REVIEW OF RESEARCH
ON THE EFFECTS OF IMPRISONMENT ON THE
HEALTH OF INMATES AND THEIR FAMILIES

Prepared by the
NATIONAL HEALTH COMMITTEE
The National Advisory Committee on Health and Disability (National Health Committee) is an independent committee appointed by, and reporting directly to, the New Zealand Minister of Health.

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Executive Summary

Around the developed world, a growing and changing prison population has given rise to renewed interest in the effects of incarceration on the health of inmates. This is a population with many complex and often co-morbid health needs, and the difficulty in separating and determining causal links has led many to conclude that health needs are ‘imported’ by inmates rather than being a product of their experience of incarceration. The truth is almost certainly a combination.

Prisoners comprise a number of more vulnerable population groups such as young people, older people, people with intellectual or physical impairments, women, and Māori and Pacific people (both overrepresented among the prison population). Each group has particular health vulnerabilities and needs which must be met within an institutional environment designed, by and large, for adult men of European descent who are ‘sound’ in ‘mind and body’.

Although prison is sometimes a setting for health improvement, the environment is in many ways a severe risk to the prisoner and to his or her family. Suicide and self-harm can be more likely among inmates. Mental health problems and addictions are prevalent and often co-morbid in prisons. Prisoners are at far greater risk of death immediately after release, supporting the view that the health of prisoners must be treated within a broader context which incorporates connections with family and continuity of care from community to prison and back to community.

Communicable diseases and the behaviours that spread them are commonly developed within the prison environment. The conditions of prison can exacerbate deterioration in older prisoners and those with pre-existing health conditions. Evidence suggests that the emotional and psychological pressures of incarceration; health issues in their own right; are also linked to the development of many chronic conditions. The experiences of life within the custodial world can also be psychologically damaging – triggering memories of past trauma or abuse, inspiring behavioural adaptations (hyper-vigilance, secretiveness, aggression, and so on) that translate poorly into family life, and undermine the prisoner's roles in the family and community and ultimately, their identity.

The families and children of inmates suffer from a range of factors associated with both the removal and the re-entry of a family member. Financial pressures and deterioration of social ties while a partner is incarcerated can lead to significant psychological strain for parent and children alike. For children, poor outcomes that have been linked with the imprisonment of a parent include behavioural problems such as aggression, hyperactivity and delinquency; mental health problems such as anxiety, depression, eating disorders and low self-esteem; and developmental problems such as regression and difficulty in school. Incarceration has been shown to have a deleterious effect on vulnerable communities, in which erosion of social networks and social capital are incorporated into a cycle – often intergenerational – of criminality, reduced life chances and imprisonment.

Large gaps remain in the body of research, notably collection of basic health status and health needs, benchmarking to evaluate improvement and information sharing among agencies and between agencies and health professionals. Furthermore, due
to an overwhelming assumption that health issues are completely imported, the question of the health effects of prison is not being adequately addressed anywhere in the world. Although there are many omissions in the international literature, the most glaring include the impact of imprisonment on oral health, the quantification of physical injuries in prisons, the effects on or deterioration of (existing) disabilities including vision and hearing and the medical impacts on the children and families of inmates. All of these are also missing from local information.

There are also many debates New Zealand is failing to engage in. These include: the experience of imprisonment; the collateral consequences of incarceration and its effect on the children, families and communities of prisoners; the experience and effects of home detention; the influence prison has during different developmental stages and the implications for categorisation, legislation and penal design; the experience of elderly prisoners and the needs of the greying prison population; the rate of violence, bullying and sexual abuse in New Zealand prisons; the experience and health needs of prison staff; the post-release experience - including mortality - and the health and service delivery outcomes for prisoners with disabilities.
The prisoner population in New Zealand

New Zealand’s imprisonment rate was reported as 197 of 100,000 people in 2007.¹ This was the third highest rate in the OECD.

Around 22,000 people move through the prisons each year. Over the past decade the number of people imprisoned has continued an upward trend. On 30 June, 1998 there were 4671 sentenced and 686, or 13%, people remanded in custody. By 30 June 2007, 6445 people in prison were sentenced and 1777, or 22%, were there on remand.² In addition to these 8,222 people in prison (the ‘muster’), the Department of Corrections was that day overseeing 20,650 people serving community sentences and 5,077 in prison-release community management.³ In recent years some policies have contributed directly to increased numbers in prison. For instance, the Sentencing Act 2002 delivered longer sentences for serious offences. Additional police officers mean more apprehensions, prosecutions and convictions overall. The Department of Corrections reported a “sharp upturn” in numbers imprisoned beginning in mid-2003 until 2007.⁴

A range of factors contribute to rising numbers in prison. More than one in five in prison are now remand prisoners. The number of charges resulting in a conviction rose by 18% between 2002 and 2006, and the number of convictions resulting in custodial sentences rose as well.⁵ Numbers of people on life and preventive detention accumulate, rising from 80 in June 1980 to 588 in June 2007.⁶ Numbers sentenced to more than 2 years in prison were stable from 1980 to 1986, then rose more or less steadily from 678 (June 1986) to 3908 in June 2007.⁷a

Recidivism is high; a Department of Corrections study found that almost half of offenders released in 2002/03 were returned to prison at least once within 48 months.⁸ There is a “tendency for persistence in the criminal careers of older offenders,”⁹ whose numbers are rising. Parole laws introduced in 2002 made longer-term prisoners eligible for parole earlier. However, a climate of public concern about recurrent offenders has meant that more prisoners are eligible but not yet released by the Parole Board than those not eligible for release.¹⁰

In 2006 an interagency suite of projects intended to reduce offending and slow the rate of growth in prison muster, collectively known as ‘Effective Interventions,’ began.¹¹ Decreases in the muster beginning in late 2007 are widely attributed to some of these measures, for instance an expansion in community-based sentences available to judges and the availability of electronic monitoring for suspects on bail. Ministry of Justice projections taking these measures into account still showed the daily prisoner population rising 18% (to 9028) by 2014.¹¹ The effects of other policies, such as new sentencing and parole guidelines and ‘Effective Interventions 2’ will not be felt until 2009. Updated forecasts are expected from the Ministry of Justice in September 2008.

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¹ The average custodial period imposed in 2003, the most recent date for which reliable data is available, was four years for men and two years, seven months for women. This data excludes 450 sentences of life and preventive detention. The median custodial period imposed for both men and women was just under two years. Department of Corrections (2004).
In 2003, the latest date for which prison census information on dependents is available, 35% of female and 12% of male sentenced prisoners reported having child custodial dependents when imprisoned. Most of these children were being looked after by the partner or other family. From 1991 to 2003 the proportion of men in segregation or protective custody rose from 12 to 19%. According to the Department of Correction’s Integrated Offender Management System (IOMS) only four women sought or required segregation in 2003.\textsuperscript{12}

Prisoners do not reflect the demographic characteristics of the general population. The prisoner population is primarily male: six percent of prisoners are women. Due to disproportionate incarceration among the 20 to 40 year age group, the prisoner population is younger overall than the general population. 35% of the sentenced population is age 20 to 29, compared with 13% of the general population. 30% of the sentenced population is age 30 to 39, compared with 14% of the general population.\textsuperscript{13}

At the same time, the number and proportion of older prisoners are growing rapidly. Between 1980 and 2007 the proportion of sentenced prisoners 30 to 39 years rose from 13 to 30%. Those 40 years and older expanded from 7 to 29 percent of the muster during the same time, though this figure is still well below their proportion of the general population (44%).\textsuperscript{14}

The prisoner population has lower levels of educational achievement and a socio-economically disadvantaged background. Half of sentenced prisoners are Māori (compared with 15% of the general population) and about 11% are Pacific people (compared with seven percent of the general population).\textsuperscript{15} The 2003 Prison Inmate census reported that 54% of the sentenced Māori inmates identified an iwi affiliation.

The international experience

Awareness of the need to re-evaluate the prison system and its effect on those who come into contact with it is growing internationally. Such awareness stems from the fact that the global prisoner population continues to increase and is also changing in composition. Our prisons are designed to house those who are young and male but are increasingly being filled by those who are neither. There has been a ‘greying’\textsuperscript{16} of the contemporary prisoner population as well as an increase in the female muster. The situation in New Zealand is in line with these global trends\textsuperscript{17} and these trends have practical, ethical,\textsuperscript{18} economic, social and cultural implications for the status quo.

Internationally, prisoner health is recognised as an exceptionally complex issue. A variety of reforms have taken place in comparable nations in response to what Sparks (1995) calls a “near terminal crisis of order and moral credibility” but critics argue that ultimately, the question of the legitimacy of the prison system lies at the heart of the debate\textsuperscript{18} and must be addressed for real change to occur. Even those responsible for the design and implementation of these reforms agree that their

\textsuperscript{c} See for example Crawley and Sparks (2005a) on their discovery of a prisoner with Alzheimer’s who “neither knew where he was, how long he had been there or what he was there for.” pg. 352
systems and strategies for change are made more problematic by factors inherent in the nature of imprisonment. These include:

- the prevalence of pre-existing vulnerabilities among those affected
- societal and institutional attitudes toward prisoners and imprisonment
- the transient nature of the prisoner population
- philosophical, jurisdictional and environmental conflicts between health care and custodial needs

The current debate can be understood as centring around two main arguments.

**The importation model**

The first argument is that prisoners are an unhealthy group and the problems that they face in prison are largely due to the way they came in. Prison is seen as having potentially detrimental health effects but it is believed that these harms are temporary (or potentially so) and can be minimised by implementing the right interventions. This argument focuses on prison as a public health setting and calls for the strengthening or implementation of health education, effective screening and treatment, staff development, the freedom of medical staff to act as health professionals rather than custodial personnel and the reduction of risky behaviours through effective management and resourcing.\(^1\)

This approach is called the importation model\(^2\) and is epitomised by the World Health Organization (WHO) and its Health in Prisons Project.\(^3\) It focuses predominantly on increasing the ability of the individual to make rational decisions and therefore ‘gain power’ over his or her own health. Reintegration and health outcomes are seen as improving with greater autonomy and self-management. Health here is defined somewhat holistically with the WHO stating that it is “a state of complete physical, social and mental well-being and not merely the absence of disease or infirmity.”\(^4\)

Critics of the WHO model argue that this definition is not being put into practice as “health is too often constructed as a set of discrete variables that can be isolated from the whole person and her environment.”\(^5\) De Viggiani (2007) notes that while epidemiological research is essential for tracking and monitoring health problems, approaching such a complex topic from a ‘singular’ perspective can lead to a “reductionist, pathological approach to prison health research and practice, while the broader health and social needs of prisoners remain obscured.” With limited perspectives guiding them, “prison health services have tended to respond primarily to immediate short-term problems rather than long-term and arguably, more sustainable and effective public health priorities.”\(^6\)

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*Isolating health and healthcare use from the experience of confinement and one’s relation to the body runs the risk of robbing these phenomena of their complexity.*

- Robert et al 2007
The deprivation model

Those arguing for a broader perspective are supportive of moves to improve prisoner health but argue that the topic needs to be addressed holistically, with acknowledgement of the institutional, social, political, environmental and cultural context. They view the health effects of prison as not only tangible but resulting directly from the ‘pains of imprisonment’ and the wider social conditions that decree such treatment in the first place. They agree that prisoners arrive with varying levels of resilience but argue that ultimately, an absence of ‘risk factors’ upon entry is no guarantee that a person will survive their sentence unscathed. Furthermore, any vulnerabilities prisoners bring with them are likely to be exacerbated by immersion in a regime designed for punishment, control and social exclusion.

Under this understanding a ‘Healthy Prison’ is by definition an oxymoron and ‘health’ has a broader meaning which incorporates the social, environmental, economic, and other determinants and measures of wellbeing.

This view sees incarceration as having negative health outcomes which reach far beyond the prison walls and which continue to have effect long after the sentence has been completed. These effects cannot be solved by their medicalisation and any attempts to counter them must consider the wider context.

This approach is known as the deprivation model and it stems in part from the writings of Sykes and, later, Toch. For both of these authors the nature of prison is to deprive people of those elements of life that are fundamental to the well-being, health and essence of the self. Consequently, the argument goes, the WHO’s goal of health through empowerment is impossible in a system that demands (and produces) submission. Proponents of this view criticise those creating the policies of reform for neglecting to seek input from prisoners themselves, for ignoring the inherent contradiction in their attempts, and for perpetuating an ultimately “bankrupt” system.

