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Unhealthy prisons: exploring structural determinants of prison health

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Abstract Prisoner health is influenced as much by structural determinants (institutional, environmental, political, economic and social) as it is by physical and mental constitutions of prisoners themselves. Prison health may therefore be better understood with greater insight into how people respond to imprisonment – the psychological pressures of incarceration, the social world of prison, being dislocated from society, and the impact of the institution itself with its regime and architecture. As agencies of disempowerment and deprivation, prisons epitomise the antithesis of a healthy setting. The World Health Organisation's notion of a 'healthy prison' is in this sense an oxymoron, yet the UK government has signalled that it is committed to WHO's core health promotion principles as a route to reducing health inequalities. This paper reports on the findings of an ethnographic study which was conducted in an adult male training prison in England, using participant observation, group interviewing, and one-to-one semi-structured interviews with prisoners and prison officers. The paper explores how different layers of prison life impact on the health of prisoners, arguing that health inequalities are enmeshed within the workings of the prison system itself.

Keywords: prison health, health determinants, healthy prisons

Introduction

Penal institutions are generally sick places. Offenders sent to prison enter a complex social world of values, rules and rituals designed to observe, control, disempower and render them subservient to the system. Emotional and psychological survival partly depend upon an individual's ability to tolerate the deprivations of prison. Most prisoners, however, come from the poorest or most socially excluded tiers of society and often have the greatest health needs. Prison may therefore be the worst place to send them given that, in the main, they are likely to be highly vulnerable or susceptible to poor health. This arguably reduces the chances of returning offenders to society in a fit state to rebuild their lives. Nonetheless, the UK Government has signalled its commitment to reducing health and social inequalities (Acheson 1998, DoH 2003, 2005) with respect to prisons by signing up to the World Health Organisation's Health in Prisons Project (WHO 1996, 2000). Recent reorganisation of prison healthcare services in England under the management of the NHS has revealed some commitment to the WHO approach, with a new emphasis on health needs assessments and health development plans for prisons (DoH 1999a, 2004, HM Prison Service and DoH 2001, de Viggiani *et al.* 2005).

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This paper reports on some of the findings of an ethnographic study, conducted with adult male prisoners and prison officers in an English prison between 1998 and 2001 (de Viggiani 2003), which explored how the health of prisoners was shaped or influenced by their prison experience. The findings provide useful insight into understanding prison health determinants, fuelling the argument that to make real progress, a much broader and more radical approach should be taken towards tackling prison health; one that lifts the debate from the traditional orthodoxy based on medical, psychiatric and security imperatives to a new public health agenda that addresses key social and structural determinants of health.

Explaining prison health

Prison health in the UK has had strong associations with traditions of medical treatment, with the biomedical paradigm dominating prison healthcare since the 19th century (Smart 1985, Sim 1990). This is still evident from the extent to which prison health research continues to focus primarily on physical and psychiatric morbidity and mortality within the prison population (Gunn *et al.* 1991, Bridgwood and Malbon 1995, Birmingham *et al.* 1996, Brooke *et al.* 1996, Bellis *et al.* 1997, Mason *et al.* 1997, Tayler 1997, Singleton *et al.* 1997, Marshall *et al.* 2000, Spencer 2001). Such studies are valuable in highlighting the prevalence and severity of health problems and confirm that prisoners experience generally poorer levels of physical and mental health than the general population (Bridgwood and Malbon 1995, Chambers *et al.* 1997, Tayler 1997, Reed and Lynne 1998, Baillargeon *et al.* 2000, DoH 2000, Smith 2000, Fazel *et al.* 2001). But problematisation of prison health in this way has resulted in a heavy focus on acute healthcare, and prison health services have tended to respond primarily to immediate, short-term problems rather than longer-term and, arguably, more sustainable and effective public health priorities. This is particularly evident with the management of drug misuse, suicide and self-harm, where energy has been directed at containment and treatment rather than prevention. Epidemiological research is undeniably important in terms of tracking and monitoring the state of prison health, yet heavy emphasis on physiological and psychiatric morbidity and mortality reinforces and legitimises a reductionist, pathological approach to prison health research and practice, while the broader health and social needs of prisoners remain obscured. There are some exceptions to this trend, where qualitative research methodologies have been used to explore prisoners' health needs and experiences, and shown that prisoners have extensive and diverse health and social needs that prison health services are rarely able to address (Fitzgerald and Sim 1982, Greenwood *et al.* 1999, Cassidy *et al.* 1998, Hughes 2000, de Viggiani 2003). It may be more appropriate, in seeking to explain why prisoners experience poorer health than the general population, to explore whether there are health-limiting factors, conditions or determinants beyond the individual that prevail within prisons and characterise imprisonment.

The Prisons Inspectorate has argued that a visionary and radical approach is needed to prison health policy and practice that addresses underlying determinants of health, notably offending backgrounds of prisoners, prison environments and quality/scope of prison healthcare services (HMIP 2000b). It is widely acknowledged that health problems arise directly from conditions of imprisonment such as overcrowding, exposure to violence and illicit drugs, lack of purposeful activity, separation from family networks and emotional deprivation (WHO 1998a, HMIP 2000b, Levenson 2002, Croft 2003, Howard League for Penal Reform 2005). Socio-economic background, childhood experiences, stressful life

events, adverse experiences in prison, and experiences of victimisation inside and outside prison have also been directly linked to some neurotic disorders, self-harm, suicide, epilepsy, asthma, coronary heart disease, dental morbidity and infectious diseases, while other factors have been identified as difficult to manage in prison, including pregnancy and certain disabilities (Marshall *et al.* 2000: 18–20).

