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Understanding the needs of vulnerable prisoners: the role of social and emotional wellbeing

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Abstract

Purpose – Social and emotional wellbeing (SEWB) is a term used to refer to the state of an individual’s overall wellbeing. This review aims to consider the importance of understanding and assessing SEWB in prisoner populations, and identify potentially important differences between groups of prisoners, including those who identify as from minority cultural backgrounds (Aboriginal and Torres Strait Islander in Australia), protective custody prisoners, remand prisoners, prisoners identified with an intellectual disability, and prisoners with an acquired brain injury.

Design/methodology/approach – The paper is a general review of the published literature, with a specific focus on work conducted with Aboriginal and Torres Strait Islander communities in Australia.

Findings – Eight domains of SEWB are identified across which Aboriginal and Torres Strait Islander prisoners, along with those in protection units, remandees, and prisoners with intellectual disabilities or acquired brain injuries are likely to experience particularly low levels of functioning. Few programs have been developed to address these needs, although attending to low levels of SEWB has the potential to make a positive contribution to prisoner health, prison management, and offender rehabilitation.

Originality/value – Relatively little literature has considered this topic previously and, as a result, the paper is necessarily descriptive. Nonetheless, issues of SEWB appear to warrant further consideration, particularly in relation to those prisoners who identify with minority cultural groups.

Keywords – Social and emotional wellbeing, Mental health, Prisoners, Aboriginal, Mental health services, Imprisonment, Prisons

Paper type – General review

The construct social and emotional wellbeing (SEWB) suggests that mental health is a state of wellbeing which relates to a person’s awareness of his or her ability to cope with everyday stressors, work productively, and make positive contributions to the community (WHO, 2010). It is well-established that a wide range of experiences can adversely impact on an individual’s SEWB, including environmental deprivation, emotional, physical and sexual abuse, emotional and physical neglect, stress, social exclusion, grief and trauma, removal from family, substance abuse, family breakdowns, cultural disconnection, racism, discrimination, domestic violence, and social disadvantage (Keleher and Armstrong, 2005). Prisoners, and in particular those who identify as from minority cultural backgrounds or are considered vulnerable in other ways (e.g. at risk of self-harm, intellectually disabled, or in protective custody), represent a group which might be expected to have histories that are characterised by such experiences (Felson et al., 2012), and accordingly would be expected to experience generally low levels of SEWB. The aim of this paper is to review what is currently known about SEWB in prisoner populations, and to consider how useful a construct it is in:

- understanding the needs of specific groups of prisoners; and
- informing the development and delivery of appropriate services.
There is a particular focus in this paper on the needs of Australian prisoners who identify as from Aboriginal and Torres Strait Islander cultural backgrounds. This is a group of particular interest, not only because of the gross levels of their over-representation in Australian prisons (Royal Commission into Aboriginal Deaths in Custody, 1991), but also because of the way in which SEWB has become a central part of national health care policy more broadly. In 2009-2010, for example, 446 of 3,100 (7 percent) of Commonwealth-funded Aboriginal and Torres Strait Islander primary health-care service employees were described as “social and emotional wellbeing staff” (Australian Institute of Health and Welfare (AIHW, 2012)). These are made up of counsellors, psychologists, and social workers who deliver programs and interventions intended to improve the SEWB of members of the Aboriginal and Torres Strait Islander community using approaches that are holistic in nature. At the recent Indigenous Justice CEO’s Forum held in Canberra (2012), for example, the Deputy Secretary of the Commonwealth Attorney-General’s Department observed that holistic approaches that strengthen connections to family, community and culture, and restore the authority of elders are likely to be among the most effective ways forward to close the gap between indigenous and non-indigenous disadvantage in the criminal justice system. In addition, the indigenous-focused literature has identified prisoner health as a necessary, if not sufficient, condition for effective prisoner management and rehabilitation (Durey, 2010; Keleher and Armstrong, 2005). Thus, the need to monitor and address poor prisoner health is considered to be more than fulfilling “duty of care” requirements but, in this context at least, central to the key goals of prison administrations. In this paper, we suggest that this approach may also have utility in understanding and responding to the needs of other groups of prisoners who might also be considered to be vulnerable.