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d Although the WHO definition is related, this definition has more in common with Māori models of health.
e De Viggiani (2006) notes that prison healthcare, particularly in the UK, continues to be dominated by the biomedical paradigm. p. 72
f See for example Sim (2002). The future of prison health care: a critical analysis. Critical Social Policy 22(2). London: Sage. pg. 307. He cites Grace (1991): “the notion of empowerment that lies at the heart of the health promotion discourse ‘means in practice, we discover again that it is the health professionals and the health promotion policy advisers and decision makers who are to control the determinants of health’” pg. 313

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g Sparks (1994) pg. 76.
…we may ultimately come to the conclusion that [prison’s] intrinsic design faults are such that it rarely or never achieves its objectives, or that it routinely produces unintended ‘perverse consequences’ which may be so severe that it must either be transformed or abandoned.

- Sparks 1994


The middle ground

There is some accepted middle ground between the two. Both ‘sides’ utilise a broad definition of health and agree that prison is not generally good for it. The disagreement begins at how this happens and what should be done to counteract it. It is accepted that there will be some degree of variation in the effects on individuals and both sides appreciate the influence imported vulnerability has on this. It is also generally acknowledged that there are innate tensions between prison requirements and health practices/needs.

It should be noted that while this debate can be said to have been going on for some time, the research focus on prison has been relatively narrow, that is, there has been a tendency to see prisoners as an isolated and homogenous ‘subject,’ ‘disconnected’ from the wider community and family groups. A great deal of the literature to date displays little to no recognition of variation in gender, class, ethnicity, age or physical/mental capabilities. More questions have been raised than answered, and many of these call for a re-evaluation of ‘fundamental’ aspects of modern society. It should also be noted that although the volume and diversity of this debate is rising internationally, New Zealand voices have remained relatively silent.

Definitions of health

The definition of health utilised is critical to the debate over prisoner health. The most commonly used definition in the international prison health dialogue is that provided by the World Health Organization (WHO). It states that health is “a complete state of physical, mental and social wellbeing, and not merely the absence of disease or infirmity.” In its Ottawa Charter for Health Promotion (1986), the WHO argues that “health is created by caring for oneself and others, by being able to take decisions and have control over one’s life circumstances, and by ensuring that the society one

\(^h\) For example: the custodial and structural environment, the loss of autonomy and the separation from family and community.
lives in creates the conditions that allow the attainment of health by all its members.” Health here is defined in more holistic terms, extending beyond a purely medicalised conception to take into account the role social context plays in the wellbeing of an individual.

Māori models of health, particularly *whare tapa whā* and *te wheke*, reinforce the need for broad definitions. For Māori, poor health is “typically regarded as a manifestation of a breakdown in harmony between the individual and the wider environment.” As with the WHO definition, these models consider wider social relations (*taha wānau*); particularly as they relate to family and the ability to “belong, to care and to share”; as inextricably linked to health. Both the *whare tapa whā* model and *te wheke* also consider *taha wairua* (spiritual), “the capacity for faith and wider communion”; *taha hinengaro* (mental), “the capacity to communicate, to think and to feel”; and *taha tinana* (physical), “the capacity for physical growth and development”; as essential to health. Other aspects Māori models identify as having a bearing on an individual's health include:

- the physical environment (*te ao tūroa*)
- the ability to express emotion in an open and healthy way (*whatumanawa*)
- access to an indisputable land base and cultural heritage (*turangawaewae* and *taonga tuku iho*)
- having a positive identity which recognises one’s own uniqueness and that of the family (*mana ake*)

### The Evidence

**Imported vulnerability**

Although there have been changes in the constitution of the prisoner population, those who are incarcerated continue to represent the most marginalised, culturally censored, socio-economically disadvantaged and ‘powerless’ of society. The majority of prisoners in any country, including New Zealand, are those who come from a context already shaped by social exclusion. Among other things, they are likely to be members of an ethnic minority, have limited education and a history of instability, unemployment or underemployment, substandard diet and housing conditions and inferior medical access. Their health reflects this disadvantage and like them, tends to be poor.

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1 Smith and Robinson (2006). The UK’s Social Exclusion Unit argues that “many prisoners have experienced a lifetime of social exclusion. Compared with the general population they are thirteen times more likely to have been in care as a child, thirteen times as likely to be unemployed, ten times as likely to have been a regular truant, two and a half times as likely to have a family member convicted of a criminal offence, six times as likely to be a young father and fifteen times as likely to be HIV positive.” See Social Exclusion Unit (2002) pg. 6

Common ailments include co-morbid mental health and substance abuse/addiction problems; higher rates of disease; cognitive, behavioural and emotional problems and self-harming or suicidal behaviour. Sykes (1958) called the phenomenon of unhealthy pre-prison context and poor social inclusion imported vulnerability. This has become a key consideration in the prison health discourse, as well as one of the drivers of the reassessment of the modern prison.

Those who inhabit New Zealand’s prisons are clearly vulnerable. Though it was a survey (rather than a census) and relied on the self-report of its subjects, the Prisoner Health Survey (2005)\(^30\) has provided us with the broadest snapshot of New Zealand prisoner health status to date. Some of its findings are:

- 52% of male and 47% of female prisoners had no educational qualifications
- less than half of male inmates and slightly more than a third of female inmates were in paid employment before entering prison
- 31% of males and 45% of female prisoners had a gambling problem at some stage in their lives with 23% of males and 34% of females identifying this as a “current” problem
- over half of all prisoners were overweight or obese. 44% reported becoming less physically active since entering prison
- more than half reported a prior diagnosis of a chronic condition – most commonly asthma
- two thirds of inmates were smokers
- almost half of prisoner population had experienced tooth pain while eating or drinking in the last month
- one in three prisoners had a history of one or more of the communicable diseases asked about (these included chlamydia or other STI; scabies and lice; hepatitis B, C or other; rheumatic fever and tuberculosis)
- almost two thirds of prisoners had suffered at least one head injury in their lifetime, and
- one in three prisoners were unable to see a nurse when they wanted to at some time in the previous 12 months. At least the same proportion was unable to see the prison doctor when they wanted to, but an error in data collection prevents a more accurate estimate.

On mental health and substance abuse, other New Zealand studies have found:

- significantly elevated mental health issues within the prisoner population in comparison with the community; in particular, post traumatic stress disorder (PTSD), bipolar disorder, major depressive episode and obsessive-compulsive disorder\(^31\)
- 89% of inmates had substance abuse and dependence issues\(^32\)
- 83% of inmates with mental illness had a co-morbid substance abuse condition
- approximately one-fifth of inmates had high levels of suicidal ideation\(^33\)
- 57% of inmates had one or more personality disorder,\(^34\) and
- among offenders under 18 years at one youth residential unit, 56% of young people (73% of the girls) had emerging diagnosable mental health disorders
such as conduct disorders, mood disorders, psychosis, post-traumatic stress disorder, suicidal ideation and schizophrenia.\textsuperscript{35}

Although national New Zealand data is not readily available, international studies also suggest high pre-prison prevalence of:

- physical, sexual and emotional abuse – particularly for women\textsuperscript{k}
- poor diet and food intolerance\textsuperscript{l}
- poor dental health
- illiteracy and both cognitive and learning difficulties including dyslexia\textsuperscript{m}
- decreased levels of social support including broken and very fragile families\textsuperscript{36}
- parental imprisonment
- histories of truancy, parental neglect and previous custodial involvement

Loucks (2005) argues “women in prison are already an extremely vulnerable population, characterised by addiction\textsuperscript{n}, depression, anxiety, suicidal and self harming\textsuperscript{o} 37 behaviour, backgrounds of abuse and deprivation.”\textsuperscript{p} Young (1996) notes that their health tends to reflect a lifetime of exclusion, marginalisation and particularly oppression. She states that this all too frequently equates to limited access to health care and exposure to risks such as blood borne viruses or sexually

\textsuperscript{k} Belknap (1996) suggests that incarcerated women are more likely to have survived incest, rape and violence than their community counterparts. Greenfeld and Snell (1999) found that 80% of female prisoners reported “an extensive history of physical, sexual and/or emotional abuse” and often a combination of all three. See Braithwaite RL in Braithwaite RL, Arriola KJ and Newkirk C (eds.) Health Issues Among Incarcerated Women, pg. 23. In summarising recent findings, Messina and Grella (2006) put the rates of reported emotional, physical and sexual abuse for female inmates at between 77% and 90%. In a three year NSW survey of young people in custody, 72% had experienced some form of abuse or neglect with females reporting higher levels of abuse, particularly that of a sexual nature. See also Robert, Frigon and Belzile (2007); Maeve (1999); Nicholls et al (2004) and Laishes (2002).

\textsuperscript{l} In a controlled study of youth recidivists Bennett and Boston (1997) found “a high level of food allergy, food intolerance and nutritional problems.” Cited in Hek et al (2005) pg. 32

\textsuperscript{m} See Bryan K (2004) pp 391-400 for a review of the literature. Estimates range from 10%-50%. In Bryan’s own study ‘17% of the young offenders reported hearing problems, 50% memory problems and 37% problems with literacy. When tested, at least a quarter scored significantly below their age bracket in all four tests (Boston Naming Test, Grammatical Competence, Comprehension and Picture Description), with almost three-quarters scoring “significantly below the acceptable limits for their age” in test two. These results are backed up by the findings of Kenny (2006). In this study 15% tested at a level suggesting intellectual disability and the reading skills of 21% and the arithmetic skills of 64% were “equivalent to those expected of people with intellectual disabilities.” See pp. 6 and 20-24.


\textsuperscript{o} Kendall (1993) believes that women are more at risk from self injury because they tend to direct their anger inward and to punish themselves rather than lashing out physically at others.

\textsuperscript{p} Loucks N (2005) Bullying behaviour among women in prison. In Ireland JL, (ed.) Bullying among Prisoners. pg. 38. See also Kenney-Herbert J (1999) “many women prisoners are likely to have relied solely on benefits before incarceration, to be single parents, to have never worked, have significant debts, and to have experienced abuse.” The Health Care of Women Prisoners in England and Wales: A Literature Review. The Howard Journal 38:1 54-66 (pg. 54) He also cites Morris et.al. 1995.
transmitted infections (STIs). Many of these factors have been found to be more prevalent among women prisoners than among men in prison.\(^9\)

Youth, another vulnerable group, in custody in New South Wales were found to have high risk behaviour:
- 81% were smokers
- 7% of boys and 17% of girls had injected drugs in the previous 12 months
- about a quarter used condoms less than half the time
- 31% engaged in binge drinking and 47% used cannabis at least weekly
- a third of the young people were overweight or obese.\(^{39}\)

Also at a greater risk are older people, ethnic minorities, immigration detainees and those with intellectual or physical impairments. For those with reduced cognitive abilities, for example, Fleming (2005) found that they were more susceptible to environmental influence, particularly as it relates to behaviour.\(^{40}\)

Concerns for these most vulnerable groups in New Zealand are highlighted in a 2004 report to the Human Rights Commission which identified a gap in policy, poor communication, and resource constraints leading to inadequate care for prisoners with intellectual or physical disabilities or mental health issues.\(^{41}\)

Another policy and monitoring gap identified in this document is the detention of asylum seekers in mainstream custody. New Zealand is not the only country in which this practice is found, but international asylum standards strongly discourage both the detention of asylum seekers and their imprisonment alongside the prisoner population.\(^{42}\) This concern includes but extends well beyond health issues.

**The prison environment**

Prison has been described as an “intrinsically non-therapeutic environment.”\(^{43}\)

Internationally, the prison environment is recognised as one in which:

- health needs are not the top priority
- resources are scarce, strictly rationed or difficult to protect
- avenues for self-care are limited (e.g. diabetics have no access to needles, medication is administered)
- standards of care can change with staff shifts and transfers between different facilities
- standards of care may also change depending on the type of crime one has committed
- the design of facilities assumes a young, male, able bodied person will be inhabiting them
- the structures used for housing people are often old, badly planned and poorly maintained
- levels of distress, anger, depression and frustration are high.

\(^q\) Eckstein et al (2007) reported higher prevalence among women in New South Wales prisons of illicit drug use, STIs, psychiatric medication, suicidal thoughts, many diagnosed medical conditions, and violent and abusive partners. The authors also note extra risk factors for cervical cancer.
In the international literature there is also a rekindled acknowledgement of the distinct social context that exists within prisons and the role this plays in the health and wellbeing of those who are forced to live there. The work of Sykes (1958) drew attention to the significance of the ‘prison code’; the normative value system that exists within prisons. He observed that “prisoners could display ‘self-centred and egotistical alienative modes’ of behaviour that arose from being forced to conform to roles commensurate with prison regimes and having to fit in with prison social life.”