Deprivation

It has been widely argued that prison is harmful, that it deprives individuals of basic human rights and needs, bringing physical, mental and social harm to prisoners and rendering them powerless and institutionalised (Clemmer 1958, Sykes 1958, Goffman 1961, Berger and Luckman 1967, Foucault 1977, King and Elliott 1977, Richards 1978, Sapsford 1978, Cohen 1979, Cohen and Taylor 1981, Fitzgerald and Sim 1982, Glouberman 1990, Mathiesen 1990, Sim 1990, Towl 1993). This deprivation perspective is principally derived from the classic US-based ethnographies of Clemmer (1958) and Sykes (1958), and is premised upon two key arguments, first, that imprisonment is synonymous with deprivation and, secondly, that prison deprivations have significant physical, psychological, emotional and social repercussions for individuals. Sykes (1958: 65–77) argued that imprisonment deprived individuals of certain key rights and possessions, which included liberty, goods and services, heterosexual relationships, security and autonomy. These 'deprivations' brought pain and hardship to individuals and threatened their sense of personal worth, self-esteem and identity:

> The individual's picture of himself as a person of value – as a morally acceptable, adult male who can present some claim to merit in his material achievements and his inner strength – begins to waver and grow dim (1958: 79).

Other writers have broadly concurred with Sykes's original arguments, albeit considering the difficulties of generalisability of his original findings, many supporting the notion that prison deprivations can lead to adverse effects for prisoners. According to Sykes (1958: 87–104), 'self-centred and egotistical alienative modes' would manifest in prisoners' attitudes and behaviours, resulting from their being forced to conform to roles commensurate with the regime and which enabled them to fit into prison society. King and Elliott (1977), likewise, observed exploitative and servile personality characteristics among prisoners at Albany Prison; the latter group were generally individuals who did not integrate well into the prison community and who subsequently became socially isolated and withdrawn. Clemmer (1958) introduced the notion of 'prisonisation' to describe how individuals became increasingly regimented and habitual in their conduct, and subscribed to a fixed system of values that were reinforced by the inflexible regime. Individuals would become so immersed in the life of the prison that they would begin to adopt '. . . in greater or less degree . . . the folkways, mores, customs and general culture of the penitentiary [and become] more deeply criminal [and] antisocial' (1958: 299). Sykes (1958) referred to these 'alienative modes' as 'survival strategies', in the sense that they enabled individuals to assimilate with and fit into the prison community. But it is unlikely that such responses brought positive benefits for prisoners, given that they effectively reinforced a social hierarchy based on exploitation and victimisation. The social order could thus bring significant negative health repercussions for prisoners.

Linked to the notion of prisonisation is the argument that prison social life is organised around a normative 'prison code'. A considerable literature has debated the significance of the notion of a code, which, it has been argued, shapes the norms, mores, customs and

behaviour of the prison community (Clemmer 1958, Sykes 1958, Morris and Morris 1963, King and Elliott 1977, Cohen and Taylor 1981, Fitzgerald and Sim 1982, Mathiesen 1990, Newton 1994), or, as Wieder (1974) has argued, provides a reference point against which individuals identify in terms of explaining or articulating their personal conduct and place within the prison social environment. Commonly, the code is described as a normative value system to which some prisoners subscribe and which is evident in their attitudes and behaviours (Cohen and Taylor 1981, Toch 1998, Sabo *et al.* 2001). In particular, they may project a 'tough' persona appearing to be able to cope with prison and they will strive to suppress and deny fear, weakness or suffering, avoid collaboration with prison personnel, avoid 'grassing up' other prisoners, mask outward semblances of appearing gay or effeminate, and appear prepared and able to fight and defend their honour when challenged (Sabo *et al.* 2001: 10). Under the code, prisoners become embroiled in struggles for dominance, jostling for recognition and legitimacy and shunning weakness and subordination (Sim 1994, Carrabine and Longhurst 1998, Sabo *et al.* 2001). Social status is governed by allegiance to the code and hence loyalty to fellow prisoners. Consequently, prison social life is organised around social hierarchies where tough 'professional' or violent offenders occupy the top stratum, a middle stratum is occupied by the majority, and an ostracised group is at the bottom, usually sex offenders, otherwise labelled 'nonces' (not of normal criminal ethos) (Cohen and Taylor 1981, Wooden and Parker 1982, Scraton *et al.* 1991, Sim 1994, Cowburn 1998, Marshall *et al.* 2000, Miller 2000, Archer 2002). Prisoners thus actively engage in 'front management' strategies to avoid exploitation, through '. . . simultaneously maintain[ing] a private, "pre-prison" sense of self and a public identity for presentation during social engagement with others' (Jewkes 2002: 211). Hence:

> . . . the tensions associated with sustaining the particular bodily, gestural and verbal codes that are demanded . . . are particularly marked, and the necessity for a deep backstage area where one can 'be oneself', 'let off steam' and restore one's ontological reserves is therefore arguably even greater than in other settings (2002: 211).

Violence, intimidation and bullying are commonplace under this scenario and represent prisoners' struggles for legitimisation and reputation (Sykes 1958, Morris and Morris 1963, Scully 1990, Scraton *et al.* 1991, Sim 1994, Cowburn 1998, Edgar and O'Donnell 1998, Toch 1998, Ireland 2000, Sabo *et al.* 2001). Sim (1994) has argued that violence is then the central catalyst of prison social life, where fighting, victimisation and bullying are routine, and institutionalised and symbolic rituals are characteristic of the hostile prison environment.

A common theme that emerges from the literature is that prisons are counterproductive in terms of providing potential for rehabilitation and positive health. Indeed, Bradley and colleagues (1998: 50) have described the prison system as 'negative' and 'barbaric', and Sim (1990: ix) has argued that prison is effectively 'double punishment' in that it not only deprives offenders of their liberty but brings them significant psychological and physical distress. On the other hand, the barbaric and brutalising effects of prison should not be overstated, for, as Cohen and Taylor (1981) have argued, positive social relations do exist among prisoners which can bring positive health outcomes, such as emotional strength, personal integrity and positive mental health. Prison is not a wretched experience for everyone, particularly those with strength and reserve to maintain some degree of control over their circumstances. Prisons vary enormously, in terms of security category, ethos and architecture and their populations are highly varied, heterogeneous and transient, which, by implication, means it may be mistaken to conceptualise prison life in terms of prison cultures or subgroups. In this regard, some critics have argued that the deprivation perspective is

overly simplistic given the diversity, high mobility and transient nature of prison populations (Morris and Morris 1963, Hughes and Huby 2000).