Defining and measuring SEWB

Within the WHO (2010) definition of mental health as a state of overall wellbeing (and not merely as the absence of a disorder) is the idea that “mental health” should be viewed holistically (Social Health Reference Group, 2004). It identifies the need to consider socio-historical factors, personal choice and values, language, culture, emotional affect, social control, and social values in assessing the health status of an individual (Gorman, 2010), and draws attention to the importance of meeting the basic needs of survival such as shelter, food and income, the need to feel safe, feel free from violence and the threat of violence, and to have control (Calma, 2009). The term SEWB suggests wellbeing has two particularly important components; social wellbeing, and emotional wellbeing. The term emotional wellbeing is generally used to reflect an individual’s emotional state at any given time, although global emotional wellbeing is the accumulation of multiple experiences which, when combined, reflect an individual’s disposition to display specific emotional states (Larsen and Prizmic, 2008). Social influences are also implicated in the process of attaining a high level of SEWB (Hochstetler et al., 2010). For example, environmental factors that have been shown to foster high levels of social wellbeing include; mutual support and respect, low levels of tension and threatening behaviour and restoration of individual control in a guided manner (Larsen and Prizmic, 2008). It has been suggested that there is a lack of these factors within the prison environments leading to adverse effect on wellbeing and mental health of many prisoners (Jordan, 2010).

In Australia, the term SEWB has, perhaps unsurprisingly, been most frequently used in relation to the mental health of Aboriginal and Torres Strait Islander communities, given that it reflects the holistic philosophy that many Aboriginal and Torres Strait Islander people have towards health (National Aboriginal Health Strategy Working Party, 1989). The available evidence suggests that levels of SEWB in this population are generally low. The 2004-2005 National Aboriginal and Torres Strait Islander Health Survey, for example, considered eight domains in which SEWB could be measured. These were psychological distress, impact of psychological distress, life stressors, discrimination, anger, removal from natural family, cultural identification, and positive wellbeing (AIHW, 2009). The survey found that over 27 percent of Aboriginal and Torres Strait Islander adults experienced high levels of psychological distress, and were twice as likely to experience psychological distress as non-indigenous Australians. Four out of ten Aboriginal and Torres Strait Islander adults surveyed reported they had experienced or have known someone who had experienced the death of a family member or friend in the last year, 28 percent reported serious illness or disability and 20 percent reported alcohol related issues. The life expectancy of Aboriginal and Torres Strait Islander Australians was found to be 17 years less than non-indigenous Australians and, despite poorer health, Aboriginal and Torres Strait Islander adults did not seek healthcare due to factors including but not
limited to cost, transport, cultural barriers, and lack of services (Durey, 2010). Although there have not been any published surveys of SEWB in indigenous prisoners, it has been established that rates of mental disorder are particularly high in this group (Heffernan et al., 2012).

1. **Psychological distress**

Psychological distress affects the day-to-day functioning and wellbeing of individuals (Ridner, 2004), making it central to the notion of SEWB. Psychological distress can be described as psychogenic pain, internal conflicts, and/or external stress which prevents an individual from being able to cope with everyday stressors, work productively, and make positive contributions to their community (WHO, 2010). It can arise during the experiences of anxiety, depression, demotivation, irritability, aggressiveness, or self-depreciation (Masse, 2000) and has been measured using the K-10, a brief symptom checklist devised by Kessler et al. (2002) designed to measure levels of negative emotional states experienced in the four weeks prior to time of assessment.

2. **Impact of psychological distress**

Psychological distress has links to poor mental health outcomes, socioeconomic disadvantage, unemployment, poverty, work, and life stressors (Sharma, 2012), all of which have been identified as causes of low levels of SEWB (Zubrick et al., 2010). Psychological distress is thought to manifest in individuals in a range of different ways, according to a number of other variables such as personality and biological traits, and the social and environmental supports that individual has available at any point in time (Sharma, 2012). When assessing for the presence of psychological distress, it is important to establish the impact that any distress has on an individual’s ability to participate in day-to-day life.