Internationally, the ideals of inmate subculture include doing one’s own time (i.e. keep your emotions to yourself) and the belief that the line between prisoner and ‘authority’ must always be maintained. Contemporary commentators, notably De Viggiani (2007), Ireland (2000, 2007), and Haney (2002), are revisiting the social aspects of incarceration and have pointed to a number of socio-environmental factors which influence health and well-being. These include:

- the role of external social influences: e.g. support networks, the ability to retain ‘street’ roles and relationships, gang membership
- the prison code⁴⁴, its enforcement and an individual’s ability or strategy to conform or adapt to it, and
- unequal power relationships and rigid hierarchies.

**Pains of imprisonment**

Sykes (1958) coined the phrase “pains of imprisonment” to describe the particular ‘types’ of suffering caused by incarceration and argues that they ultimately contribute to an erosion of self. He identified five main ‘pains’:

- “The loss of liberty (confinement, removal from family and friends, rejection by the community and loss of citizenship: a civil death, resulting in lost emotional relationships, loneliness, boredom)
- The deprivation of goods and services (choice, amenities and material possessions)
- The frustration of sexual desire (prisoners figuratively castrated by involuntary celibacy)
- The deprivation of autonomy (routine regime, work, activities, trivial and apparently meaningless restrictions - for example lack of explanations for decisions), and
- The deprivation of security (enforced association with other unpredictable prisoners, causing fear and anxiety; prisoners fighting for the safety of their person and possessions).”

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⁴⁴ Internationally, the prison code is a well documented feature of prison life. De Viggiani (2007) pg. 74, cites Clemmer 1958; Cohen and Taylor, 1981; Fitzgerald and Sim, 1982; King and Elliot, 1977; Mathieon, 1990; Morris and Morris, 1963; Newton, 1994; Sykes 1958; Wieder, 1974. It is the “normative value system to which some prisoners subscribe, evident within their attitudes and behaviours” (see also Sabo et.al, 2001; Toch, 1998.)

⁵ Liebling A and Maruna S (2004) Introduction: the effects of imprisonment revisited. Liebling A and Maruna S (eds.) *The Effects of Imprisonment* pp 5-6. They quote Sykes: “Imprisonment then is painful. The pains of imprisonment, however, cannot be viewed as being limited to the loss of physical liberty. The significant hurts lie in the frustrations or deprivations which attend the withdrawal of freedom, such as the lack of heterosexual relationships, isolation from the free community, the withholding of goods and services and so on. And however
Sykes wrote about these pains with the male prisoner in mind and feminist commentators argue that lack of privacy and the loss of their role as mother are additional ‘pains’ suffered by female inmates.\(^{45}\)

**The nature of prison life**

As Kendall (1993) asserts, “the nature of prison life is reminiscent of past experiences such as abuse, in which again [inmates] had no control over their circumstances.” She warns that “standard practices such as body searches, cell searches, constraints or any other invasion of personal boundaries may unwittingly trigger the trauma of memories of past abuse.”\(^{46}\) Haney (2002) is in agreement, arguing that “time spent in prison may rekindle not only the memories but the disabling psychological reactions and consequences of these earlier damaging experiences.” As Newkirk (2006) explains, “one of the symptoms of post traumatic stress disorder is the experience of flashbacks of the abuse during which the feelings and other sensations with it are relived.”\(^{47}\)

Qualitative research has given women the chance to express their feelings about having to undergo the “degradation ceremonies”\(^{48}\) and invasions of privacy and intimacy that remain a largely unquestioned reality of the prison experience. Hamelin’s (1989) research highlighted that the inmates perceived the goal to be humiliation; a finding that was supported by Frigon’s studies. One of Frigon’s interviewee’s states: “Lift your breasts, spread your legs, lift your hair, open your mouth, lift your tongue…I hate it, it’s humiliating.” Another explains: “being naked is humiliating for me because I am fat, it’s very difficult.” One woman shares the shame she felt having to show the guards that there was blood on her sanitary napkin before they let her change it – watching her closely the whole time.\(^{49}\) These practices are culturally inappropriate for many women, and could have a particularly damaging effect on those whose self-respect is linked to notions of modesty, or whose histories have taught them to be ashamed or scared of exposing their body.

Faith (1994) calls this “institutional violence.”\(^{50}\) The Australian organisation Sisters Inside asserts that these ‘correctional’ invasions do more than just remind women (and men) of previous abuse but are themselves institutionalised forms of physical, psychological and sexual abuse perpetrated by the state and accepted by society at large. Haney (2002) argues that “the degraded conditions under which [prisoners] live serve to repeatedly remind them of their compromised social status and stigmatised social role as prisoners.” For him, the danger of such practices is that they contribute to an erosion of the sense of self and the internalisation and then enactment of negative, destructive and anti-social ideas.

painful these frustrations or deprivations may be in the immediate terms of thwarted goals, discomfort, boredom, and loneliness, they carry a more profound hurt as a set of threats or attacks which are directed against the very foundations of the prisoner’s being. The individual’s picture of himself as a person of value...begins to waver and grow dim.” Wyner’s (2003) narrative reflects much of what Sykes was alluding to. She felt that she no longer belonged to herself and “feared that that real ‘me’ had been destroyed.” See pages 132 -134. Wyner’s story offers an interesting case study of the effects of imprisonment as she began her sentence with little or no ‘risk factors’.
American studies in particular also point to the prevalence of sexual abuse, bullying and victimisation occurring inside the walls of prison, committed both by the inmates and by those responsible for them. Research from the US suggests that males are more likely to be victims of in-prison sexual abuse in general but female prisoners are at greater risk from sexual assault by correctional staff.\(^1\) Those most at risk for victimisation appear to be those seen as deserving: sex-offenders and those incarcerated for child abuse, and those considered ‘vulnerable’.\(^1\) In a recent New Zealand article one inmate described how he had been one of many involved in a planned ‘hit’ on another inmate convicted of child abuse. At the time the interview was conducted the victim of the attack was in hospital about to lose an eye if not his life.\(^52\)

Incidents resulting in injury while in custody often attract media headlines. Recently there have been cases of violence in Rimutaka prison, with one inmate taken to hospital with broken ribs, a broken collarbone and bruising after being attacked by six others. In August 2006 a young inmate was strangled to death by another, older inmate as they were being transported back to Auckland Central Remand Prison. In October 2007 a high-profile arrestee was reported to have been badly beaten shortly after he was remanded in Auckland’s Mt Eden prison, but refused to name his attacker or reveal any information about the assault.\(^53\)

In a tense, monotonous and oppressive regime, violence becomes an event. De Viggiani (2006) calls it the “central catalyst of prison life.”\(^54\) It provides an outlet for frustrations in a context where everything is rigidly controlled. Scarce (2002) explains how a fellow remand prisoner was looking forward to being sent to a notoriously violent state penitentiary as his time would pass more quickly there due to its unpredictability and chaos.\(^5\) Violence is also a means of establishing a reputation and ensuring one’s place in the inmate hierarchy. As one inmate interviewed by de Viggiani (2006) explains: “everybody’s trying to prove that they’re somebody, because when you come into jail you lose your identity straight away...then there’s all this striving to be noticed, just to be an individual. It’s just one big competition to be noticed.”\(^55\) In the same article, a corrections officer notes that “that’s what prison is all about: where you are in the pecking order.”\(^56\)

In such a rigid social hierarchy based on dominance and power,\(^57\) any signs of weakness are dangerous. These can include displaying emotion or even showing understanding or compassion for the plight of another. As one inmate puts it: “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

\(^1\)This could include a young or inexperienced prisoner, a member of an ethnic or territorial minority (e.g., foreign national, rival gang member), etc.

\(^5\) Scarce (2002) pg. 314. He goes on to give a fascinating account of how his fellow inmate readied himself for his new environment; “What really struck me was the change in Chepe’s personality, in his self, after he was sentenced. Formerly he’d been easygoing, jovial, a small but strong man who seemed to have to dig deep to intimidate others. After his sentencing, he began a conscious transformation of his self. He was shifting from a jail persona to a prison persona. He began mumbling quietly to himself in Spanish, and his speech became more rapid. As exciting, even fulfilling as The Walls promised to be, it was also going to be a place of danger for Chepe. To prepare himself for that, he began lifting ‘weights’ (inmates jury-rigged exercise equipment out of chairs and broom handles) and jogging more frequently. His eye and head movements began to match his speech – darting. Like a leopard that knew it was about to be released back into the jungle, Chepe was transforming his physique and his psyche for what was to come.” Pg. 314-315
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.”

Keve (1974) asserts that “prison is a barely controlled jungle where the aggressive and strong will exploit the weak, and the weak are dreadfully aware of it.” Haney (2002) argues that living in such an environment will leave no-one unchanged psychologically. In her review of the literature on bullying, Ireland (2000) suggests that for those further down the pecking order, the strategies adopted by those facing victimisation include self-harm or other behaviours designed to gain segregation, social withdrawal or responding with greater violence. The strategies observed by McCorkle (1992) include keeping to oneself, “avoiding certain areas of the prison, spending more time in cells, requesting protective custody, getting tough, keeping a weapon nearby and lifting weights.” He noted that “the more fearful, older and socially isolated inmates primarily used avoidance behaviours…the younger inmates who use the inmate culture as a source of status and privilege tended to employ more aggressive or proactive techniques to deter attacks.” Haney (2002) argues that both aggressive and avoidance strategies can have deep and sometimes permanent psychological, emotional and behavioural ramifications; none of which translate well into families or the wider community.

In New Zealand, anecdotal reports - as well as those that make the papers - suggest that violence, bullying, victimisation and abuse are prevalent in our prisons, but there is a paucity of published, local research.

Institutional abuse can be less overt, such as a lack of or withholding of care. In Young’s (2000) study, 14 out of the 15 women she interviewed said that they had received inadequate medical care while in prison and all of them described care that was non-empathetic, including being treated as if they were “undeserving of care”. Reed and Lyne (1997) reviewed the health practices in various UK prisons and found examples of this. One ward nurse informed them that “what they (young prisoners) respond to best is a good shouting at.” A doctor at another institution had sanctioned the ‘care’ of a suicidal prisoner which involved leaving him naked in an unfurnished room. An elderly inmate complained to Sim (2002) that there was an underlying assumption that prisoners were trying to “blag” the system any time they asked for help. He felt that was used as justification for the withholding of care from those who needed it and Sim notes that this is something he has personally observed in both prison officers and medical staff.

Research suggests that victims often tend to become aggressors later in life. This is important for understanding and recognising the need to prevent victimisation both in and prior to prison. See Freudenberg (2001) pg. 219

“I was poorly about five weeks ago, I had the flu and I went for tablets … and I was told ‘we have nothing for the flu in this place’ … so I said to meself ‘where do I go, Boots [the] Chemist round the corner!’….And then I went back to me cell … three little blankets and there was not enough weight in them to keep the warmth in me body so I had to sleep with me clothes for three nights to get warm … only for an officer … he come over and he asked what was wrong with me, I’m 70 odd, I’ve never cried, I was in tears, I was in pain everywhere, pain in me lungs and everywhere, and he sent for two hospital people and they miraculously found some tablets for me … they couldn’t find them four days before but then when he came over they found tablets for me … I’ve been in five months they should know that I’m not at the bloody counter every day looking for tablets and if I come, there must be some reason for coming … if you go everyday and you’ve got the toothache today and a headache tomorrow…they know you’re bloody acting the goat don’t they?” Quoted by Sim (2002) pg. 307-308.
female inmates, Wahidian (2000) found “a perception of the women being disadvantaged in primary health care and specific follow up for chronic conditions.”

Withholding of care is not restricted to those who work inside prisons. When Graeme Burton\(^x\) was brought into Wellington hospital for treatment the New Zealand Herald reported that “Wellington Hospital staff are understood to be unhappy about having to treat Burton, who they regard as undeserving.”\(^y\) Crampton (2007), herself a hospital nurse who frequently treats prisoners, notes that the “fear of violence...taints all nurse/prisoner/patient interactions” and that the guards escorting the inmates can amplify the health professionals’ pre-existing fears and judgements about their patients.\(^z\) The expectation that the prisoner may be ‘playing’ them to gain medication\(^z\) can lead them to err on the side of distrust. Maeve (1999) notes that “health care providers were socialised to judge all complaints as efforts of manipulation until proved otherwise.”\(^66\) It is not just individuals working at the ‘coalface’ who can tarnish their own professionalism with prejudice. Belzile and Frigon (2003) found that some Canadian hospitals were unwilling to treat prisoners, lest they be labelled “trash hospitals.”\(^67\)

**Health effects of incarceration**

Prison can have a positive impact on health. Food and shelter are guaranteed and access to health services can be greater than they would be in the community. The regimen of prison life can offer stability for those whose lives were unstable. Incarceration has the potential to serve as a ‘time out’ for people who otherwise feel trapped by unhealthy lifestyles marked by drug use and abusive and destructive or overwhelming relationships.\(^aa\) Imprisonment can be used as a period of self-reflection and can link people to those who can help them change their lives.

