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The experiences of military veterans prior to and during incarceration in Scottish prisons: An analysis of mental and social wellbeing.

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Abstract

Background

Concern has been voiced over the needs of ex-military personnel following their discharge from military service and subsequent transition to community living. This concern has extended to include veterans, particularly those who have mental health, drug or alcohol problems, who come into contact with criminal justice services and are imprisoned. Research examining the experiences of military veterans prior to and during their incarceration in Scottish prisons was carried out. This study sought to examine whether veteran prisoners form a unique prison sub-group with different health, social and criminogenic needs when compared to non-veteran prisoners, and how veteran prisoners differ from non-prisoner veterans. Additionally an exploration of veterans' experiences of prison, and what they believed caused or contributed to their imprisonment, was conducted. This sought to identify whether veterans in prison had unique vulnerability/ risk factors and whether they had a common or idiographic pathway that led to their incarceration.

Methods and design

This study comprised of three separate but linked parts. It adopted a mixed-method approach combining quantitative analysis of survey data (Part 1) with qualitative interpretative phenomenological analysis of focus group (Part 2) and interview data (Part 3). Survey data examined, through the use of standardised questionnaires, a range of themes; including, mental health and wellbeing, substance and alcohol use, childhood experiences, offending histories, and military experience. In Part 1 participants were recruited into three separate groups. Group 1 consisted of veterans in prison, while Group 2 consisted of prisoners who had no military experience and Group 3 comprised of

Scottish Prison Service staff who had previous military experience. In Parts 2 and 3 participants were recruited from the veteran prisoner population, with participants in Part 3 having declared current mental health and/or substance use problems.

Findings

Analysis of survey data identified many differences in health and wellbeing, and some differences in length of, and discharge from, military service, when comparing veteran prisoners with a non-imprisoned veteran group. Both groups, however, appeared to have similar levels of combat exposure. Comparison between veteran prisoners and non-veteran prisoners identified more similarities than differences across most of the measures. Many of the mental health drug or alcohol problems experienced by veteran prisoners were also experienced by non-veteran prisoners. Post-traumatic stress disorder did appear to be a specific problem for veteran prisoners but this did not appear to be attributable to their military experience. Additionally, veterans being raised by a mother-figure other than their birth-mother appeared to be a unique risk factor for veteran imprisonment but this finding should be viewed with caution as the number of participants raised by a mother-figure other than their birth mother was small.

Findings were mixed regarding how veterans described their experience of imprisonment: some found it unchallenging yet unstimulating while others described feelings of ongoing punishment and a sense of being embattled. Reciprocal processes of dehumanising both prisoners and staff were also evident, as were contradictory experiences on the availability and quality of care provision in prison. Veteran prisoners appeared to identify with their prisoner identity rather than their veteran identity, believing that they were the same as other prisoners and had the same needs. This was evident when veterans described their experiences of forming and maintaining

interpersonal relationships, albeit within-prison relationships appeared superficial in nature.

While some veterans appeared reluctant to ask for assistance in prison, concerns about the inadequacies or availability of support services appear valid. Gaps in provision of care, particularly mental health care, existed at the time of the study. Lastly, some participants appeared to feel unprepared for their release from prison back to the community. This may stem from their previous experience of transitioning from the military to civilian living but it is more likely the recognition that many prisoners leave prison only to return back to custody. For some veteran prisoners this is because they believe community services are unavailable or unable to help as they struggle to cope with community living. As such, some may consider prison living the easier option.

Conclusions and implications

Many of the findings suggested that veteran and non-veteran prisoners had, or were believed to have had, by veteran prisoners, similar 'needs' and reasons for offending. Veteran prisoners should, therefore, not be regarded as a specific sub-group of the prison population, and addressing prisoner needs should not be prioritised according to their pre-prison occupational status. Lastly, where gaps in service provision exist, the SPS and its partner agencies, including the NHS, should continue to address these. This should include giving consideration to the adoption of a trauma-informed approach within the prison environment.