3. **Life stressors**

Life stressors such as divorce, family illness, death, and serious accidents are considered to have a significant impact on SEWB (Australian Bureau of Statistics, 2007), particularly when these experiences are cumulative (Yehuda et al., 1995). Individuals who experience a high number of life stressors are also suggested to have increased risk of substance abuse, and violent life stressors are considered to affect the wellbeing of individual’s more than non-violent life stressors (van der Velden et al., 2010). However, the presence of social support has been shown to help buffer against life stressors (WHO, 2010).

4. **Discrimination**

Discrimination has been described as the rejection and persecution of a specific individual or group and can occur due to cultural or religious beliefs, disability, appearance, or a range of other factors (Whitbeck et al., 2002). Discrimination can be either daily (which is repeatable and thus internalised as normal by the individual), or major (which is lifelong and rare). Research into this aspect of SEWB has suggested that discrimination can lead to psychological distress, and can increase mental health disorders, aggression, depression, and anxiety (Noorbala et al., 2012).

5. **Anger**

Anger is considered to be a good indicator of psychological distress and, as such, is thought to play an important role in SEWB (AIHW, 2009). It is known to be implicated in disruptive behaviours, an increased likelihood of participating in offending behaviour, and can lead to poor social relationships and poor health (Gendreau and Keyes, 2001). It is thus considered important to assess the intensity of the emotion and the relation between anger and thoughts and feelings (AIHW, 2009).

6. **Removal from natural family**

Removal from natural family was included in the 2004-2005 National Aboriginal and Torres Strait Islander Health Survey given the significant role it has played in Aboriginal and Torres Strait Islander history (known as the "stolen generation", see Bringing Them Home, Wilczynski et al., 2009), and the lower levels of SEWB
Aboriginal and Torres Strait Islanders appear to exhibit as a consequence (AIHW, 2009). However, Aboriginal and Torres Strait Islander individuals are not the only individuals who experience detrimental effects as a consequence of removal from natural family, and it is well established that disruption in families can lead to an increase of mental disorders, psychological distress, substance abuse, and criminal activities (Collin et al., 2008).

7. Positive wellbeing
Positive wellbeing allows for focus on the positive factors in an individual’s life, not just those that are associated with distress (Schimmack, 2008). This is consistent with the WHO’s (2010) definition of mental health as not merely the absence of illness but as a whole of life experience (WHO, 2010). Positive wellbeing occurs when individuals experience high levels of functioning in the domains of physical health, general health, vitality, social functioning, and mental health (King, 2008). It can also buffer against negative aspects of SEWB, such as high levels of psychological distress, anger, and life stressors.

8. Cultural identification
Culture can be understood as defining the way an individual thinks, feels, and behaves. It has been suggested that people who identify closely with a cultural group have higher levels of wellbeing (Franklin and Platt, 1994). Conversely it has been shown that individuals who experience cultural disassociation experience higher rates of suicide, hospitalisation for emotional disorders, diabetes related hospitalisation and deaths, and experience disproportionate involvement in the criminal justice system (Holdenson et al., 2003; McDonald and Steel, 1997). Furthermore, the experience of racism can increase experiences of anger and hostility, lessen self-worth and damage an individual’s sense of identity (Jones and Day, 2011).

Prisons and SEWB
The way in which the construct of SEWB has been operationalised in the National Aboriginal and Torres Strait Islander Health Survey assists in establishing a method of measuring SEWB in a way that reflects its holistic nature. It is, however, clear that much work is still to be done in this area and there has not previously been any substantive consideration of the importance of SEWB in prisons. This is despite the WHO (1996) identifying prison settings as the focus of the Health in Prisons project, describing prisoners as deprived of basic human rights and needs, and prisons as causing physical, mental, and social harm.