Importation

It has also been argued that prison communities exhibit and share the cultural norms and values of their host societies (Ditchfield 1990: 8). Prisoners 'import' values, attitudes, beliefs and social norms from their respective communities (Irwin and Cressey 1962, Irwin 1970, Cohen and Taylor 1981, Hughes and Huby 2000), or, as Goffman (1961: 23) has argued, they enter prison with their 'presenting culture'. Today's prisons are not completely closed systems or 'total institutions'. They have permeable boundaries and transient populations and represent microcosms of wider society. Prisoners' backgrounds and biographies, therefore, contribute to their abilities to cope with and survive imprisonment. Spencer (2001: 18) has argued that '. . . the seeds of poor health are sown for the majority long before they entered an institution'. Some individuals begin their prison sentences with pre-existing health problems that may even precipitate their criminal behaviour, for instance if they have an existing drug problem or personality disorder (Marshall *et al.* 2000). Fairhead (1981) has indeed shown that impaired social functioning and mental disorder are common among persistent petty offenders who comprise the majority of the prison population. Likewise, other researchers have argued that many prisoners come to prison with poor physical or mental health on account of having previously had poor access to healthcare, minimal incentive to take preventive health action and with histories of risky lifestyles (Krefft and Brittain 1983, Raba and Obis 1983, Marquart *et al.* 1999, Smith 1998, Hughes and Huby 2000).

Marshall and colleagues (2000) have referred to the well-established link between poverty, social exclusion and health, which merits important consideration with regard to the demography of the prison population. Others have likewise noted that most prisoners are from socially excluded groups and hence the health risks they face in prison stem from a wider social environment of inequality and disadvantage. Prisoners may therefore be more susceptible to preventable health problems and more likely to resort to drug misuse, self-harm or disorderly conduct (Singleton *et al.* 1997, Smith 1998, Home Office 2000, Smith 2000). Importation factors are therefore highly significant in terms of explaining the health status of prisoners and can help explain how broader health determinants, including social inequality, impact on the prison population.

Summary

Evidence suggests that factors intrinsic and extrinsic to prison play an important role in the health of prisoners. The effects of imprisonment can be harmful, whether these constitute direct physical assaults and injuries or more insidious effects on mental and social wellbeing. The remainder of this paper discusses an ethnography that was conducted in a male prison, which explored experiences of prison life and how these were perceived to impact on prisoners' health and wellbeing.

Research design and methodology

The research was conducted in a category-C[1] adult male training prison that held around 500 sentenced prisoners. Access to the prison was negotiated with the Prison Service and the Home Office through the senior governor of the prison. This was before the development and introduction of research governance frameworks for prison health research and for the host university. Ethical guidelines available from the British Sociological Association

and the Economic and Social Research Council were therefore adhered to. Access to research participants was then achieved through non-coercive one-to-one discussions between the researcher and potential participants, and recruitment involved signed informed consent. Participants were guaranteed privacy during their participation in interviews and their confidentiality and anonymity were protected during data analysis.

The research may be characterised as a reflexive, subtle realist ethnography (after Hammersley 1992), based on grounded theory methodology (after Glazer and Strauss 1967). This inductive approach enabled exploration of participants' experiences of imprisonment from a loosely relativist perspective, accepting the diversity of values and beliefs among participants of the prison experience and recognising that their accounts were representations of participants' somewhat unique and shifting life worlds (Hammersley 1992: 52). This methodology is helpful in striving to generate theories that, on the one hand, do not overstate or generalise about perceptions and beliefs of prisoners and prison officers, yet, on the other hand, enable the researcher to be *reasonably confident* in interpreting and coding themes arising from the data.

The research combined three qualitative research methods: participant observation, a group interview and one-to-one, semi-structured interviews with prisoners and prison officers, with the aim of generating theory through an inductive, 'organic' process. Research participants were living in or based on an enhanced wing, which, for the prisoners, meant that under the Incentives and Earned Privileges Scheme (IEPS)[2] they had earned maximum available privileges, including access to enhanced accommodation. The researcher (author) was directed to this wing by the prison governor because it posed the lowest security risk, which brought several advantages: (i) enhanced prisoners generally have broad experience of the prison system having earned their 'enhanced' status; (ii) the researcher was free to move about the wing and talk to or interview prisoners undisturbed in their cells; (iii) the prisoners had longer periods of association relative to those on other wings, making them more accessible to the researcher; (iv) these prisoners were generally more settled than most as they were anticipating release or transfer to open prison. The wing accommodated 40 prisoners at any one time and employed six full-time prison officers. There was a rapid throughput of prisoners, some spending only a few weeks there and others up to a year. This meant that, as such, the wing population did not form a cohesive group.

The researcher spent around five months visiting the prison, usually for whole days at a time, meeting prisoners and staff and learning about prison life. The earlier weeks were used to visit departments and wings, engage in sporadic conversations with staff and prisoners, maintain a field diary and reflect on the day-to-day experience, with the objectives of becoming accustomed to prison life and the regime, overcoming personal fears and prejudgements and becoming increasingly socially engaged with research participants. Once trust, rapport and mutual respect had been established with prisoners and prison staff it would then be easier to access and interview research participants in the more formal sense, and thereby try to elicit accurate and fair interpretations of their values and perceptions of prison and its impact on health. Prolonged periods were spent by the researcher in the prison, often playing pool, darts or board games, watching television or spectating at outdoor football and softball tournaments between the wings. This also involved making tea for the wing officers, thereby enabling the researcher to chat informally with them, listen to gossip and arrange meetings with new contacts. The level of trust built up with staff enabled the researcher to move about the prison unmonitored, abiding by certain rules concerning personal safety and security. It meant that the researcher was able to access staff and prisoners at short notice and use certain contacts to check out information gleaned from discussions and interviews.

Two months after the researcher's arrival at the prison, seven prisoners were recruited to participate in a group interview, essentially planned to explore collectively the research questions with potential interviewees and gauge their perspectives on health in relation to imprisonment. While this did not constitute 'formal' data collection, it was an opportunity to begin talking about the research with participants in terms of determining how best to conduct the one-to-one interviews. These volunteers and subsequent interviewees were selected opportunistically, through building up relationships on the wing. In total, 35 prisoners and four prison officers participated in the one-to-one semi-structured interviews, which were tape-recorded, carried out in cells or private rooms on the wing and lasted between 60 and 90 minutes. The number of interviews reflected the stage at which data saturation was perceived; in the case of the officers, the number of interviews was small because the wing only employed six permanent staff and two of these were not available to be interviewed.