Table of Contents

List of Tables and Figures

Tables

Figures

List of Abbreviations

AUDIT	Alcohol Use Disorders Identification Test
BBC	British Broadcasting Corporation
BC	British Columbia
BPAQ-SF	Buss-Perry Aggression Questionnaire – Short Form
CASP	Clinical Appraisal Skills Programme
CDC	Centre for Disease Control
CECA	Childhood Experience of Care and Abuse
CES	Combat Exposure Scale
DASA	Defence Analytical Services and Advice
DAST	Drug Abuse Screening Test
DSM-III	Diagnostic and Statistical Manual of Mental Disorders, Third Edition
DSM-IV	Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition
DSM-V	Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition
GAF	Global Assessment of Function
GBJWS	Global Belief in a Just World Scale
GHQ-12	General Health Questionnaire -12
GSE	General Self Efficacy
HM	Her Majesty
ICD-10	International Statistical Classification of Diseases, 10th Revision
ICM	Integrated Case Management
IP	Internet Protocol
IPA	Interpretative Phenomenological Analysis
MOD	Ministry of Defence
NAPO	National Association of Probation Officers
NHS	National Health Service
NICE	National Institute for Health and Care Excellence
PCL-C	Post-Traumatic Stress Disorder Checklist – Civilian
PHQ-9	Patient Health Questionnaire – 9
PTSD	Post-Traumatic Stress Disorder
SAMH	Scottish Association for Mental Health
SPS	Scottish Prison Service
SPSS	Statistical Package for the Social Sciences
TA	Territorial Army

UK	United Kingdom
UNODC	United Nation Office on Drugs and Crime
USA	United States of America
VA	Veteran(s) Association
VICSO	Veteran in Custody Support Officer
WHO	World Health Organisation

Chapter 1 - The rationale for conducting the research and the aims of the study

1.1 Introduction

There has been concern voiced over the imprisonment of military veterans (Doward, 2010; Shenton, 2010) and a possible future rise in their numbers (Brown, 2008; Treadwell, 2010). Within the United Kingdom (UK), uncertainty over the exact numbers exists (The Howard League for Penal Reform, 2011b), while the figures for the United States of America (USA), over the last few decades, have been high (Noonan and Mumola, 2007). Some military veterans have histories of poor mental health and substance use. Those who experience difficulty re-entering civilian life, and who may be predisposed towards poor mental health, may come into contact with criminal justice systems (Brown, 2008) and some may end up in prison, diminishing society's current sympathetic opinion of veterans and military service personnel (Treadwell, 2010).

Little is known about the intrinsic and extrinsic factors that lead military veterans to custody and whether these differ from those found in non-veteran prisoners. Similarly, little is known about how veteran prisoners differ from non-incarcerated military veterans, or what veteran prisoners' views are on leaving military service, their journey to incarceration and their experience of prison. By drawing upon the limited existing international literature and by conducting new field-work, this research examines these factors in the context of a wider piece of work which also aims to describe the perceived needs of military veterans in the Scottish prison system. The study has a particular focus on the mental and social wellbeing of military veterans, particularly those who experience

poor mental health or substance misuse problems. It also examines military veterans' perceptions of the effectiveness of current support measures provided to incarcerated ex-service personnel, again, with a particular focus on services that support those with complex mental health needs.

1.2 Military and veterans

In 2013, the total strength of the UK Armed Forces was 176,660 personnel and the UK, annually, recruits more than 14,000 people into its Regular Forces (DASA, 2013). It is common for new recruits into the UK Armed Forces to be between the ages of 16 and 19 years (DASA, 2010c). Many of those recruited into the Army are recruited from 'broken homes' having experienced a childhood of deprivation with few formal qualifications, poor literacy and numeracy skills, and often joining for the wrong reasons or as a 'last resort' (House of Commons Select Committee on Defence, 2005) because they did not have access to '*meaningful civilian careers*' (Gee, 2007:17). Further, some UK Members of Parliament question whether the UK Ministry of Defence deliberately targets poorer, more deprived areas for its recruitment (BBC News, 2006a), although adopting such a recruitment strategy provides employment and development opportunities to a youth population who are often marginalised (Gee, 2007). Many will leave military service before the age of 25 years (Kapur *et al.*, 2009) after completing their minimum contractual term (Gee, 2007) and return to civilian life with a military veteran status: a status that the UK Government has been keen to promote, through the introduction of Veterans' Day (now called 'Armed Forces Day'), calling for veterans to be recognised as being a "*nation's pride"* (BBC News, 2006b).

What constitutes a 'military veteran' differs depending on who is asked and in which country the question is posed. In a recent study (Burdett *et al.*, 2012), 200 UK ex- military

service personnel were asked whether they would describe themselves as a veteran and just over half answered yes. Burdett *et al.* suggest that their participants' sense of self-identity was not influenced by existing UK policy, or by participant age, length of service, or exposure to combat, and that it differed from existing public perceptions of who and what a veteran is. Instead self-identity of veteran status, in the sample studied by Burdett and colleagues, was attributed to two factors: serving as a regular rather than a reservist and having a low educational attainment.