Feminist commentators have noted that for women, sometimes “incarceration becomes a time to reconstruct themselves, physically and mentally.”\(^68\) Maeve’s (1999) study found that many women saw their sentence as their big chance to get healthy. For women, “the use of healthcare and their relationships with professionals can be experienced as a safe haven.”\(^69\) However she notes that for these women and the system they were embedded within understood health very differently. The women Maeve talked to “believed that competence regarding health issues belonged to others, while the others (in this case the larger society generally, and the

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\(^x\) Graeme Burton was let out on parole after serving a sentence for murder. Soon after his release he broke parole and was only apprehended after killing one person and injuring two others. This was a very high profile case and the public was outraged.
\(^y\) One of the experiences she shares relates to a guard who asked her “why are you being so nice to that kiddy fiddler?”
\(^z\) She also notes that the high levels of addiction within the prisoner population often cause difficulties when it comes to providing analgesia and anaesthesia. Inmates may not want to disclose substance abuse information in the presence of correctional officers and will subsequently be prescribed levels of medication that don’t reflect their levels of tolerance.
\(^aa\) American research puts the rate of women experiencing intimate partner violence at 22% but for incarcerated women, pre-prison intimate partner violence estimates range from 34% - 72%. Arriola KJ, Smith LS and Farrow M (2006). Criminalizing the Victim: Interpersonal Violence in the Lives of Incarcerated Women. Found in Braithwaite RL (ed). *Health Issues Among Incarcerated Women* pg. 50.
department of corrections specifically) operated from a position of understanding health as personal responsibility. Thus, incarcerated women and the prison health care system understood health from two entirely different, non-congruent philosophical positions – health as protection and punishment, and health as individualism and responsibility, respectively.” 70 The research conducted by Belzile and Frigon (2003) highlighted the varying support roles prison nurses were playing for female inmates and how the “clinical space becomes a space for validation where women feel they can be themselves, and be listened to and learn about who they are.” 71 They found that the prison nurses most able and most likely to offer this kind of support were those who saw themselves as independent of the prison administration and who answered to health rather than to custodial authorities.

While we lack the depth of research to be able to make similar claims in New Zealand, the Prisoner’s Health Survey (2005) recorded some positive signs for health. Two thirds of inmates consumed two servings of fruit and three servings of vegetables per day. Nine in ten had seen a prison nurse, and two thirds had seen a doctor in the previous twelve months. There are also certain interventions, such as the Mason Clinic and the Faith-based unit, which have produced very positive outcomes.

Internationally, it is widely accepted that the conditions of imprisonment can have a negative effect on the health of those incarcerated. Commonly recognised catalysts for poor health include “overcrowding, exposure to violence and illicit drugs, lack of purposeful activity, separation from family networks and emotional deprivation.” 72 Those forced to inhabit it are severed from their normal lives and held captive, sometimes indefinitely. The status of prisoner is an identity that is inherently restricted and both legally and socially considered ‘less’ than human in many respects. bb As de Viggiani (2007) puts it, “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.” For some, ‘prisoner’ is a role they were ‘born’ to play; a matter of following in Mum or Dad’s footsteps. cc In some cases it will replace their pre-prison identity permanently.

Life in prison is fundamentally different from life outside the gates. As such, those who are incarcerated have to be able to adjust to these changes. “Emotional and psychological survival partly depend upon an individual’s ability to tolerate the deprivations of prison.” 73 Yet the conditions of confinement limit the options of those trying to do so. The coping strategies adopted and the resources available to each person differ, sometimes dramatically. The effect of incarceration will therefore vary and there is no simple formula for predicting outcomes.

bb In Hapimana & Ors v Attorney General [2007] NZSC 70, Press Summary, the Supreme Court found that “in subjecting the appellant prisoners to the Behaviour Management Regime (BMR)…the Department of Corrections failed to treat them with humanity and with respect for their inherent dignity, as is required by s 23(5) (of the NZ Human Rights Act).”

cc In some cases, both parents.
Mortality

Not everyone survives imprisonment. Research conducted by Fazel and Benning (2006) revealed that between 1978 and 1997 the death certificates of 1631 men who had died in the prisons of England and Wales read:

- suicide and “undetermined causes” (51.2%)
- natural causes (44.3%)
- “accidental causes” (2.0%)
- homicide (1.8%)
- no information available (0.3%).

Of those deemed a natural death, “diseases of the circulatory system” (largely ischemic heart disease, then cerebrovascular disease) were the most prevalent diagnosis (53.5%), followed by “diseases of the respiratory system” (almost half pneumonia), and neoplasms. In comparing their findings to the general population they noted a raised incidence of respiratory pneumonia and infections, particularly septicaemia. Overall, standardised mortality ratios for natural causes tended to be lower in prisoners than in the general population. However the authors noted that as their data was restricted to those who died in prison it did not include those whose condition was not fatal until they had left prison; those granted compassionate leave for instance; or those whose condition had kept them out of prison altogether.

In terms of the New Zealand statistics, a recent OIA request to Corrections revealed that there have been 42 “apparent natural deaths in custody” since 2000 (18 Māori, 19 Pakeha, 2 Pacific and 1 “Other”) and 49 “apparent un-natural deaths in custody”, excluding suicide (32 Māori, 13 Pakeha, 1 Pacific and 3 “Other”).

The rate of suicide in prison is particularly high and Simpson et al (1999) suggested that New Zealand inmates were 4-6 times more likely to kill themselves than the general population. 84% of suicides were found to occur within the first year of custody, 64% of these in the first six months. Approximately 20% of prisoners had thought about suicide and 2.6% had already attempted it. According to the NZ Ombudsmen’s 2005 report, there were 26 investigations into deaths in custody from January 2003 – July 2005. Eight prisoners committed suicide in 2003/04 (6 Māori, 1 Pacific, 1 “Other”), five did so in 2004/05 (3 Māori, 1 Pakeha, 1 “Other”), six in 2005/06 (4 Māori, 2 Pakeha) and another five in 2006/07 (3 Māori, 2 Pakeha).

It is acknowledged that imported vulnerability plays an important role in the instance of suicide in prison and Liebling (1999) suggests that those most vulnerable for suicidal and self-harming behaviour are women, young people, those on remand, inmates with a history of psychiatric problems, those housed in segregation, those with a life sentence, and those having difficulty coping. In a later study, Liebling et al (2003) found that the variables that most directly led to distress and therefore heightened the chance of suicide were perceived lack of physical safety, lack of respect, frustration of relationships, fairness, dignity, clarity, security and order and family contact. There are also high correlations between suicide and overcrowding and between suicide and alcohol or substance abuse. The cross-cultural research by Rich and Runeson (1992) found that depression and alcohol abuse were the two most common diagnoses for those who commit suicide. Women have a higher prevalence of depression than men. Maas-Robinson and
conducted by Kruttschnitt and Vuolo (2007) highlights that the overarching prison regime itself has a significant impact on the mental health and well-being of those subjected to it. In their exploration of the experiences of female inmates in the USA and the UK they noted that although there were many similarities, some of the factors which seemed to increase the risk of self harm in one country were protective factors in the other.

Local information suggests that Māori are particularly at risk. Simpson et al (2003) report that “Māori are overrepresented among prisoners who commit suicide, both in comparison with other prisoners and in relation to [Māori in] the non-imprisoned population.” Māori report fewer suicidal thoughts and “appear to avoid psychological treatment,” but attempt suicide at around the same rate as non-Māori inmates. Simpson et al (2003) also found that young people were less likely to seek psychological help than older inmates and had a heightened concern for the stigma that would result if they did so.

Internationally it is recognised that self injurious behaviour is more prevalent in prison than it is in the general population, although as Lohner and Konrad (2006) note, the specific make up of the prisoner population (in terms of age, sex and ethnicity) makes it difficult to compare rates with the general population. In terms of lifetime rates, Brinded et al (1995) found that “51% of sentenced females had attempted suicide during their lifetime compared with approximately 4% for the general population. In Lohner and Konrad’s (2006) review of the literature the rates of self injurious behaviour ranged from 1.4% to 25%, although it should be noted that their focus was on male inmates. It is generally acknowledged that female inmates are even more prone to self injurious behaviour. The National Task Force on Suicide in Canada (1986) puts “the ratio of self-injurious behaviour compared with completed suicide” at 45.1:1 for females and 11.8:1 for men.

**Explanations for suicide and self harm**

The international research on prison suicide and self harm has tended to focus on “the individual characteristics of inmates as explanatory variables, particularly indicators of mental health...the causes of suicide are widely assumed to reflect underlying mental and emotional disorders, and hence public policy seeks to change potential victims,” with emphasis on the prediction, prevention, and treatment of suicidal prisoners. Some experts argue that such an atomised focus has neither succeeded in interpreting nor preventing inmate suicides and Liebling (1995, 1999) has stressed the need to “move beyond the medicalisation model toward an understanding of prison suicide in terms of the institutional conditions under which inmates are held.”

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**Endnotes:**
- Everett Thompson (2006) argue that women are also more likely to attempt suicide than men. See their chapter in Braithwaite RL et.al. (eds.) *Health Issues among Incarcerated Women*, pg. 99-100.
- Although prior self-harm, mental distress and length of sentence universally correlated with an increase in the risk of self harm, factors which had the opposite effect in different regimes included closeness to correctional officers (+ risk in UK, - risk in USA) and being committed for a violent offence (- risk in UK, + risk in USA).
- In spite of having a much lower suicide rate than non-Māori in the general population. See Simpson (2003).
Using qualitative data, Frigon (2001) showed that “self-mutilation, self-injurious behaviour and suicide attempts are ways of communicating pain, distress and powerlessness.” Anecdotal evidence suggests that self harm is sometimes used as a last resort by those who have limited influence to force a change in situation, environment, treatment or decision. Livingstone (1994) reported that “young offenders who self-injured were 20 to 25 times more likely to report bullying related difficulties in the prison setting than young offenders who did not self-injure. Livingstone and Chapman (1997) suggest that self-injury serves an instrumental function for the young offender: it enables the victim to avoid further victimization without ‘informing’ on the inmate who is bullying them.”

There are many plausible explanations for self-harming behaviour in the international literature. Kuppers (1999) concludes that suicide attempts are often directly related to an inability to cope with the separation from loved ones. Women are noted as experiencing particular difficulties after being separated from children, although it is important not to underestimate men’s emotional distress, particularly as it relates to separation from their children and families. Robert, Frigon and Belzile (2007) argue that such behaviours can also be understood as an attempt to reassert control, relieve stress, or separate oneself from one’s body. Haney (1990) also sees these behaviours as survival strategies. She interviewed 44 female inmates, of which 59% had mutilated themselves and 92% had self-injured via cutting and slashing, hitting their heads or burning themselves. As one of the female inmates interviewed by the Correctional Service of Canada (1990) explains, “prison is a frustration and anger so intense that cutting into the arteries of my own arm alleviates some of the pain.”

Liebling (1999) makes no distinction between suicide and self-harming behaviour and argues that the ‘lesser’ attempt is often an intercepted version of the former or a sign that a more lethal attempt is to follow. She also argues that international research, such as Towl (2003), highlights that the psychological staff employed in prisons are not necessarily there to work with the suicidal, or to offer traditional mental health treatment. This appears to be the case in New Zealand as well. Furthermore, although counselling is provided to those staff members having to deal with a suicide, it is not necessarily available to other inmates, even if they shared a cell with the deceased or found the body.