Subsequent data analysis was based on the transcribed semi-structured interview data and those from the initial group interview. Where possible, interview transcripts were returned to interviewees for verification and editing, before undergoing analysis through systematic reading, re-reading, sifting, sorting and coding data into categories, themes and subthemes. Five data categories emerged from this process, which related to the prison regime, prisoner occupations, prisoner-staff relations, prisoner social relations, and relations beyond prison, with over 200 themes and subthemes. Given the extensive range of findings, this paper focuses on issues that arose relating directly to the organisation of the institution – the prison regime, prisoner occupations and staff-prisoner relations. Findings relating to prisoner social relations and relations beyond prison – which also have major implications for prisoner health – are discussed elsewhere (de Viggiani 2003, de Viggiani 2006).

Research findings

Prison regime

The Prison Service operates what is termed the Incentives and Earned Privileges Scheme (IEPS), which enables prisoners to earn privileges through good order and discipline (GOAD)[2]. Under the scheme, prisoners 'graduate' between 'induction' (or 'basic'), 'standard' and 'enhanced' conditions, where the accommodation usually shows a marked improvement and they can earn privileges commensurate with their progression.

Prisoners who participated in the research generally perceived the scheme as unjust, disempowering and limited in terms of rehabilitation. It was seen to represent an authoritarian and paternalistic system of control that stifled prisoners' potential for rehabilitation and future release.

> This regime . . . is about complete control between the prisoner and the staff . . . This prison is basically a controlling institution. As long as they can control you, that's it. As far as I'm concerned, rehabilitation and all the rest of it is bullshit.

Arrival at prison for the first time was described as a difficult and stressful time by most prisoners.

> When I first came in I was worried about everything . . . I've always said that if you serve six months bodily, you're doing twelve months mentally, because your mind works twice as fast in here, . . . and I don't think that's good.

On arrival, prisoners were processed through Reception where they underwent a strip search, confiscation of clothing and possessions, they were allocated a prison uniform and a prison number and read a summary of the prison rules. They were addressed by surname and number only and interviewed almost immediately regarding their dietary requirements, drug misuse history (if any) and healthcare needs, before being escorted to an Induction wing that accommodated around 70 prisoners. There they were placed in a rudimentary shared cell (with one or two other prisoners) with an in-cell toilet and sink; they also had access at specified times to the supervised communal shower facilities on the wing. Regardless of whether prisoners had been to prison before, and how long they had been in the system already, all prisoners were processed in the same way, essentially as 'new' prisoners:

> By the time you get to a jail like this, you've done induction and all that, you know the routine. But then they stick you on the induction wing and you're only allowed out of your cell two nights a week. I don't think that's right. That shouldn't happen because you've already done induction. It's just another excuse to keep you locked up.

Respondents described the first few days of prison as disempowering, alienating and overly petty and bureaucratic. Induction, which involved being assessed by wing staff for their security risk and then allocated employment or education, could last up to three weeks. Despite being a 'training prison', prisoners undergoing induction were locked in their cells for up to 23 hours a day. One respondent described the experience of reception and induction as 'a complete and utter shock to the system'. Essentially, new prisoners who had not been to prison before were unfamiliar with the rules and regulations and did not know what to expect of prison:

> . . . you don't know what is going on, you don't know the rules, and the official rules aren't necessarily the actual rules. It was completely alien to me.

The atmosphere across the induction and standard wings was described as tense and threatening. Consequently, most described the early part of their stay in negative terms, experienced fear, apprehension, paranoia, a sense of vulnerability, loss of dignity and low self-esteem.

While these harsh conditions were supposed to provide incentive for prisoners to comply with the GOAD philosophy, they were instead perceived as control strategies designed to disempower and force individuals to yield to the regime. This would mean they would begin their time in the prison locked up, sedentary and reneged of personal autonomy and responsibility, as one prisoner explained:

> You've got to get used to not thinking for yourself . . . You're told when to get up, when to get ready for bed, when to eat, when to go and do exercise, when to go to work . . . everything. You've got to work your head around that, big time . . . The screws basically think for you.

The daily routine was described as monotonous and boring, with long periods of 'bang-up':

> You're just staring at four walls. I don't care who you are . . . People say, 'Oh, yeah, I can do my bird. I can do it standing on my head'. Put them behind that door and they can snap like that. They're in tears. Nobody can handle staring at walls for 23 hours a day.

Long periods of 'bang-up' meant that prisoners became increasingly sedentary and unfit:

> . . . you're not getting that much exercise, you're laying around in your cell all day, and what can you do apart from lay on your bed? So your muscles and your bones are just seizing up, really.

Prisoners also sensed they were under constant surveillance, which was perceived as the key to the regime's control ethos, though also as eroding personal autonomy, privacy and dignity. It also reinforced a sense of paranoia among prisoners, some of whom admitted that they preferred longer periods of solitary confinement to shared cells with open conditions, where privacy was never assured:

> Every time you were let out of your cell they [the officers] were just standing watching you . . . During association, one of the screws would creep into the room and just stand at the back and watch everybody.

The IEPS was regarded as a divisive strategy intended to control prisoners, a mechanism that forced compliance and good behaviour, yet which lacked any value as a rehabilitative tool:

> It's just a form of control. That's all it is. The more they give you, the more they can take off you. It's just another way the prisons are trying to keep people calm and keep 'em in . . .

The IEPS was also perceived as a 'divide and rule' strategy whereby prisoners were differentially and unfairly awarded privileges; it became evident that despite having reached the same GOAD benchmarks, prisoners did not automatically receive new privileges (*e.g.* transfer to enhanced status). This was more or less admitted by one officer who remarked:

> If they worked as a team we would be finished. So you have to treat each one of them as an individual . . . You're playing a game with each one of them really . . . Officers have to be two-faced. In fact they are extremely two-faced.