There is a body of research that has investigated prison social climate which supports this view, suggesting that institutional environments can adversely influence the wellbeing and treatment outcomes of prisoners. Factors such as privacy safety, structure, support, emotional feedback, social stimulation, activity, and freedom have all been identified as important influences here (Moos, 1968). For example, Worthington (2012) examined the influence of social climate within prisons, concluding that working in certain areas of the prison (described as “dirty work”) was associated with lower levels of staff wellbeing and less positive interaction with prisoners. It is, however, the role that SEWB potentially plays in relation to organisational outcomes that are of most interest, particularly in relation to the good order and discipline of the prison, suicide prevention, and offender rehabilitation.

Behavioural problems
Although a percentage of prisoners who display disruptive behaviour will do so for premeditated or instrumental reasons or to avoid looking vulnerable, it has been suggested that a significant amount of problematic behaviour is due to emotional and psychological distress (Toch and Adams, 1986). For example, it has been suggested that violent behaviour can be a coping technique for those who have not learnt more appropriate ways to deal with distressing environments and emotions (Zamble and Porporino, 1990).
Self-injury and suicide

Rates of self-injury and suicide are typically higher in prisoner populations than in the general population (Fruhwald and Frottier, 2005). This may be because prison environments exacerbate risk in those who are already at risk because of mental health problems or poorer social and socio-economic standing (Fazel et al., 2011) or, it has been suggested, as a result of over-crowding (Leese et al., 2006). Others such as Blitz et al. (2008) point to the high rates of physically victimisation in prisons, with prisoners more likely to witness or be victims of violence than those in the general population. This can lead to higher levels of stress, emotional distress and increased health concerns, and increases the risk of suicide and/or self-injurious behaviour.

Rehabilitation

The promotion of SEWB can potentially add to, integrate and facilitate rehabilitative change in a number of ways. For example, there is evidence that suggest when prisoners are released back into the community, they can find normal day-to-day life over-whelming. This is particularly the case when low levels of family support and abuse, neglect, and mental health issues are present (Serin and Lloyd, 2009). Helping prisoners to acquire emotional regulation skills may assist them to manage the negative emotional states that arise from these experiences and which are often associated with re-offending (Day, 2009). For example, Zamble and Quinsey (2001) found that 75 percent of a sample of 300 parolees reported experiencing psychological distress in the 30-day period prior to re-offending, with 65 percent experiencing negative emotions in the 48 h leading up to the re-offence. Other research has also reported similar findings (Hanson and Harris, 2000; Wisener et al., 2005), suggesting that it is dysphoric emotional states that act as acute dynamic risk factors for re-offending. Attending to issues related to SEWB may also, of course, assist with the process of engaging offenders in a behaviour change process as well as helping them to successfully integrate any changes into life after release (Felson et al., 2012; Heffernan et al., 2012).

There would thus seem to be some rationale for considering levels of SEWB in prison populations, and identifying ways in which low levels of SEWB can be improved or managed. There may also be a case for targeting those groups of prisoners who are likely to experience particularly low levels of SEWB, such as Aboriginal and Torres Strait Islander prisoners in the Australian context, but also those who are in protective custody, are on remand, or experience particular types of mental health problem or disability. These groups are considered next.

Protective custody

Protective custody began in the early 1960s when attempts to make prisons more humane began (Wormith, 1988). Since that time, the numbers have risen significantly and it has been estimated that up to 50 percent of prisoners will experience some type of segregation at some point in their incarceration history (Correctional Service Canada, 1999).

Protective custody prisoners are generally considered to be the most vulnerable group within prison populations. They include sex offenders, those who cannot pay drug debts, high profile prisoners, and lawyers. Protective custody facilities are also often less affluent than mainstream custody facilities, and have been described as sensory depriving and isolating (Grassin, 1983; Scott and Gendreau, 1969). These environments appear to be more strongly associated with higher levels of depression, anxiety, anger, phobic reactions, hallucinations, somatic complaints, and lower self-esteem (Miller and Young, 1997). Prisoners in long-term protective custody have been found to experience greater difficulty socialising with others and reoffend at higher rates than mainstream prisoners (Browne et al., 2011), although Wormith (1988) has suggested that protective custody prisoners appear to be less antisocial and criminally orientated than mainstream prisoners.
Remand prisoners