**Post-release mortality**

The risk of death in some groups spikes immediately after release. An Australian study found mortality, particularly from drug and alcohol overuse, to be 17 times higher than in the general population in the two weeks following release. A subsequent NSW study found that the risk of death in the first two weeks of freedom was almost five times higher for non-Aboriginals than it was while they were...
incarcerated.\textsuperscript{100} Studies from the UK\textsuperscript{101} and Europe\textsuperscript{ii} attest to the potential lethality of the post-release period, particularly the first two weeks. As prisoners are at risk of greater social exclusion upon release,\textsuperscript{iii} particularly if they have served a long sentence, it is interesting to note that a longitudinal study in the US concluded that “men with a low level of social support were two to three times more likely to die over the next dozen years than men with a high level of social support.”\textsuperscript{102} A 2007 American study\textsuperscript{103} of released men also noted high mortality among released prisoners. It too listed drug and alcohol as the greatest contributors but this was followed by cardiovascular disease, homicide and suicide. A recent longitudinal Australian study noted that “for all causes of death\textsuperscript{kk}, except cancer in women, the mortality rate was significantly higher in the prisoner cohort in comparison with the NSW population.”\textsuperscript{104} They also found that “the excess all-cause mortality increased with increasing number of imprisonments.”

We are unable to draw any conclusions on the mortality rates of former inmates in New Zealand. The NHC is aware of one informal longitudinal study currently being conducted by a group whose members have a lengthy history of imprisonment but the results remain unpublished.

\textbf{Mental health}

Internationally there is little research to precisely explain the effect of prison on mental health. The majority of the research focuses on quantifying the in-prison prevalence of mental health issues (which tend to be understood as completely imported) and highlighting the barriers to treatment in particular prisons/prison systems. New Zealand literature takes the same approach. There have been some attempts to look into the effects of prison on mental health but there are real obstacles to producing reliable results. Until very recently the accepted experts (Zamble and Porporino 1988, Zamble 1992) believed that any effects were temporary and that prison was just a behavioural and psychological “deep-freeze.” As soon as an individual returned to the ordinary life he or she would “thaw out” for a bit, and then return straight to normal. There has since been a paradigm shift in psychology and a subsequent move to examine inmate mental health in the light of disaster and trauma literature,\textsuperscript{105} however in “comparison to research on other traumatic events, research on imprisonment is primitive”\textsuperscript{*106} and further research is needed.

\textsuperscript{ii} Verger et al (2003) found the risk of death through overdose for post-release inmates to be 124 times higher than the general population among the 15-34 age group and 274 times higher for those 35-54. See also Joukamaa M (1998).

\textsuperscript{iii} This is particularly true for males. Females are more likely to maintain social support while in prison, particularly as many are the primary caregivers of children before incarceration and many expect to resume these roles upon release. See Kariminia et al (2007) pg. 389. In their study the risk of death through suicide for women in the post release period did not increase, while the risk for men rose substantially. They link this to increased social support for women and draw attention to Klein et al’s findings that “family relationships are an important factor in determining the success or failure of prisoners in adjusting to life after release.”

\textsuperscript{kk} This included mental, behavioural and drug related mortality, cardiovascular disease, cancer, diseases of the digestive, respiratory, endocrine and nervous systems, and death through accident, suicide and homicide.
In New Zealand the most frequently cited research in this area, *The National Study of Psychiatric Morbidity in New Zealand Prisons* (1999), focuses on the prevalence of mental health problems in prison rather than the effects of incarceration on mental health, but it does highlight the enormity of the mental health problem for inmates and the probable consequences of failing to address these issues.

There is growing acceptance that prisons must be seen as heterogeneous in both environment and population, and that the distress felt by prisoners and the effects incarceration has on them will vary accordingly. Having a mental health problem is increasingly recognised as an imported vulnerability and the literature suggests that it increases the susceptibility of an inmate to the ‘pains of imprisonment’. However not all mental health issues will be identified upon reception and any pre-existing mental health issues are likely to remain undetected once the prisoner is placed within the general muster. Furthermore, with the “markedly elevated prevalence rates for major mental disorders when compared with community samples... the level of need demonstrated...requires a level of service provision that is quite beyond the capacity of current forensic psychiatry services, Department of Corrections Psychological Services or the prison nursing and medical officers” Brinded et al (2001) found that 80.8% of inmates diagnosed with bipolar disorder were receiving psychiatric treatment in prison however the treatment rate dropped for those suffering from obsessive-compulsive disorder (55.3%), major depression (46.4%), post-traumatic stress disorder (41.4%), psychosis/schizophrenic disorders (37%) and substance-misuse disorders (35%).

Around the world, prison “appears to be a good greenhouse for developing mental health problems.” Toch (1975) “estimated that one in nine females would suffer a self-destructive breakdown while incarcerated.” The research conducted by Rhodes (2004) and Haney (2002, 2003) suggests that correctional tools such as the use of solitary confinement have real and sometimes lasting psychological effects and that those who have pre-existing mental health issues are more likely to experience these.

The potential effects of solitary confinement cited by Haney (2002) include: “hypersensitivity to stimuli; cognitive dysfunction (confusion, memory loss, ruminations); irritability, anger, aggression, and/or rage; other-directed violence, such as stabings, attacks on staff, property destruction and collective violence; lethargy, helplessness and hopelessness; chronic depression; self-mutilation and/or suicidal ideation, impulses and behaviour; anxiety and panic attacks; emotional breakdowns; and/or loss of control; hallucinations, psychosis and/or paranoia; overall deterioration of mental and physical health.”

The findings of a small qualitative study in the UK suggest that even those who have no previous mental health problems find it difficult to stay healthy under the conditions of incarceration. Prisoners discussed how being locked-up for 23 hours a

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8 Rhodes LA (2004) Total Confinement: Madness and Reason in the Maximum Security Prison. California: University of California Press. See also King RD: The effects of supermax custody, in Liebling A and Maruna S (eds.) (2004) pp. 124-127 for a review of the literature on the negative psychological effects of solitary confinement. Although there are questions raised as to the validity of some of the data, the consensus seems to be that there are real and very negative psychological outcomes for those who are subjected to it.

9 18 male prisoners, 13 female prisoners and 21 prison staff.
day with nothing to do and no mental stimulation “led to extreme stress, anger and frustration.”

One commented that having to sit there with nothing to do all day made his head go round and round until he felt like banging it against the wall.

The Ombudsmen’s (2005) report criticised the environment of extreme boredom as a risk factor for New Zealand inmates. Qualitative studies have also highlighted how long periods of lock up may “compound feelings of social isolation.”

I know I’m not going to be the same when I get out there. I mean I’m more aggressive, I’m more upfront with myself because of what I’ve had to put up with in here. They’re not making me any better….I mean we’ve been locked up all day and we only get out at dinner times…. I’m 52 years old, right? I mean probably one of the oldest here and I mean there’s 18, 19, 20, in their 20s. They don’t want to be locked up at 5 o’clock every night. Do you understand? I mean what you got….you know, not attention but you need a bit of company, do you know what I mean?

- Female inmate (UK) interviewed in Kruttschnitt and Vuolo 2007

Research into those wrongly convicted has shown distressing changes in personality. “They had marked features of estrangement, loss of capacity for intimacy, moodiness, inability to settle and loss of a sense of purpose or direction. They were withdrawn and unable to relate properly….In fourteen of the nineteen cases the personality change caused significant impairment and fitted the diagnostic category of ‘enduring personality change after catastrophic experience’.” Thirteen of the men had severe post-traumatic stress symptoms. The distress caused to family members was also noted.

Although there have been a number of studies which have shown similar, lasting psychological issues in those ‘rightly’ convicted, it is generally acknowledged that it is very difficult to separate damage done in prison from that which is historical. For example, Guthrie (1999) found that before imprisonment, the male inmates he surveyed had already experienced three times the number of traumatic events than their non-imprisoned counterparts. However, qualitative research and anecdote suggests that prison is having a severe and lasting mental health impact on many of those subjected to it. According to Bonnie Kerness, the associate director of the American Friends Service Committee’s Criminal Justice Program in Newark, New Jersey, “people (are) coming out of prison with anywhere from moderate to severe symptoms of post-traumatic stress disorder.”

In a custodial environment, control is paramount. In 2000, both the Prison Reform Trust and the Inspectorate of Prisons (HMIP) called attention to the patterns of drug prescription in UK prisons. They called for medical practitioners in both the community and in prisons to re-evaluate the rate at which they were prescribing antipsychotic drugs, and combinations of tranquillisers, anti-depressants and sedatives. Both agencies, as well as O’Brien (2001); Rickford (2003) and Kesteven (2002) noted that prisoners, particularly women, were being over-prescribed powerful and often outmoded drugs, and were being left on their prescriptions for longer than advisable. Langner et al. (2002) found that “80% of the women incarcerated in Canadian federal penitentiaries have prescription medication orders
(excluding over the counter (OTC) medication), the average number of orders being
3.1 medications per women.”\textsuperscript{120} Psychotropics\textsuperscript{nn} made up 42% of those orders.
Similar discoveries were made by Kjelsburg and Hartvig (2005) in their study of what
was then 90% of the Norwegian prison population. They found that 50.6% of male
inmates and 71.2% of female inmates were on prescription medication – with a large
proportion (34.5% males and 44.4% females) on psychotropics. Withdrawal, adding
to distress on re-entry and the potential for addiction, increased mental illness and/or
further offending, are real dangers of the practices highlighted by these
commentators.

\textit{Physical health}

The international literature on health effects of imprisonment centres on mental
health, but physical issues are linked. In a study of 557 Australian prisoners, Butler
et al (2007) found that “a diagnosis of any mental illness (symptoms of psychosis,
anxiety or affective disorder) was positively associated with a history of head injury,
back problems, asthma, peptic ulcers, cancer and epilepsy/seizures.” They found
that smoking levels remained relatively similar but that those with mental health
issues were less likely to have exercised in the past four weeks.\textsuperscript{121}

Evidence from the UK suggests that as prison worsens mental health, this has an
impact on physical health. Emotions such as anger and anxiety are overwhelmingly
apparent in the prisoner population and have been linked to the development of
chronic conditions.\textsuperscript{122} Emotional suppression, widely acknowledged as one of the
central rules of prison life,\textsuperscript{123} has been linked to heightened mortality, increased
incidence of heart disease and hypertension,\textsuperscript{124} and a decline in the immune
system.\textsuperscript{125} Fogel (1993) found that the “stress (depression, stress-related physical
symptoms, and weight changes) women encounter when first incarcerated is related
to health status six months later.”\textsuperscript{126} Both Birmingham (2003) and O’Brien (2003)
found that “prisoners experienced a worsening in the sort of mental health problems
presenting in primary care, such as sleep disturbance, worry, fatigue and
depression.”\textsuperscript{127}

\begin{quote}
\ldots\text{not letting me get to education, not giving me a chance to do work, not giving me a chance to do anything\ldots\text{you build up anger, you know what I mean\ldots\text{it’s going to release one day, it’s just building up inside you and you’ve got to hold it down, hold it down, hold it down.}}
\end{quote}


In Lester (2003), only 35% of respondents fell within the normal limits of the Hospital
Anxiety and Depression scale. Catalysts for distress included threats from other
prisoners (20%), cell conditions (21%), physical violence (11%) and racism (4%).
Worries about home and family were also high among a majority of prisoners; a

\textsuperscript{nn} Psychotropics are psychoactive substances that are used medically as anti-psychotics and to combat anxiety, insomnia and pain. They can be extremely addictive and have the potential for some rather nasty side effects including increasing anxiety and insomnia and creating hallucinations. The most common illegal psychotropics include LSD and peyote and the most common licit versions include benzodiazepines, which are renowned for their addictive potential.
finding shared by Ingram-Fogel (1991) and Mellor (2003).\textsuperscript{128} Both writers and Liebling (2005) highlight the role of unfairness in treatment in increasing mental distress. Singleton et al (1998) found that high levels of psychological distress correlated with an increased reporting of physical complaints. Ginsberg (1992) reports a variety of psychosomatic symptoms that present in the (female) prisoner population. They include “hypertension, headaches, skin diseases, hair loss, vertigo, vision problems, sleep disorders, anorexia and bulimia.”\textsuperscript{129}

Butler (2001) compared recent health complaints between inmates and the general population and found that both male and female inmates reported higher levels of headaches and between twenty five times (female) and forty times (male) higher rates of insomnia. He also notes that in the past month almost 90\% of the female inmates surveyed reported menstrual problems.

\textit{Injury}

Despite the recognition that prison can be a violent environment there is a paucity of literature focussing on the rates of injury in prison, either here or abroad. “A surveillance project in the Michigan Department of Corrections reported an annual rate of 505.7 injuries per 1000 prisoners from April 1994 through March 1995. In the Hawaii correctional facilities, annual injury rates averaged 683 per 1000 prisoners from 1992 to 1996. Intentional injuries (prisoner-prisoner, prisoner-guard, and self-inflicted) represented approximately one fifth of all injuries in these 2 prison systems.”\textsuperscript{130} In a survey of the health of female prisoners in Queensland, Hockings et al (2002) found that 20.9\% of the women had been injured in the previous three months, with 67.9\% of these injuries occurring whilst in protective custody. Fractures were the most reported injury, followed by sprains/strains and open wounds. The most commonly reported causes of injury were being struck by a person or object, falling from a low height and cutting, piercing or stabbing.