Indeed, prisoners perceived that privileges were allocated on a nepotistic basis, benefiting a minority as a means to achieve compliance or GOAD among the majority. On the other hand, prisoners who were awarded privileges were stigmatised by others; enhanced prisoners, for instance, were often labelled as collaborators or 'nonces' by the majority. Accepting privileges was also seen to equate with breaching the prison code. This fostered tension among prisoners, adding to the stress for those who had earned enhanced status, and was apparent in the way many prisoners abstained from activities beyond their cells.

The prison regime achieved a high degree of security and control, but was flawed as a rehabilitative strategy; essentially, it forced prisoners to become subservient or to rebel. Prisoners were rendered emotionally, psychologically and physically dependent on the system, and were discouraged from taking control or responsibility for themselves. The priorities of the Prison Service – good order, discipline and security – combined with the continual problem of overcrowding, essentially undermined prisoners' health, rendering them sedentary, idle, emotionally unstable, psychologically disturbed and socially dislocated.

Occupation

Prisoners were forced into long periods of idleness. Most expressed concern at the level of underemployment in the prison and the resulting long periods of forced idleness. Unless they had earned a Facility Licence, enabling them to work a 40-hour week outside the prison, the maximum working week was 20 hours (Monday to Thursday). Prisoners complained of idleness, apathy, boredom and lack of motivation. Respondents felt there was little opportunity for purposeful activity and described their experiences of imprisonment using terms such as 'lie-down time', 'jail mode' or living in a 'dream world':

> You're sitting here like this, and you're just a vegetable, really. They may as well be giving you injections for five years, to knock you out, like.

Prison officers echoed this, one describing prisons as 'dumping grounds' where boredom was fostered by the inflexible regime and overcrowded prison estate. Another officer remarked:

> Once the judge says, 'Send him down', that's it. These people might just as well be dead, 'cos the general public outside neither know, nor care what happens to them. Yet, we are expected to keep them in custody and then return them so that they lead a full life. But we are not doing that. It's all wrong, the emphasis is all wrong.

Concern was expressed about the wages. A satisfactory regular wage ensured prisoners could purchase basic necessities from the prison canteen (shop):

> The basic necessities in here are your toiletries for your own self-esteem. Yes, the prison provides toiletries, but, to be fair, they're the cheapest toiletries you can get. So you buy your own to help you feel good, for your own self-esteem. Secondly, phonecards help you to keep that contact with the outside world. And then there's tobacco, and that's everybody's lifeline in here.

Pay was a major incentive to comply with the IEPS, particularly for those prisoners who did not have access to private funds sent in by relatives (prisoners could receive a weekly allowance to supplement their wages). A differential pay scale operated whereby prisoners could receive between £4 and £8 per week, depending on their privilege status (basic/induction, standard or enhanced); this pay scale applied to all standard prison employment and was also paid to those attending education or vocational training courses. However, enhanced prisoners and an increasing number of standard regime prisoners could also apply for contract jobs (or to work outside the prison if they had earned a Facility Licence). These jobs were paid at an hourly rate, which enabled prisoners to earn between £20 and £40 per week. Contract work generally comprised menial and repetitive assembly-line work, but because of the attractive pay it was highly popular and had long waiting lists. Conversely, training and education were unpopular because of the guaranteed lower pay.

This system of differential pay, which was intended to be an incentive to prisoners to comply with the regime, was viewed as inequitable by prisoners, even those with enhanced status who could access the more lucrative jobs. First, the standard weekly wage was felt to be far from adequate:

> . . . inmates are either scraping to get through a week or having to have money sent

> in . . . At the moment, I get £6 a week for phonecards, tobacco and toiletries, which isn't enough. So I have to get money sent in. I'm lucky. A lot of these don't have money sent in and struggle.

Secondly, the differential wage scale, the opportunity to earn hourly wages through contract work and access to external private funds meant that new prisoners and poor prisoners were effectively discriminated against since they would arrive at the prison with one week's advance of £4. This inequality led to a culture of debt and baroning, whereby some unscrupulous, richer prisoners exploited poorer prisoners with loans based on 100 per cent return ('double bubble'). Where a debtor failed to honour the debt payment, there would likely be repercussions (commonly, victimisation, violence or becoming a drug trafficker):

> Out there, if someone owed you £2 you wouldn't go and throw a jug of hot water in his face because of it. But it happens in here. If someone owes you £4, and he was supposed to pay you last week but can only pay you half this week and half next week, you wouldn't go up and cut him now, would you? But I've seen it done in here.

Thus, the system of differential pay was a divisive feature of the regime that fostered inequality, exploitation and bullying.

Opportunities for education and training were also limited and severely rationed. Prisons are required to provide employment and education for prisoners, although this is often limited to young offenders where there is a statutory obligation to provide education in line with the National Curriculum. There seemed to be a certain level of ambivalence at this prison, however, regarding education and training for adult prisoners, evident from one officer's comment:

> Sitting folding plastic bags for Age Concern is not giving these training. It's basic training that I think we're lacking in. I'm not saying they're going to go out and *get* jobs, but at least someone could take them on at a level where their skills were going to be beneficial and they could be further trained. But that's sadly missing.

It was evident that prisoners were also reluctant to sign up for education or vocational training because this was new or unknown to them, and thus taking up such a challenge was intimidating, as one prisoner remarked:

> If you ain't very good at maths, or reading and writing, like, and you're 28, nearly 30-years-old, then you're thinking you're going to be the only divvy in the class who can't read or write.

Another respondent's comment illustrates how important it is for prisoners to be supported in making employment, education or career decisions; often the easy option is to avoid new challenges:

> To be honest, I really have no idea what I wanna do . . . I know what I *won't* be doing, I won't be out labouring and things like that no more. I really don't want to do that again. I'd like to keep on with computers, like, 'cos I've worked with shovels and pigs and that in the past, and that's been all right for a few beers at the end of the week, but I've never had any money put by. But then I've never really wanted to work in an office or indoors really.

Several respondents were anxious about their inability to support their families or dependants economically following release from prison. Most had little insight into how they would earn a living in the future:

> . . . it can be extremely frightening for a lot of people. They're going out into a world where they must stand completely on their own two feet. But they're going out with a discharge grant of £40, sometimes with no home and nothing to go to . . . It's very humiliating.