Protective custody is not the only environment in which prisoners are likely to experience lower levels of SEWB than the general prison population. Sawyer et al. (2010a, b), for example, found that when compared to adolescents in the community, adolescents on remand have poorer mental and physical health, greater family dysfunction and poorer school attendance. Although this study did not make direct comparisons between remandees and sentenced prisoners, other research has suggested that prisoners experience higher levels of depression and anxiety than the general prison population in the early stages of imprisonment (Brown and Ireland, 2006). What is less clear is how long-term remand prisons are affected. Delays in court cases, common in many jurisdictions, has led to longer periods of time before cases are heard which, in turn, has resulted in longer periods on remand (Kirby et al., 2000). Nonetheless, it would appear likely that remand prisoners are a particularly vulnerable population.

Other types of prisoners at risk

Two other groups of prisoner may experience lower levels of SEWB due to the presence of either acquired brain injury (ABI) or learning disability (LD). ABI is an injury to the brain, which occurs as a result of trauma, hypoxia, infection, tumour, substance abuse, stroke, or degenerative neurological. The rate of ABI is particularly high in prisoner samples. Williams et al. (2010) found that 16 percent of prisoners had severe ABI and 48 percent mild ABI and that these prisoners were likely to spend more time in prison. ABI can lead to deterioration in cognitive, physical, emotional, or independent functioning (Department of Human Services and Health, 1994). ABI prisoners are more likely to experience psychological distress, have fewer social supports, make poorer decisions and have more health complaints (Williams et al., 2010).

Individuals with a LD are those who have significant sub-average intellectual functioning, and concurrent deficits or impairments in adaptive functioning in areas such as communication, self-care, home living social/interpersonal skills, use of community resources, self-direction, functional academic skill, work, leisure, or health and safety (American Psychiatric Association, 2000). Although it is difficult to reliably establish prevalence rates, some estimates are as high as 29.5 percent (Crocker et al., 2007). Other estimates are at 1.4-1.8 percent, which is more reflective of the proportion of people with LD in the general population (Lambrick and Huppert, 1999). What does seem clear, however, is that prisoners with an LD are likely to experience lower levels of SEWB. For example, Australian prisoners with an LD are more likely to have a history of homelessness, sexual, emotional and physical abuse, substance abuse, mental health issues, and associate with negative social peers (Cockram, 2005; Glaser and Deane, 1999; Hayes, 2005). In addition, prisoners with an LD are more likely to have been charged with a sexual offence than prisoners without an LD and, as a consequence, more likely to be held in protective custody (Holland and Persson, 2010).

Conclusions

This paper considers how the construct of SEWB might be useful in informing the ways in which prisoners are managed. Prompted by Australian interest in SEWB, particular in relation to the low levels of SEWB in indigenous Australian and high levels of over-representation in Australian prisons, it is suggested that other groups of prisoners may also experience particularly low levels of SEWB. The needs of groups such as remandees, those held in protective custody, and those with ABI or LDs are poorly understood, but likely to be particularly complex given the ways in which psychological, social, and environmental factors impact on their experiences. The notion of SEWB provides one way to discuss these interrelated and overlapping needs in a way that is easily accessible and places emphasis on prisoner health. There is also a rationale for adopting this approach, given the potential contribution of low levels of SEWB to a range of negative institutional outcomes, including disruptive behaviour, self-harm and suicide, and poorer rehabilitation.

It is nonetheless very clear from this review that thinking about SEWB is in its early stages. It is a difficult construct to operationalise and measure, and it will be important to not only document low levels of SEWB but to find ways to assess whether change has occurred. Health focused programs and interventions that
have the potential to improve levels of SEWB are not routinely delivered in prisons, but if they can be shown to play a role in effective prison management and successful rehabilitation then there is much more scope to strengthen this aspect of service delivery. Conceptualising prisoner health in this way invites the delivery of a much broader range of psycho-social interventions than are currently possible in circumstances when a diagnosis of mental disorder is necessary to access services.

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