. While prison healthcare as a whole is typically reported as being far from perfect (Brooker, et al., 2008), significant advances towards an equivalence of standards with community care have been made (Caulfield & Twort, 2012). Perhaps unsurprisingly, the women who have most contact with psychological health practitioners in prisons have histories of mental health treatment, suicide attempts, and drug abuse (Diamond, Magletta, Harzke, & Baxter, 2008; Faust & Magaletta, 2010). This was the case for the participants here. Given the high incidence of women

with mental health problems, and the often vulnerable nature of these women, it is perhaps no surprise that prison mental health teams are not always able to meet the level of demand for their services (Nacro, 2009). Here, while there were positive reports, there was still some lack of consistency. Despite the heavy demands placed on mental health services in prison, it is important to note that this demand comes from only a proportion of women with mental health problems.

It is important to highlight that five of the twelve women who discussed the impact of prison upon their mental health said this impact had been positive. Indeed, two of these women reported that prison was the first time they had fully engaged with mental health support services: be this taking medication as prescribed; or attending regular counselling. Three women - one from each of the three prisons in this research - specifically stated how good they had found the mental health support in prison. For one woman, rather than any specific support, it was the prison regime (specifically having a routine and working outdoors) that appeared to have helped her. The final of these five women cited completing the Enhanced Thinking Skills programme (an accredited Offending Behaviour programme for prisoners with a need for cognitive skills intervention) as the change point for her. However both of these women stated that previously they had not been given the support they felt they needed. For the first woman (O1), she explained failing to cope on entering prison and requesting counselling, but was denied this, while SO5 suggested that in three previous sentences over the past 14 years she had not received any emotional support.

In terms of treatment and treatment access, the chaotic lives of many individuals involved in the criminal justice meant that twelve of the women in this sample had failed to engage with treatment for their mental health and emotional problems prior to prison, even when they themselves had initiated the search for help and support. A high proportion (11/12) of the women who had failed to engage with treatment prior to prison had reported significant issues in their lives since childhood. This is in-line with a meta-analysis of research that shows that childhood maltreatment is associated with poor treatment response and less remission of symptoms of depression (Nanni, Uher, & Danese, 2012). This suggests that it is harder to engage those with significant issues, and that these individuals are likely to be harder to treat. However, they are the individuals who most need support and prison could offer an opportunity for this. This issue of 'treatment resistance' may be best challenged through time with a therapist (Strauss, 2009). For many women, prison represents the first time they may have had a stable routine and thus presents an opportunity for women to more fully engage with treatment over a period of time.

While some authors have commented that women's increased use of medication in prison is negative (Rickford, 2003), the reports from women in this sample indicate that these increases may be due to them engaging with appropriate treatment. However, Rickford does also note that 'there is anecdotal evidence that this increase in medication is not a result of careful exploration of the mental health needs of women but rather a response by under-trained staff who resort to medication to contain a 'problem'' (p. 23). Whilst this suggestion should not be discounted, this did not appear to be the case for the sample of women who took part in this research. Although it should also be noted that not all women taking medication for their mental health problems were also given access to counselling or psychological therapies.

Given that a number of women reported initial problems in finding the 'right' anti-depressant for them, it seems that counselling support is even more important. Some women had not engaged with

treatment in the past due to drug and alcohol abuse, and for these women prison presents a particularly significant opportunity to address their mental health issues. Undergoing detoxification in prison can result in the emergence of painful memories and feelings of guilt, and thus is a time when mental health support is particularly needed. This can provide an opportunity to address the underlying causes of these women's mental health and emotional issues, and substance misuse issues, in a way that is often highly challenging when they are not in custody. However, as mentioned above, adequate opportunities for mental health support are not always available in prison. For those women who discussed the treatment they had been offered in prison, there appeared to be a lack of consistency between type of treatment offered and type/history of mental health problems. Some women reported medication only, some were offered a combination of medication and counselling, and some were offered counselling alone. While it may be the case that treatment is offered on a more individualised basis, and so type and longevity of disorder may not be an accurate predictor of treatment offered, Plugge, Douglas, and Fitzpatrick (2006) suggest there is often inconsistency across establishments.

Of note here is the finding by Webb et al. (2011) that the prevalence of suicide in people with a history of one or more custodial sentences is significantly higher than that of those with no history of involvement with the criminal justice system. Webb et al.'s research - which covers data over a 25 year period - shows a strong independent effect of criminal justice history on suicide risk, and that this risk is greater in women than in men. The findings from this study of Danish adults are important as they highlight the potential impact of being imprisoned, not only on the mental health of individuals in prison, but also later, when these individuals are back in the community. That this effect is more significant in women suggests an even greater need for support to help women in contact with the criminal justice system overcome mental health problems.