There was also a great deal of ambivalence among respondents about the offending behaviour courses most were expected to participate in as part of their sentence management. These were organised by the education department and usually ran for one to two hours, one day a week over a series of successive weeks; they included Enhanced Thinking Skills, Anger Management and drugs and alcohol courses (CARAT). First, respondents felt that the courses were not relevant to them, that they were merely enrolling and attending to satisfy the authorities (parole board, sentence management team, probation). Secondly, many viewed the courses as ineffective in addressing their offending needs. One respondent said he could not take the drugs course seriously enough because the tutors were unable to empathise with prisoners who had been seriously drug dependent.

> It really gets my back up . . . they've *never* been to the depths we've been to!

Furthermore, respondents felt that a short course in a classroom could do little to address their problems:

> If you're not drug aware, then you wouldn't be taking drugs. I've taken every kind of drug there is, so I'm very aware of drugs! Yet they think they should send you on a course to be more aware of them, what damage they do and stuff. They think we're all thick and that we don't understand what we're doing!

The general perception of most respondents, including prison officers, was that prisoners were not being effectively prepared for release. Education, employment and sentence planning were perceived to be short-sighted in the sense that motivation to prepare for release was stifled by the incentive to earn as high a wage as possible, regardless of the quality of the work; this was linked to everyday social survival in prison, particularly for those who were dependent on drugs or tobacco, or who were victims of 'double-bubble'. It was difficult therefore for prisoners to choose education and training, particularly when they felt it was not relevant to their personal circumstances. Ambivalence towards offending behaviour courses seemed to reflect the belief that the courses were not relevant or appropriate to their needs.

Staff/prisoner relations

It became evident from talking to prisoners and prison officers that the traditional prison code to some extent governed how they related to one another. There was evidently a line that should not be crossed:

> You don't cross that barrier. They are screws, we are cons, and that's it.

An officer's uniform and authoritarian conduct further affirmed this division. Inmates thus tended to minimise contact and interaction with officers, addressing them as 'boss' or

'governor', rather than by name. Likewise, prisoners also tended not to collaborate too closely with staff as this would signify crossing the line:

> If I sat in here for half an hour talking to a screw, the other guys would be asking fucking questions, like. Personally, I wouldn't want to sit and chat to a screw, like. It's not good for your health! The rest of the guys would be thinking you're a bit of a grass or something funny like that.

A common concern of prisoners was that prison officers tended to treat them like children, or '. . . being talked to as if you're a piece of shit'. Respondents perceived a patronising and humiliating 'parent-to-child' approach used by some officers towards prisoners. Indeed, the officers interviewed felt that some prisoners preferred to be treated more like children than responsible adults, one officer conceding that he found it easier to work with prisoners he treated like children. Another officer referred to prisoners collectively as 'children in long pants that haven't learnt the way of life'. In his view, most had little self-awareness, sense of direction or purpose and were highly self-centred. A third officer stated that the aggression and lack of discipline of some prisoners warranted an authoritarian approach. Speaking of a particular prisoner, he admitted:

> I treat him cruel, but he thrives on it. He actually produces better results being treated like that than he does if you try the caring and sharing approach. He sees that as a sign of weakness, you see. So every time he comes near me, I tell him to hop it.

Prisoners correspondingly felt that most officers were patronising towards them, particularly in their tendency to publicly berate them, usually shouting insults to make themselves heard. Some prisoners viewed this as childish behaviour in itself, perceiving such officers to be on a 'power trip', '. . . wanting authority, . . . and thinking they're something they're not'. Such behaviour, however, was also felt to be damaging to relations between prisoners and staff, and in turn demoralised and dehumanised prisoners:

> If you're treated like an animal, you start to act like an animal. And when you're acting like an animal, you're being treated like an animal. And it keeps on and on and on. It's just a full circle. You then believe that you're not intelligent.

Prisoners also referred to officers who either publicly censured or made favourites of particular prisoners: '. . . if your face don't fit, then you've had it'.

> You'll get officers that get on your case, and they'll stay on your case for a while. They'll keep on and on and, like, you're trying to do things and the officer's sort of stepping in your way each time. Like with jobs and that, if you say, 'Oh, I'd like to go for that job', the officer'll then turn round and get you totally the opposite job. And, I mean, that's just wrong, it's unfair.

Alternatively, officers were sometimes perceived as being nepotistic towards certain prisoners. One officer admitted that he would always be more supportive of prisoners whose alleged offence had been a 'grace of God' crime:

> . . . there are some people in here who are genuine victims themselves, who really have been in the wrong place at the wrong time. They have committed a particular type of

> offence which leaves them grieving, particularly manslaughter charges and things like this. And you find that they need help as much as anybody else does.

Thirdly, prisoners perceived that prison officers and healthcare staff had little concern for their health and social welfare, reflected in their apparent complacent attitudes. Several prisoners had witnessed assaults of other prisoners. Another described how he had been resuscitated in an ambulance following a heart attack in his cell, which might have been avoided had the wing staff listened to his complaints of feeling unwell and his request to see a doctor; he had an ongoing fear of dying in prison. Officers were also perceived to spend minimal time interacting with prisoners, despite their responsibilities as personal officers, which was interpreted as laziness. It was also felt that prisoners' requests were usually ignored or devalued by officers:

> They just sort of look straight through you. They nod and say, 'Yes', to everything, and then when you've gone out the door, they mutter something to their mate, like, and then do nothing about it, which I hate. And that just gets me even more frustrated.

Receiving contradictory information and advice from officers was another common complaint. Officers, on the other hand, felt that certain prisoners tended to badger them with 'trivial' requests or complain excessively.

Positive relations between prisoners and prison staff were evidently hampered by the ideology of control that characterised the prison regime and the prevalent values of the prison code. Prisoners felt at worst victimised and at best neglected, particularly by prison officers, which had the effect of undermining their self-esteem, confidence and self-worth. The paternalistic and authoritarian attitudes of some officers stifled opportunities for good prisoner-staff relations, based on respect, reciprocity and positive regard, and effectively disempowered prisoners through their treatment like children. This contributed to the overall ethos of control, discipline and subordination. Prisoners mistrusted staff and felt patronised by the style of management, compounded by their complacency and differential treatment of prisoners.