In their survey of young offenders in New South Wales, Kenny et al (2006) found that “78 \% (523) males and 58\% (68) females had sustained an injury at some time in the past requiring them to see a doctor or nurse or to attend hospital.” One fifth of males and a third of females with an injury reported that it caused a lasting disability. Just under a third identified persistent pain as a resulting issue.\textsuperscript{131} The leading cause of injury was again “struck by a person or object” which Kenny et al note is a euphemism for assault and which was the cause of 21\% of male and 22\% of female injuries. They also found that 41\% (275) males and 29\% (34) females had sustained a serious head injury, with 50\% of these the result of being “struck by a person or object”.

\textit{Chronic Conditions}

The literature on chronic conditions is scarce and mainly consists of attempts to quantify the prevalence. Often these surveys rely upon self-reported health status so are subject to recall error. In New Zealand it is recognised that survey questions which rely upon having received a diagnosis from a doctor are likely to underestimate the true prevalence of disease, and more so for Māori.\textsuperscript{132} Butler
(2001) compared the prevalence of chronic conditions\textsuperscript{00} between inmates and the general community and discovered that “male prisoners compared poorly with community males, particularly in regard to problems of the back and eyesight/vision. The disparity between the health status of the incarcerated and non-incarcerated groups was more pronounced for females with back problems, asthma, eyesight problems and haemorrhoids more common in female prisoners than females in the general community.”\textsuperscript{133} Kenny et al (2006) found that 33% (223) males and 35% (41) females had been diagnosed with asthma at some stage and Bridgwood and Malbon (1995) noted that “nearly half (48%) of the prisoners surveyed had a long-standing illness or disability compared with only 29% of the general population (males aged between 18 and 49 years).”\textsuperscript{134} 17% of those were musculoskeletal and 15% respiratory conditions. For women, approximately 40% identified a long-standing illness or disability in Singleton et al (1998). Musculoskeletal and respiratory conditions were again top of the list, although women complained of the latter at a greater rate than the former.\textsuperscript{135}

D’Souza et al (2005) looked at chronic conditions and CVD risk factors in the prison population and found that compared to the wider Australian population “even when the prison sample was restricted to the non-Indigenous sample, the prevalence of angina and hypercholesteremia...were higher in prisoners aged 45-54 and 25-34.”\textsuperscript{136} They also note that “the prevalence of risk factors for diabetes and CVD including elevated random glucose, hypercholesterolaemia, hypertension, obesity, and smoking were high among the prison population.”

In regards to diabetes, the literature tends to show low rates within the prison population although again, many of these rely on self report an/or previous diagnosis. Kenny et al (2006) found low rates among almost all of the young offenders they surveyed but it is interesting to note that 11% of the young women who were incarcerated were diagnosed with diabetes. This is compared to a total rate of 1%. Butler (2001) also found higher rates of diabetes for female inmates than other groups.\textsuperscript{99} D’Souza et al (2005) cite a 1994 New Zealand study which found that those prisoners who were diabetic had a high number of “previously undiagnosed diabetic complications.”\textsuperscript{137}

In the literature diabetes is used as one example of how correctional practices can get in the way of health needs. Maeve (1999) notes that “women who were diabetic were unable to exercise control over the amount of insulin they took, (thought most were the sole proprietor of this prior to their incarceration). Therefore, women who understood how to control their insulin requirements in relation to their dietary intake, or lack thereof, were forced to give themselves ordered doses regardless of the appropriateness of the dose. In prison, “non-compliance” was a serious issue on many levels.”\textsuperscript{138} She goes on to say that “ultimately, women could not be responsible for what they could not control.”

Although there is a paucity of research on chronic conditions within prisons there is an acknowledgement that this will become a more pressing concern as the prison population continues to age.

\textsuperscript{00} These included eyesight/vision problems, back problems, asthma, arthritis, high blood pressure, peptic ulcers, haemorrhoids and diabetes.

\textsuperscript{99} Male inmates (1.6%), Males in the community (2.2)
**Dental Health**

There is little that looks at the dental health impact of imprisonment and it seems to be assumed that services must only get better for those entering prison. In New Zealand any inmate is entitled to the same sort of dental care they were accessing while in the community which means that the disparities present in general society are continued within prisons. If a prisoner is deemed to have not taken care of their oral health while in the community then only relief of pain treatment is provided. The same appears to be the case for those with sentences of less than a year. NZPARS (2007) argue that this is inhumane and that “poor dental care is often a product of a person’s upbringing and environment rather than a deliberate decision to ignore their dental care”. They also note that “the lack of dental treatment can lead to infections and more serious problems.” Some prisoners reported to the Ombudsmen that because prison dental services were liable to pull teeth rather than treat them, those wanting to keep their teeth tried to ignore their dental problems. In the international literature there are links drawn between the use of illicit substances and poor dental health.

The 2005 Prisoner Health survey highlighted that during the last four weeks 31.6% of prisoners had experienced toothache and 45.9% reported discomfort while eating or drinking. It should be noted that with regard to dental care the 2005 Ombudsman report states that “we did not receive one good report from prisoners”. Prisoners frequently complained of delays in treatment and having to suffer pain because of this.

Cropsey et al (2006) cited a recent American study which found that “the average male inmate has 7.09 decayed teeth, 15.3 surfaces of decay, and 4.07 missing teeth. Compared with the general, noninstitutionalized U.S. adult population, prisoners had 8.4 times the number of untreated decayed teeth.” Their own research examined the link between poor oral health and smoking status in the prison population and found that smokers were more likely to have missing, filled and decayed teeth than either non-smokers or ex smokers.

**Disability**

The following quote is from Maeve (1999) and was the most vivid account found on the experiences of prisoners who are disabled within a correctional setting. Internationally it is a neglected topic, although it is touched upon in the literature concerning elderly prisoners and also quantified in various forms and degrees by a range of health surveys. A 1996 survey of American inmates found that 37% reported at least one disability. This was compared to 26% reporting such a disability in the general population.

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These included “a physical, mental or emotional condition or difficulty seeing, learning, hearing or speaking.” Freudenberg (2001) pg. 222
“She had significant hearing loss during childhood secondary to antibiotic therapy, but lost most of her hearing when a few weeks before her sentencing she was severely pistol whipped by a boyfriend. Therefore, she entered prison without hearing aids. Her hearing loss was clearly documented through past medical records contained in her prison medical chart. However, Theresa was frequently sentenced to the lockdown unit for “failure to follow instructions.”

Indeed, lockdown was where I met Theresa. I happened by her room one day and could see that she was in a panic, almost disoriented. Lockdown is a difficult experience, made worse for women by the particularly loud clanging noises of doors, and the crying and hollering by other women, that continues both day and night. Women in lockdown are often in the midst of their own terrors and panic at being locked in isolation for 23 hours of every day without direct human contact. Because she was being punished, Theresa could only converse with officers and health care providers through her door, making it impossible for her to successfully understand conversations, yet always feeling bombarded with distorted and disturbing sounds.”

Murray et al (2003) reviewed the literature on audio impairment and found that rates of hearing loss ranged between 17 and 83 %, depending on the definitions used and populations assessed. The top of that range comes from Bowers’ (1986) study of a New Zealand based cohort; with 54 % of Pakeha and 83% of Māori prisoners suffering from a hearing loss of 15 dB or greater in at least one ear. Their own research found that the hearing of prisoners was significantly degraded as compared to “the Australian normative population.” Although rates were similar between genders, the hearing of Australian Aboriginals was worse than that of other prisoners. McRandle and Goldstein (1986) interviewed 73 inmates with a mean age of 28.6 and found that 7/20 women and 19/53 men had a hearing impairment, with many of these also identifying past head trauma.

In terms of intellectual disability, a recent New South Wales study found that 15% (199) of the young offenders tested had scores consistent with intellectual disability. Maxwell and Stanley (2004) cite another New South Wales study looking at both youth and adult offenders that found “a third of those in adult and juvenile detention facilities were assessed as meeting international criteria for intellectual disability.” The only local research available was conducted by Brandford (1997), who identified low rates of intellectual disability; roughly comparable with the general population. Maxwell and Stanley (2004) note that her methodology “relied on reports in files rather than on a comprehensive psychometric assessment comparable with the Australian research” and question the validity of her results. 139

In its latest report, the Department of Corrections states that it works in partnership with the Office of Disability Issues to ensure its congruence with the New Zealand Disability Strategy 2005. The only measure specified for those in Correction’s care is the “continued assessment and improvement of prison buildings to provide for the
needs of disabled prisoners”. We are as yet unable to determine the scope or success of this measure.

**Risk behaviours**

Smith (2000) argues that ‘unhealthy’ practices may be contributing to the ability of the individual to survive the pains of imprisonment. Smoking, drug use, sexual behaviour, aggressive and violent behaviour, self-harm and eating disorders are all regarded by authorities as ‘risk behaviours’ but seen by many inmates as coping mechanisms. Kendall (1993) suggests self-injury as one of the “coping strategies” women are likely to turn to in response to the pains of imprisonment. It is recognised that women are more likely to attempt to cope with their problems by focussing their frustrations “inward” than men and are more susceptible to suicide, depression and substance abuse than to violence and aggression. Benn and Tchaikovsky (1987) used Home Office figures to argue that approximately 1 in 6 women will self mutilate in response to an intolerable situation as opposed to fewer than 1 in 100 men.

> A lot of girls will [self harm] when they’re rattling or depressed. They’re trying to scream out for help and nobody will listen.

- Female inmate (UK) interviewed in Krutschnitt and Vuolo 2007

Drug use by an inmate may also be a self-prescribed means of alleviating physical, mental or emotional pain. Monceau et. al. (1996) argue that high rates of psychotropic use could be related to their ability to “speed up” the passage of time and reduce anxiety levels. Both male and female inmates in Nurse’s (2003) study admitted that they used drugs to relieve the “long hours of tedium.” One said: “this is the first time I’ve come into prison with a drug addiction, but I got my addiction through my last prison sentence.”

**Communicable disease**

Internationally, high levels of disease in prisons are universally acknowledged including tuberculosis, hepatitis B and C and STIs, particularly HIV. Seroprevalence of hepatitis B core antibody in Australian prisons ranges from 18% to 28%, indicating that more than two thirds of the population in prison are vulnerable to infection. The conditions of incarceration can be conducive to the spread of disease with overcrowding, poor ventilation, risk behaviours and pre-existing vulnerabilities all contributing to potential transmission. Nearly 30% of new acute hepatitis B infections in the United States appear in people with a history of incarceration.

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“Men may be more likely than women to act out against others, while women are more likely to act out against themselves.” Paris (1997) quoted in Loucks N (2005) pg. 28.
International literature on prison health effects focuses heavily on communicable diseases and highlights their link to prison practices such as tattooing, piercing, sexual behaviour and drug use. In a recent study in New South Wales, 73% of women and 53% of men admitted to injecting prior to incarceration, and 62% of women and 48% of men reported injecting during their prison stay. 64% of the women and 40% of the men were Hep C antibody positive. Among the adolescents, 8% of boys and 18% of girls were Hep C antibody positive. It is surmised that these gender differences reflect the fact that women and girls tend to be injected by their partners or at the 'end of the line' (for needles).

New Zealand information is limited, but in the New Zealand’s Prisoner Health Survey (2005), 10% of inmates reported using a needle in prison. After a 1991 outbreak investigation, tests of 273 inmates in one New Zealand prison revealed a hepatitis C antibody positive rate of 23%. More recently, a 2004 national seroprevalence study of injecting drug users attending needle exchanges found 45% of the study participants had been in prison; of those, 40% had injected while in prison.

Other potential health effects suggested by international literature include:

- a worsening of chronic conditions or other ailments due to lack of care or resources, poor or unsuitable environment, overcrowding, rigidity of prison rules, conflicts between prison practices and health needs, and distress
- behavioural, psychological and developmental adaptations to prison life which do not translate well upon re-entry into the community and family (these include an inability or unwillingness to express emotion, hyper-vigilance, increased aggressiveness, gang membership, atrophied autonomy and distrust of authority)
- problems upon re-entry including stigma, limited housing and/or employment opportunities, increased debt, a breakdown in relationships and further social exclusion, and disintegration of one’s sense of identity and roles in the family/community.