Since the 1990s there have been significant advances in prison healthcare towards achieving an 'equivalence of stands' between the NHS and prison healthcare (see Caulfield & Twort 2012 for an overview). However, the challenge is not an easy one: prisoners typically have far higher levels of need than the general population and the 2007 HM Inspectorate of Prisons review noted that prison mental healthcare should be 'based on the complex needs of those in prison, including the specific needs of women (p.14)'. However, given the government's lack of a full understanding of the needs of women in prison (Ministry of Justice, 2010) it is unlikely this is currently achievable. Indeed, in 2009 the Lord Bradley report identified that mental health provision lacks a female-specific focus and this remains the case today.

This paper does not seek to comment upon the detail of the changes that may be needed to improve the mental healthcare of women in prison, but seeks to highlight that this care remains inconsistent at a time when there is potential to engage and treat highly troubled women. Further to the findings presented here, it would be useful in future research to explore whether there are any differences in experience by factors such as ethnic group. For example, the Bradley Report (2009) highlighted the need for more consideration of various groups, including women and black and minority ethnic groups.

Conclusion

To some extent, the findings presented here are more positive than previous research concerning mental health support in prison. It may be that these women, having now engaged with treatment and support, were therefore more likely to take part in the research, but nonetheless the data presented here provides important insight into the experiences of women in prison.

Contrary to previous research (e.g. Staton et al., 2003), this research found that entering prison does not automatically equal worse mental health for women. While many are likely to have problems coping at least initially, as entering prison is a challenging time for most, these problems with coping often recede. As prisoners get used to their situation they begin to learn to adjust, and furthermore, prisoners typically become busier as their sentence progresses and they begin working (inside or outside the prison). Being occupied has been found to correlate with fewer problems with self-harm and suicidal ideation (Kruttschnitt & Vuolo, 2007). Indeed, there is the potential for prison to be a time to address some of the underlying causes of mental health problems, working on appropriate treatment, and laying the foundations for adaptive, positive coping mechanisms for the future. For some of the women in this sample prison provided an opportunity to reduce their mental health and emotional needs (and aside from the personal benefit of this, it should be remembered here that mental health is also a criminogenic need), and thus it is even more important that this opportunity is not missed and that treatment is appropriate.

Much of the existing literature simply states the prevalence of the past experiences of women in prison in a specific area of need, but fails to provide any insight into how women actually think and feel about their experiences and how this has impacted on the rest of their lives. This research has presented a greater level of detail and focus on the lived experiences of these women.

Acknowledgements

The author would like to express gratitude to those women who took part in this study, and to HM Prison Service for supporting the work.

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Table 1
Age, ethnicity, and age at first conviction by type of establishment

	Mean age ⁴	Ethnicity ⁵	Mean age at first conviction ⁶
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⁴ Based on 42 women. The OASys record for one woman was not available, although she appeared approximately 35 years old.
⁵ Based on 42 women. The OASys record for one woman was not available, although she appeared to be White.

All	34.38(SD=10.43)	White 80.95%	26.88(SD=8.93)
Open	32.94(SD=8.93)	White 72.22%	27.28(SD=6.60)
Semi-open	36.42(SD=12.15)	White 91.67%	27.92(SD=10.02)
Closed	34.5(SD=10.33)	White 83.3%	25.09(SD=10.59)

Table 2
Category of current primary conviction by establishment type

Offence category	Number of women (percentage of whole sample)	Number of women by type of establishment	
Theft or fraud	7 (16.3%)	Open	4
		Semi-open	3
		Closed	0
Possessing firearms	1 (2.3%)	Open	1
		Semi-open	0
		Closed	0
False imprisonment	1 (2.3%)	Open	0
		Semi-open	1
		Closed	0
Burglary	3 (9%)	Open	0
		Semi-open	1
		Closed	1
Drug offences	19 (44.2%)	Open	9
		Semi-open	6 ⁷
		Closed	4
		Open	

⁶ OASys data on age at first conviction available for 41 women.

⁷ Five recorded from OASys records, one from interview and confirmed by prison officer post interview.

Murder	1 (2.3%)	Semi-open	1
		Closed	
Death caused by careless driving	2 (4.7%)	Open	2
		Semi-open	
		Closed	
Assault/Grievous Bodily Harm/Wounding	7 (16.3%)	Open	2
		Semi-open	
		Closed	5
Conspiracy to murder	1 (2.3%)	Open	
		Semi-open	
		Closed	1
Manslaughter	1 (2.3%)	Open	
		Semi-open	
		Closed	1

Table 3

Summary of participant's experiences of mental illness and treatment engagement

First experienced before prison	23
First experienced before prison, but after involvement with the criminal justice system (waiting for court appearance)	4
First experienced after entry to prison	6
Engagement with treatment prior to prison	8
Lack of engagement with treatment prior to prison ⁸	12

⁸ Of the eight women who had previously engaged with treatment, five had reported significant childhood issues, ranging from sexual abuse (SO7), to family illness (SO11), and violent behaviour at school (O8). Of the twelve women who had previously failed to engage with treatment, eleven had reported significant childhood issues. While there are not sufficient numbers here to analyse the statistical significance of this, it is interesting to note that more women who had failed to engage described highly troubled life histories.