Discussion

This research has revealed how the institution of prison can have a major impact on health, particularly in terms of mental and emotional wellbeing. In particular, prisoners' capacities to cope with and 'survive' imprisonment, emotionally, psychologically, physically and socially have an important bearing on their health. These research participants had to adapt to and cope with a compulsory, paternalistic and authoritarian structured way of life and assimilate with institutional norms and procedures reflected in the prison code. The institution, with its regime and traditions, brought significant deprivations for prisoners, given that they experienced alienation, loss of privacy, loss of independence, heightened surveillance, competition for wages and divisive rules and strategies inherent within the regime and evident within the conduct of prison officers. These problems were compounded by overcrowding within the prison and across the prison estate, and combined to bring about reduced self-esteem and self-efficacy, reduced motivation, high levels of stress and an increased likelihood of risk-taking behaviours. The findings reveal a range of deprivation and importation factors relating to the regime and structured environment of the prison.

Deprivation and prison health

The IEPS was a paternalistic and authoritarian system of control, whereby prisoners were stripped of their autonomy, responsibilities and identities, equivalent to Foucault's (1977) 'normalisation process', since prisoners were denied their dignity, privacy and self-respect, and expected to conform to the Prison Rules. They became completely subservient to the prison authorities and were then rewarded for good order and discipline through the divisive rationing of privileges. On arrival at prison reception, prisoners were ordered to surrender all that identified them as responsible adults, allocated a prison uniform and number and addressed only by surname. This procedure signalled the beginning of a 'mortification' process (after Goffman 1961), as their self-confidence, self-esteem and identity were diminished, and they felt progressively alienated by the system. As they entered induction, prisoners experienced fear, panic, anxiety, loss of privacy, vulnerability and heightened visibility as they came under constant surveillance from the prison staff and their fellow prisoners. It seems that the regime was therefore engineered to disempower prisoners, forcing them to surrender control to the system, a short, sharp shock approach designed to instil obedience and compliance, similar to Sykes' (1958) 'figurative castration' and Illich's (1977) 'emotional impotence'. Induction was meant to be the start of a rebuilding process, whereby prisoners would be rewarded for good conduct and treated increasingly like responsible adults. But the paternalistic and authoritarian approach to custody forced prisoners into subordination, causing most to become almost totally dependent and childlike. For many respondents, this was a time when they felt mentally low, and some experienced physical or psychological harm arising from institutional or inmate brutality and aggression.

Being treated like a child, or 'infantilized', as Miller (2000) has described it, was a key feature of the regime, and also of relations between prisoners and prison staff. Even as enhanced prisoners, interviewees described how officers had been condescending and 'parent-like' towards them. As in Foucault's (1977) analysis, some prisoners sensed that they were being treated as 'delinquents', and, as Cohen and Taylor (1981) noted, a proportion regressed socially, distancing themselves from others, becoming socially withdrawn. Prisoners were nonetheless acutely aware of this process, particularly of the paternalistic manner of some staff, and the tendency for censure or nepotism by some prison officers.

Being a 'training prison', each prisoner had a structured sentence plan, which identified the offending behaviour programmes they were expected to complete and the educational opportunities available to them to help them plan for their release. But most respondents reported that they spent very little time engaged in purposeful activity, partly due to lack of meaningful employment and shortage of training opportunities. Respondents described their daily routines as monotonous, boring and unproductive. Underemployment and low-skill work prevailed in the prison, which provided little incentive to work beyond earning wages. Furthermore, the offending behaviour programmes were viewed with general cynicism and antipathy. Those prisoners who were at greatest risk of re-offending were least likely to benefit from the employment, training and offending behaviour programmes on offer. Thus, while the prison was highly effective in rendering prisoners subservient to and dependent upon the regime, through this very process it fostered idleness and apathy, distracting prisoners from the important goal of rehabilitation (through empowerment, personal responsibility and autonomy) towards short-term privileges – in-cell TV, computer games, canteen provisions, higher wages, use of the gym, etc. Lack of real direction led to greater anxiety concerning the future and little hope for release.

As suggested previously, imprisonment can cause health problems or exacerbate pre-existing ones. McCallum (1995) found that prison organisation, culture and relationships inside and outside prison could be damaging to prisoners' health. Marshall *et al.* (2000)

found that loss of privacy, overcrowding, social isolation, restrictive and repetitive routine, low stimulation and the prisoner social hierarchy could precipitate or exacerbate neurotic mental health problems, such as depression, anxiety, drug misuse, violence, self-harm and attempted suicide. This was particularly the case where prisoners were sharing cells designed for one.

Overcrowding has certainly been recognised as a key factor in terms of prison hardship and deprivation. The 2004 House of Commons Home Affairs Committee session on prisoner rehabilitation stated that prison overcrowding had reached highest recorded levels, with the occupancy level at 106 per cent; an equivalent occupancy level of 106 per cent was recorded for the prison where this research was conducted. This level of overcrowding meant that 17,000 prisoners were being held two to a cell designed for one in 2004 (House of Commons Home Affairs Select Committee 2005). A recent estimate by the Howard League for Penal Reform (2005) puts this figure at 12,000.

In 2002, the Prisons Inspectorate declared categorically that overcrowding was raising serious human rights concerns, having discernible damaging effects on safety, respect, purposeful activity and resettlement – the Inspectorate's four 'tests' of a 'healthy prison' (HMIP 2002). Research conducted in 2002 by the Prison Reform Trust and the National Council of Independent Monitoring Boards concluded that overcrowding was threatening prison safety, leading to prisoners being held in inhumane, degrading and unsafe conditions and was damaging attempts to maintain family support and reduce re-offending by prisoners (Levenson 2002). A Report prepared for the Joint Committee on Human Rights (Croft 2003) made a number of observations regarding the conditions prisoners were expected to live under while sharing cells designed for one occupant – for instance, having to use the in-cell toilet in the presence of cell mates and as a seat while eating meals; restricted space also meant there was no space for prisoners to exercise or undertake in-cell activities. The report also stated that overcrowding meant the Prison Service could not meet Key Performance Indicator targets such as providing 24 hours of purposeful activity per prisoner per week or guaranteeing fresh air for prisoners.