**Older prisoners**

There have also been a limited number of studies on the effects of prison on the health of elderly inmates but no such research has been conducted in New Zealand. International studies point to an acceleration of biological age for prisoners, with prisoners having a ‘physical age’ approximately ten years older than their community counterparts. According to the Florida Corrections Commission (1999) an elderly inmate has on average three chronic health problems and US studies estimate that the cost of providing the care they need is about three times higher than that required by the general prisoner population. Fazel’s (2001) study found that 85% of the 203 men over the age of 60 interviewed….had at least one major illness documented in their medical record, while 83% of the respondents self-reported a major illness. Those most apparent included “psychiatric, cardiovascular, musculoskeletal and respiratory disorders.” In Canada, Gal (2002) reported similar findings.

As the research shows for other people in the prison system, the effects of incarceration on the health of older prisoners is dependent on many factors related
to the vulnerabilities or resilience they bring in with them and the particular environment they enter into. International studies have highlighted that those who are new to the system at a late stage in their life are extremely susceptible to the pains of imprisonment.\textsuperscript{157}

In their qualitative study of older prisoners Crawley and Sparks (2005a) found that "the prison sentence represents nothing short of a disaster, a catastrophe, and, in consequence, they are often in a psychological state of trauma."\textsuperscript{158} They also found that older prisoners with poor health or limited mobility were unable to participate in employment, educational or treatment programmes and found it difficult to find a sense of purpose. They noted that this was particularly debilitating in terms of identity for a generation whose sense of self is inextricably linked to work.\textsuperscript{159}

For those with serious health problems the prison environment is particularly poorly suited to improved health outcomes and the wellbeing of frail bodies. Crawley and Sparks (2005a) point to an increased potential for debilitating falls from slippery flooring and an abundance of stairs; an increased potential for psychological damage from high noise levels and unpredictable and often violent neighbours; and an increased potential for ill health from poor ventilation and having to sleep on a thin mattress with a restricted bedding allowance.\textsuperscript{160} Their research also draws attention to the dangers posed to the health of those at risk from heart attacks, strokes and falls in an environment where access to health care is rarely immediate and generally inaccessible late at night.

In a subsequent qualitative study, Crawley and Sparks (2005b) found that the special health needs of elderly inmates were not reflected in their treatment by the prison staff. This included the allocation of a top bunk in a room on the third floor of the prison to a 73 year old arthritis sufferer, and elderly prisoners being restricted from the exercise period because they hadn't made it through the gate on time. There was a general consensus among older prisoners that staff were untrained in their needs and that it was impossible for them to conform to rules and regulations that were designed for young, able-bodied men. Butler and Milner (2003) surveyed 226 elderly inmates in NSW prisons and "found that 31.2%...reported movement restriction; 6.5% reported difficulty with walking; 6.5% reported difficulty with finishing work obligations; 4.3% had trouble with eating; and 2.2% reported difficulty toileting."\textsuperscript{161}

The literature points to the possible psychological and behavioural implications of experiencing one's mortification in a hostile, restricted and uncaring environment. Potter et al (2007) note that "staff are likely to encounter a high level of inmate fatigue, agitation, anxiety or depression that may arise from acknowledged functional decline and the lack of supportive care available to them." They cite Kitwood (1997), who suggests that this is particularly likely for those suffering from cognitive decline or a terminal illness. There is the danger that without the proper care and support inmates will become overly reliant on staff and Potter et al (2007) warn that this can result in "learned helplessness."\textsuperscript{162} There is also a danger that prisoners will pull away completely and resist any and all forms of 'compliance' with the regime, even if it means rejecting care. While investigating the lives of others who suffer similar

\textsuperscript{5} It is important to note that these issues can also be a problem for those who are obese. In a recent New Zealand case, a severely obese inmate campaigned for home detention on the grounds that he was unable to maintain his own hygiene while incarcerated.
deprivations and restrictions, Cutler et al (2006) found that they “routinely demonstrated agitation, discomfort, humiliation and consequently, resistance to care.”

The international focus has also broadened to include the effects imprisonment has on the wider community, including the children and families of inmates.

**Children, families and whānau**

In the last decade a number of countries such as the US, UK and Australia have intensified their investigations into the unintended consequences of imprisonment. Upon investigation, each of those jurisdictions has recognised that not only have they failed to take these children and families into account in their own debate and decision making around imprisonment but also that there are very real implications for whānau and for the public should this not change. As the NSW Standing Committee on Social Issues observes, “the lack of statistics and the paucity of specific research on children of imprisoned parents has led to a vacuum in correctional and community services policy and practice for this group.” Travis and Waul argue that, “while the problems and needs of these children and families clearly intersect both the criminal justice and health and human services systems, these systems do not always recognise that the incarceration and re-entry of a parent produce consequences for a larger family unit.”

PARS have estimated that 20,000 New Zealand children are affected each year by having a family member in prison and we can assume that a majority of these children will be Māori. However it should be noted that these issues are not currently being explored in New Zealand and we have no research data to indicate how many people outside of the prison gates are affected by our penal system, nor what these effects are in our local context.

International studies suggest a number of negative effects for those whose lives are intertwined with the incarcerated but they also note that these will be influenced by the pre-existing health of the people and relationships involved. The most commonly hypothesised health problems for the children of incarcerated parents are infectious diseases, developmental and behavioural problems, mental health issues, low self esteem/poor self concept and criminality. Kingi (1999) found similar reports of behavioural and emotional effects on the children of incarcerated women in New Zealand. Qualitative reports from overseas also reflect these statements.

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*This was a multi-state study looking at the experiences of elderly people in secure care homes.
*Kemper and Rivera (1993) list “tuberculosis, sexually transmitted disease, pneumococcal disease, varicella and genetic and behavioural problems such as alcoholism and drug addiction” as potential health issues for these children. See also Quilty et al (2004)
*Crowe (1974) found that “adopted children whose birth mothers were incarcerated were more likely than other adopted children to have been arrested, incarcerated and have a psychiatric record at the age of 25”. Cited in Murray (2005) pg. 449.
*See for instance the reports from the submissions and hearings conducted by the Standing Committee on Social Issues (1997). “Witnesses and submissions to the Committee have variously described the experiences and emotions of children of imprisoned parents as being “disastrous”, “damaging”, “inhumane”, “traumatic” and “devastating”. The Committee has been told that children whose parents are in prison are “negatively stigmatised and stereotyped”, “grief stricken”, “depressed”, “anxious”, “angry”, “ashamed”, “isolated”, “struggling” and “insecure”.”
and some paint a very worrying picture of the effects of parental incarceration on children.\textsuperscript{xx}

\begin{quote}
In one specific instance the Committee heard of a three year old boy whose mother was given a 12 month prison sentence, experiencing severe gastric complaints and refusing to eat to the point where he had to be hospitalised. This child was diagnosed as suffering from clinical depression. All of his illnesses, both physical and mental, were attributable to the separation from his mother.

- Standing Committee on Social Issues (1997) pg. 4
\end{quote}

The research of Johnston (1995) highlighted that “young children whose relationship with a parent was disrupted by that parent’s imprisonment….often experience ‘survivor guilt’ and feel as though they are to blame for the parent’s disappearance.”\textsuperscript{171} Lorde (1984) notes that “children only know themselves as reasons for the happenings in their lives”\textsuperscript{172} Young children in particular are likely to experience a parent’s imprisonment as “simple abandonment.”\textsuperscript{173} Bernstein (2001) suggests that “the experience can be morally as well as emotionally corrosive” for children and many “lose respect for a legal system that, in their eyes, has shown their parents so little in the way of justice.” This is not helped by the fact that many are present during the arrest\textsuperscript{yy} and are often forced to collaborate with authorities, i.e. providing statements or even being strip searched, during the official proceedings.\textsuperscript{174}

Some of the ways these issues may manifest include: depression, anxiety, acting out, increased aggressiveness, post-traumatic stress disorder, truancy, difficulties with authority, loss of self-esteem, bed wetting, problems sleeping, eating problems, difficulty in school, hyperactivity, abandonment issues, stigma, shame, grief, regression, and emotional shut-down. In terms of “anti-social and delinquent outcomes through the life course”, the Cambridge Study in Delinquent Development (Murray and Farrington, 2005) found that parental incarceration predicted “worse outcomes for children than parent-child separation caused by other reasons”, even when other risk factors were controlled for.\textsuperscript{zz}

\textsuperscript{xx} See page 13 of Standing Committee on Social Issues (1997) for a disturbing account of a young boy falling through the cracks through lack of care after his mother’s imprisonment.

\textsuperscript{yy} “Stanton (1980) found that 53% of the 4-8 year olds she studied had witnessed the arrest of a family member. Johnston (1991) found that only one fifth of the children studied had witnessed their mother’s arrest, but over half of these were 3- to 6-years old.” From Johnston D in Gabel K and Johnston D (1995), pg. 72

\textsuperscript{zz} Comparison groups included children who had not experienced parental separation, children separated from their parent in their first ten years through that parent’s hospitalisation or death, children separated from their parent in the first ten years by other means, and children whose parents were incarcerated before they were born.
“The baby gets really ratty…he’s never been away from the baby before…and the baby is really close to him…the first couple of days he was so miserable…I couldn’t get him to sleep…he wouldn’t eat…he wouldn’t even let me put him down…It took him about a week to settle down…[now] he’ll do things like…crawl to… and wait by the front door, cos he’s thinking [his dad is] going to come through….Or he’ll go over to his dad’s pictures and he’ll say hello to them and he picks them up and waves them around.”


Philips et al (2006) used data from the Great Smoky Mountain Study to compare the experience of children whose parents had never been arrested with those whose parents had. Even after accounting for parental risks and race, the children of incarcerated parents (and those on home detention) were 80% more likely to live in households under economic strain. They were also 130% more likely to experience family instability. They note “these are both factors that research links with the increased likelihood of children developing serious emotional and behavioural problems (including substance abuse and delinquency) and, in turn, of becoming involved with criminal authorities.”

There have been few studies on the impact of incarceration on families and the research that does exist tends to be qualitative. American research makes up the core of what is available and it paints a bleak picture of already fragile families being stretched financially and emotionally, frequently to breaking point. Most of the current literature focuses on the female partners of male inmates. The most comprehensive study to date on the effects of prison on prisoners’ wives was carried out by Pauline Morris in 1965. She undertook her research in the UK, interviewing 825 imprisoned men and 469 of their wives. The imprisonment of a partner was experienced as “a crisis of family dismemberment rather than a crisis of demoralisation through shame.” The women she talked to consistently reported experiencing financial difficulties (63%), deterioration in their work (81%), deterioration in social activity (63%), deterioration in relationships with extended family (60%) and deterioration in relationships with friends and neighbours (57%).

Braman (2002) notes that it is the family members who overwhelmingly bear the brunt of the social burden of incarceration. For him stigma is contagious. One interviewee describes how community perceives the stigma of criminality: “basically… if there’s one criminal, there’s another, and another…a consistency within every family.” In comparing the experiences of incarcerated men and their families he found that while the prisoner lives with ‘peers’ who both share and accept the criminal label, those left behind in the community are the ones who are still
subject to the norms, judgements and therefore reprobation of that social context. It is important to note that stigma has been linked to a number of negative outcomes including “poor mental health, physical illness, academic underachievement, low social status, poverty and reduced access to housing, education and jobs.”\textsuperscript{181} One woman explained that she deals with her situation by hiding the fact of her husband’s incarceration from family and friends; a strategy that brings with it new complications, including having to distance herself from support networks and lie to people she cares about. Braman (2002) explains: “as Louisa describes herself lying, her voice quivers with disappointment in herself and she begins to cry. Although she does not want her husband to be branded a criminal, she does feel guilty about her lying.” She herself asserts: “I feel terrible because I’m living a lie. I’m living a lie. I’m not normal. I’m abnormal.”\textsuperscript{182}

Not only does such ‘necessary’ dishonesty cause distress, particularly for children,\textsuperscript{aaa} but also erodes social networks and the resources that come with them. As Braman (2002) states: “Many spouses and parents of prisoners that I have spoken with will not tell the extended family about the incarceration of a loved one, or will lie about the type of crime committed. Unfortunately…withdrawal from friends and family has an indirect effect on…ability to cope with…increased parenting duties [for those who do] not want to open [themselves] up to discussions about [their partners]. Low-income families often rely on extended networks of family and friends to cope with poverty and hardship. The fluid households and expansive exchange networks that these families maintain are….adaptive necessities for making ends meet….Perhaps the most significant consequence of stigma among families of prisoners, then, is the distortion, diminution, and even severance of these social ties.”\textsuperscript{183}

It has long been recognised that there are definitive links between poor socio-economic status and negative health outcomes.\textsuperscript{184} The emotional, financial and psychological burden of losing a partner\textsuperscript{bbb} - and his associated income - to prison falls overwhelmingly on women,\textsuperscript{185} who struggle to keep their families together and healthy. Research from the UK found that “in households where the prisoner had previously been in paid employment, incomes fell between £150 and £500 per week.”\textsuperscript{186} Smith et al (2007) worked out that the average loss of income as a direct result of the imprisonment of a family member was approximately £175 per month\textsuperscript{187} and “the full cost per family over six months, including the cost to agencies and the cost of support provided by family and relatives, averaged £5,860.”