Moving from individual self-identification of veteran status to a societal context, four definitions of veteran status, and their advantages and disadvantages, have been proposed (Dandeker *et al.*, 2006) (Table 1-1). These definitions range from being 'very inclusive', where a person who served for a single day along with their family would be defined as a veteran, to a much more exclusive group. In the exclusive group the criteria is much more specific, although still open to interpretation, such as a person who has been actively deployed.

Dandeker and colleagues (Dandeker *et al.*, 2006) also identified international differences in the definition of veteran status. In the UK, for example, defining military veteran status adopts an inclusive approach: veteran status is confirmed after completing one day's military service. While New Zealand adopts a similar approach to the UK other countries differ. The USA, Netherlands, Australia and Scandinavian countries all adopt the more exclusive criteria for obtaining military veteran status (Dandeker *et al.*, 2006). In the USA, veteran status is confirmed when a person has completed a minimum period of active service (currently 24 months) and has received an honourable discharge. In both the Netherlands and Australia, a person's military service has to include deployment overseas before veteran status on discharge can be confirmed.

Table 1-1: What's in a name? Defining and Caring for Veterans. (Dandeker *et al.*, 2006:163)

	Definition	Advantages	Disadvantages
1.	All personnel who have served more than one day (and their dependents)	• Clarity • Appeals to recruits	• At odds with service • Public opinion • Cost
2.	All personnel who have completed basic training	• Less inclusive • Fairer	• As above
3.	All personnel who have completed one term of engagement	• Closest match to public/ charities opinion	• Excludes the most vulnerable
4.	All personnel who have served in an active deployment	• Pleases the public • Perceived to be a clear role of the MoD	• Difficult to define active deployment

For the purpose of this study the UK definition of a military veteran will be adopted with the term 'veteran' being used to define all military veteran types, irrespective of age, length or branch of military service, or conflicts they have served in. Using the UK's definition has led some to suggest that between 4.8 million (The Royal British Legion, 2005) and 5.5 million (Dandeker *et al.*, 2006) veterans live in the UK, of which around 10% reside in Scotland (The Royal British Legion, 2005). However, given that many of the proposed figures are estimations, it is likely that the exact figure for the number of veterans living in the UK remains unknown.

1.3 Transition from military to civilian life

In addition to the normal turnover of UK service personnel, other factors are now influencing the number of military personnel leaving the service. The UK Government has engaged in the downsizing of UK Armed Forces with associated large-scale redundancies (HM Government, 2010) and this is ongoing. Furthermore, by the year 2015, deployment of UK military personnel to Afghanistan will come to an end (House of Commons Defence Committee, 2013), seeing the return home of large numbers of conflict theatre exposed military personnel.

The majority of Armed Forces personnel manage the transition between military and civilian life without difficulty (Iversen, Nikolaou, *et al.*, 2005) and there are transitional support services available to assist with this (The Howard League for Penal Reform, 2011a). However, the war in Afghanistan, and other recent conflicts, has raised awareness of the dangers of military service and there is concern that a proportion of those leaving the Armed Forces and returning to civilian life will experience difficulty (The Howard League for Penal Reform, 2011a). Some experience a range of difficulties including a mistrust of those not seen to be part of the military 'family' (SAMH, 2009; Brewin, Garnett, and Andrews, 2011); unemployment (Iversen, Dyson, *et al.*, 2005), particularly if they are 25 years of age or over (The Royal British Legion, 2006b); boredom and a lack of money (Treadwell, 2010); homelessness (Dandeker *et al.*, 2005; Johnsen, Jones and Rugg, 2008); post-traumatic stress disorder (PTSD) (Buckman *et al.*, 2013), ongoing poor mental health (Fossey, 2010; The Royal British Legion, 2006a, 2006b; Hoge, Auchterlonie and Milliken, 2006), and suicidality (Kapur *et al.*, 2009). Many of these are post-service issues, however, there are also pre-service vulnerabilities and service-related factors, such as military rank, service culture, and stigma that can influence transition from military service to civilian living (Klein, Alexander and Busuttil, 2012). Once discharged back into civilian living, there is also concern that those veterans with complex health and social welfare needs could experience difficulties that result in an increase in future contact with criminal justice systems (Brown, 2008; Treadwell, 2010), with the UK media reporting a 30% rise in the proportion of veterans in prison over a five year period (Travis, 2009).