The findings of this research reinforce many of these themes implying that deprivations associated with regime and occupation, and probably compounded by overcrowding, represent important health determinants.

Importation and prison health

The prison population was highly transient in that prisoners were constantly passing through the system, usually progressing from a local B-category prison to a 'C-cat' and possibly then on to a 'D-cat' open prison. The IEPS also mean that prisoners moved between wings, progressing through induction, standard and enhanced. The movement of prisoners was also partly determined by the state of overcrowding of the prison estate and how much flexibility there was in the system to move prisoners about. This transience inevitably meant that prisoners came from very varied backgrounds – in terms of geographic origin, type of offence and experience of prison.

Most prisoners were from working class backgrounds and were therefore accustomed to casual or unskilled employment, and less inclined towards education. Indeed, many of the prisoners interviewed could not read or write. By contrast, prisoners with professional or semi-professional backgrounds or who had higher than average levels of educational attainment stood out from the crowd. It was therefore more usual that prisoners opted for unskilled employment in the prison, where the focus was on wages and less on self-development; for the majority, education was unpopular and ostracised, and perceived by some as a 'feminine' pursuit. This dominant 'working class' culture was also evident in the

belief of many prisoners in a strict sexual division of labour, where men should work and women should care for children; this was particularly evident where respondents sensed that they had 'lost control' over their families.

Many prisoners had come to prison with long offending histories, some with extensive experience of the prison system as juveniles, young offenders or adults. There was a sense among many of these that the prison system had little to offer them and that, in fact, custody was an 'occupational hazard'. As such, prison to them was therefore 'lie down time' and risk of recidivism was likely to be high; they usually described the experience as 'doing time' and 'keeping their head down', as Irwin (1970) identified. Prisoners who had been initiated into crime as children, and had grown up in families or neighbourhoods where crime had been the norm for multiple generations, drew their values and beliefs from 'the street' and were likely to bring these to prison.

Conclusion: reorientating prison health

WHO's Health in Prisons Project (HiPP) was launched within the European Union in 1994, with the purpose of promoting and overseeing the development of health promotion in prisons within member states (WHO 1996). The project is based on WHO's 'settings approach' for health promotion (WHO 1991; see also Baric 1992, Mullen *et al.* 1995), derived from the original Health For All 2000 declaration (WHO 1985) – that all social settings should provide opportunities for supporting and enhancing health – and the Ottawa Charter for Health Promotion (WHO 1986), which emphasised action on the broad determinants of health. For prisons, the WHO vision was to create a 'whole climate' for improving health (1996: 1), where personal safety, fulfilment and dignity were considered important prerequisites for health (WHO 1998b: 2). Since the launch of HiPP, WHO's vision and values have been supported and endorsed by the Prison Service (HM Prison Service 1997: 2), the Prisons Inspectorate (HMIP 2000b: 106–09), the former Conservative government (DoH 1992) and New Labour, in Saving Lives: Our Healthier Nation (DoH 1999b) and Choosing Health (DoH 2005).

The Statement of Purpose for the Prison Service requires prison authorities to abide by a humane duty to care for prisoners, where prisoners must be supported in preparing for useful, productive and law-abiding lives following release (Home Office 1991: 3). The United Nations Convention on Human Rights also states that prisoners must be treated with dignity, valued as human beings, and have access to adequate healthcare services, including health promotion (UN Secretariat 1990). But recent Inspectorate reports have consistently argued that the Prison Service is failing in its duty of care (HMIP 2000a). It is indeed widely reported that the prison estate of England and Wales is overcrowded, which has direct and indirect implications for prisoner health. The Prisons Inspectorate (HMIP 2005) and the Howard League for Penal Reform (2005) have linked suicide, self-harm and other mental health problems to overcrowding, particularly where prisoners are expected to share cells designed for one. The World Health Organisation (1998b) has stressed that prison overcrowding has unequivocal effects on prisoner health, contributing to loss of control by staff and bullying among prisoners. In particular, it suggests that a prisoner should not be expected to share a cell with someone with a history of violence or bullying.

The notion of a 'healthy prison' remains something of an oxymoron without significant reform of the way prisons are managed and offenders are treated. Indeed, Smith (2000: 349) has argued that while prisoners are held in overcrowded conditions, with poor facilities, few

opportunities, high levels of stress, and increased surveillance and control, their health is likely to suffer. Risk-taking behaviour is merely symptomatic of individuals' personal struggles to cope with prison; it is the effect of prison rather than the cause of the problem of poor health. Public health measures for prisons should therefore challenge the social and structural determinants of poor health before focusing on promoting healthy lifestyles (2000: 351). But to date there has been little theoretical or critical debate concerning prison health. 'Prison health' is generally accepted as an all-embracing term, while there are important questions still to be explored, specifically: 'does prison make people sick?', 'does prison healthcare work?' and 'does prison work?' This broader debate is needed in order to recognise the value that an 'upstream', public health approach can bring to prisoner health.

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Notes

1 On arrival at a prison ('Reception'), sentenced adult male prisoners are assessed and categorised according to their likelihood of escaping. The category they are assigned (A,B,C or D) determines the type of prison and wing they will be held in. Category-A is assigned to those whose escape would be highly dangerous to the public, the police or the security of the country, and where the possibility of escape must be impossible. Category B is assigned to those for whom high conditions of security are required and for whom escape must be made very difficult. Category C is assigned to those who cannot be trusted in open conditions (prisons without walls), but who do not have the resources or will to make a real escape attempt. Category D is assigned to those who can be reasonably trusted in open conditions. Prisoners commonly move between these categories to reflect their behaviour, their progress and the stage of their sentence (Leech and Cheney 2000).
2 The Incentives and Earned Privileges Scheme – often referred to as the Progressive Regime – was introduced to prisons in England and Wales in 1995 as a 'carrot-and-stick' approach to prison management. Incentives and privileges for prisoners are used to prevent unruly or antisocial behaviour and to promote Good Order and Discipline (GOAD). It is underpinned by the Prison Rules, published by the Home Office (Cavadino and Dignan 2002).

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