The same study also found that many of those women who had been working part-time prior to their partner’s imprisonment had to stop as child care became a solo responsibility. Those families that had been financially secure before the sentence were having real trouble maintaining their assets, particularly if they had mortgages to pay. Not only were many of them unable to maintain their ‘normal’ financial

\textsuperscript{aaa} Most of the literature on the effects of imprisonment on children notes that those who are forced to keep the incarceration of a family member secret are likely to suffer emotionally, physically and psychologically. See for example Gabel and Johnston (1995).

\textsuperscript{bbb} Smith et al (2007) assert that “the pressures on mothers of children with imprisoned fathers are greater than those where separation from a parent is enforced, for example, through divorce or death.” One of their interviewees explains what it has been like for her to lose her husband to jail: “It’s like he’s my rock….he’s always been there, and he’s not now, I’m on my own. It was like he died when he went. There’s no other way to explain it. It’s like I’m in this grieving process.” Pg. 33
responsibilities but found that they were being dragged down further into the poverty trap with the additional expenses they were incurring due to the imprisonment of a family member. Families described sending cash for basic necessities such as toiletries; buying clothing, shoes, electronic equipment and newspapers; and having to pay for phone calls as ways in which they were “subsidising” the cost of imprisonment. Furthermore, as Braman (2002) argues, “in addition to phone, travel and child care costs, there are a number of additional expenses that are difficult to quantify, such as stress-related medical expenses….lost income….and the legal bills.” He notes that “these costs bear down disproportionately on families that are the least able to absorb them. The effects of incarceration are particularly devastating to these families because they generally have the highest marginal costs…so additional expenses or burdens are more keenly felt.”

“…financially we’re punished as well…if we don’t pay [the extra] for the visit, then we don’t see him…we have to…pay for…the things he needs, who else is going to supply them for him? ….I think it’s unfair …rich families…they can afford to send £10 every week …Whereas a family that hasn’t got any money, £10 every week is a lot and it’s coming out of the children’s things…."


It is not just the partners of inmates who are haemorrhaging emotional, financial and temporal resources as they attempt to provide support for those incarcerated. As incarceration erodes ‘romantic’ relationships or eradicates their potential altogether, it is family members who have to bear the brunt. The literature highlights that when it comes to childcare, financial and emotional support and housing post prison, the female members of the inmates family are the most likely to be an inmates ‘community provider’. This overwhelmingly tends to be the case if he or she does not have a partner or if the partner also happens to be in prison or is otherwise unable or unwilling to provide support. The ex/inmate’s mother or grandmother is at the top of this list. Many of these women, particularly if they are elderly, will not cope well with the additional strain and are at greater risk for poverty and ill-health. Kingi (1999) notes that the family caregivers of inmate’s children often find that they are unable to maintain the care and highlights that children were often passed between relatives, sometimes ending up in CYFs custody as families ran out of resources.

However there are many more prisoners who come out to no support at all. Wolff (2002) argues that “at the point of incarceration, each individual enters with a stock of social capital. With time and isolation, that social base and connection are weakened. In prison, a prisoner’s identity often changes. Slowly, the prisoner’s social capital becomes more prison-based, rather than community-based.” For those who have made the transition completely, re-entry is a much more daunting period

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cc Freudenberg (2001) argues that the concentration of incarceration within certain communities “reduces the number of males available for marriage, contributing (with male joblessness) to higher rates of female-headed households…[and] may undermine the ability of young men to be effective fathers when they leave prison or jail.” Pg. 223. See also Lopoo and Western (2005).
and any networks they have are likely to be restricted by parole conditions. Wolff (2002) notes that “the formation and mobilization of social capital is influenced by four factors: the willingness of the prisoner’s social relations to provide assistance, the ability of the prisoner to motivate help from his/her social relations, the resources and endowments of the social relations, and the social context of these relationships.” It is fair to say that there are more than a few ex-inmates who are completely in the red in terms of social capital. Those who still have ties in the community may erode them completely when they get out after a long or particularly damaging stretch of prison time. Freudenberg (2001) highlights that a prison experience which provokes anger is likely to promote future violent behaviour and Bonnie Kerness argues that many people are coming out of prison with “hair trigger tempers.” Furthermore, a recent US federal study of 16,000 released inmates found that “two-thirds were rearrested on felony or serious misdemeanour charges within a few years” and nearly 20% were headed back for a violent offence when their last sentence had been a non-violent one.

For those heading back to their families, the financial strain felt during the period of incarceration is not likely to diminish when the family member returns home. This can be a period of increased deprivation and distress for the partners and families of prisoners. There is an expectation that old roles will once again be taken up but the reality is often not so straightforward. Families who have been barely managing to support a family member inside prison can collapse completely under the financial strain of trying to provide for someone once they are back in the home. Employment prospects are poor for former inmates and Petersilia (2003) argues that those attempting to reintegrate are “largely uneducated, unskilled and usually without solid family supports – and now they have the added stigma of a prison record and the distrust and fear that it inevitably elicits.” Holzer et al (2004) suggest that in addition to this, those who were in legitimate employment before their sentence are unlikely to regain it after the completion of a prison sentence where both skills and social networks have been eroded. In their US study of employer hiring preferences, they found that only 12.5% of employers would definitely hire an ex-offender, with more than 60% indicating they would “definitely not” or “probably not” hire someone who had been in prison. As incarceration reduces the employability of ex-inmates it increases the rates of unemployment within what tend to be already disadvantaged communities. Evidence from the US suggests that those who do eventually find work are likely to be paid half as much as those with similar backgrounds who have never been imprisoned.

After release, the reintegration period is one of readjustment for families and it can be a very stressful time. Research suggests that many families struggle with the changes that have taken place during the period of incarceration. Furstenberg (1995) found that many of the partners left to fend for the family alone have since developed new independence and successfully taken over the roles of those who have been away. For inmates expecting a seamless transition back into their old roles, this can be a distressing situation and one that they may respond to negatively or even violently. Both Furstenberg (1995) and Nurse (2001) suggest that men tend to view their partner and children as a “package deal.” They found that inmates who arrived home to find that their partner had begun a new relationship while they were inside were likely to withdraw from “active involvement in their children’s lives.”
The international literature also suggests that family members may actively prevent an ex-inmate from reconnecting with his or her children.\textsuperscript{200}

There is no doubt that some of those parents in prison are there because of the injury they caused their own families and that for those families the physical removal of a family member has added to rather than taken from their well-being.\textsuperscript{\textsuperscript{\textdaggerdbl}} There is also no doubt that in the period leading up to prison even previously strong relationships have been eroded and previous family stability has been derailed as people slide out of control and into the criminal justice system. Considering the high rates of substance use and abuse presenting in those incarcerated, particularly in the month preceding imprisonment,\textsuperscript{201} it is fair to say that many of the families are already fragile and the notion of imported vulnerability is just as applicable to the situation faced by the children of prisoners as it is to their parents. However it is important to remember that there are parents in prison who are or who are trying to be good parents, that “children are fiercely loyal creatures”\textsuperscript{202} and that it is difficult to make any generalisations about the wants and needs of those experiencing parental incarceration. It is also important to note that “workers in the area generally agree that only a small minority of prisoners are unequivocally unsuitable for contact with their children”\textsuperscript{203} and that “even parents involved in criminal activities can still steer their children in pro-social directions.”

Housing and employment are two of the most crucial aspects of successful re-entry but both are problematic for former inmates and securing them can destabilise a family that has managed to adapt during the incarceration period. “The returning prisoner’s search for permanent, sustainable housing is a daunting challenge – one that portends success or failure for the entire reintegration process...Housing is the linchpin that holds the reintegration process together. Without a stable residence, continuity in substance abuse and mental health treatment is compromised. Employment is often contingent upon a fixed living arrangement. And, in the end, a polity that does not concern itself with the housing needs of returning prisoners finds that it has done so at the expense of its own public safety.”\textsuperscript{204} Given that the more accessible housing in New Zealand tends to come with potential health hazards (e.g. dampness and poor insulation), those who do find stable housing may find their health is compromised because of it.

Research from the US has identified a geodemographic aspect to these problems. The most vulnerable communities are most susceptible to a cycle of imprisonment, creating instability and eroding the social capital and cohesion of the whole community.\textsuperscript{205} In their longitudinal study on neighbourhoods in the South of Florida Rose and Clear found that as crime was dropping throughout the area the neighbourhoods where the rates fell the least were those with the most ex-inmates. Freudenberg cites Peterselia (2000) in arguing that as prison increases the number of gang members, more young people are leaving prison and exerting a more negative influence once back in the community.\textsuperscript{206} Local anecdotal evidence

\textsuperscript{\textdagger} See Travis J and Waul M (2003). ‘Prisoners Once Removed: The Children and Families of Prisoners’ in Prisoners Once Removed pg. 21. He lists “more attention to the children, more available resources, fewer distractions, and less fear of or actual violence in the home” as potential benefits for some children.

\textsuperscript{\textdaggerdbl} Ziebert (2006). He cites Rose and Clear (2002:196) and Hagan and Dinovitzer (1999:126) who argue that “Control and socialisation theories tend to see children as situated in a struggle of allegiances between family and peers, with the absence of a parent shifting the balance of this struggle in favour of anti-social peers.” Pg. 3
suggests that as people return from prison with gang connections, families and communities have to choose whether to exclude people or invite gang influence. This is not a choice that people should have to be making.

Conclusion

There are currently immense gaps in the literature on both the direct health effects and ‘unintended consequences’ of imprisonment in New Zealand. The international evidence suggests that this is an issue that has very real and very lasting implications for public health and safety, for social and cultural well-being and for the health and well-being of some of the most vulnerable members of our communities.

While there is growing public concern about the rising economic costs of imprisoning greater numbers of our citizens than ever before, it is worth noting that Smith et al (2007) estimate that the “total cost of imprisonment would rise by 31 per cent if the costs to the family and wider society were included in the calculation.” Even from a purely financial point of view, this is not an acceptable outcome. It becomes even less acceptable when we consider those outcomes that are less tangible or easy to quantify such as reduced life chances, further social and economic disadvantage, emotional and psychological trauma and increased mental and physical health issues.

Those individuals, families and communities whose lives are affected by imprisonment tend to already be among the most disadvantaged in this country. If we mean it when we say we are committed to reducing inequalities then we cannot continue to ignore the needs and experiences of this population.
NOTES


3 Department of Corrections (2008), Offender Volumes tables.

4 Department of Corrections (2008), pg. 8.

5 Ministry of Justice (2007).

6 Department of Corrections (2008), Offender Volumes tables.

7 Department of Corrections (2008), Offender Volumes tables.


9 Department of Corrections (2008) pg. 12.

10 Department of Corrections (2008), pg. 13.


12 Department of Corrections (2004).

13 Department of Corrections (2008), Offender Volumes tables.

14 Department of Corrections (2008), Offender Volumes tables.

15 Department of Corrections (2008), Offender Volumes tables.


17 See Smith and Robinson (2006) Beyond the Holding Tank


21 WHO (2007)


24 De Viggiani (2007) pg. 116


26 Taken from Health Promoting Prisons: A Shared Approach, London: Department of Health, 2002


28 Durie M (1994).


Journal of Prisoner Health 2(2) pg. 74. He is quoting Sykes.

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See for example Cooper and Berwick (2001) and Guthrie (1999)

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Kruttschnitt and Vuolo (2007) pg. 140. See also Liebling (1994)


Van Harrevald pg. 699. They are talking about inhibition of anger in particular and cite Gallacher, Yarnell, Sweetman, Elwood and Stansfield, 1999; Julius, Harburd, Cottingham and Johnson 1986; and Suls, Wan and Costa 1995.


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