1.4 Rationale for the study

Despite a recent report by the Howard League examining UK ex-military service personnel in prison (The Howard League for Penal Reform, 2011b) there generally appears to be a paucity of research on veterans with complex health and social welfare needs, criminality and incarceration. With the exception of a small, but growing, portfolio of recent studies from the King's Centre for Military Health Research (King's College, London) much of the UK research examines the mental health and wellbeing of active military personnel and veterans. In the USA, there have been some studies examining veteran mental health and offending, although these have focused heavily on Vietnam era veterans (Beckerman and Fontana, 1989; Kulka *et al.*, 1990), PTSD (Saxon *et al.*, 2001; Riggs and Sermanian, 2012; Goldberg *et al.*, 2014), and the health and wellbeing of US military service personnel following more recent conflicts (Smith *et al.*, 2011; Smith and True, 2014). There appears to be little research, either nationally or internationally, looking at the relationship between veterans, offending and imprisonment. Also, to date, I have been unable to identify any studies that examine the experiences of veterans in prison who have drug, alcohol or mental health problems.

It is unknown whether a veteran's pathway to incarceration and reoffending differs from other non-veteran prisoners. Some risk factors are known (Erickson *et al.*, 2008) but many of these are shared with non-veteran prisoners. However, veterans who end up in prison may have been exposed to experiences that are unique to this population group and these may make their support 'needs' different from non-veteran prisoners. As one veteran in prison states, "[veterans] *are not criminally minded, but ill due to their experiences endured whilst servicing their country*" (Veterans in prison: Sleeping Tigers - Defence Management, no date). The veteran argues that 'treating' veteran prisoners the

same as mainstream prisoners fails to acknowledge the uniqueness of their 'need', however, there appears to be an absence of evidence to support the assertion that veteran prisoners' have differing needs from other prisoners.

This study seeks to identify the needs of military veterans specifically located within the Scottish prison system. It is recognised that a study focusing on military veterans in Scottish prisons may negate generalisability to other jurisdictions' support for veterans in their prison systems. Nonetheless, similarities in sentencing decisions when comparing England and Wales' judicial system with that of Scotland (Millie, Tombs and Hough, 2007), and, excluding population ethnicity, some similarities in prison population profile (Berman and Dar, 2013; Scottish Government, 2011), suggests some comparability between UK prison populations. Moreover, UK Armed Forces recruit from across the UK, and there is no restriction placed upon discharged service personnel as to which Home Nation they return to. A person raised in England can choose to live in Scotland post-military service and if incarcerated will be located in a Scottish prison. A person raised in Scotland who lives in England after service discharge and is convicted of a criminal offence will be incarcerated in an English prison. As such, it is likely that the support needs of UK military veterans in Scottish prisons will be similar to the needs of veterans in prisons in England, Wales and Northern Ireland.

Prisons in Scotland have in-situ a number of systems, processes and services that support all prisoners to address their health, social and offending needs. These include: individualised Integrated Case Management (ICM) processes (Scottish Executive, 2007); enhanced primary healthcare services that include basic mental health provision (Scottish Prison Service, 2002; Graham, 2007), and clinical and non-clinical addiction treatment and support teams (Scottish Prison Service, 2010). Prisoner healthcare services are meant

to be equivalent to those delivered by a country's national provider (WHO Europe, 2008; UNODC, 2009), although in Scotland, historically, this was not so. This has now changed. Healthcare in Scottish prisons is now the responsibility of Scotland's National Health Service, which works in partnership with the Scottish Prison Service to address prisoner health needs. This integration (on the 1st November 2011) between prison and healthcare providers looks to address a number of deficits in service provision that had previously existed, including inequality of access to care and the limited range of clinical interventions that address the complex health needs of prisoners (Prison Health Advisory Board, 2007).

Recently, mirroring developments in English prisons, there has been the emergence of a system of support for prisoners who have disclosed their military veteran status (Scottish Veterans Prison In-Reach Working Group, 2011). Nonetheless, despite existing support systems in Scottish prisons, no specific prison-based offender or health strategy addressing the needs of veterans in Scottish prisons has been established by statutory providers or their partner agencies. However, it is not known whether a specific strategy is required. As yet, it is unknown as to whether veterans in Scottish prisons see themselves as being different to, or the same as, other prisoners. Uncertainty also exists as to whether 'traditional' prison services provide veteran prisoners with the appropriate means of addressing their mental health, substance use, criminogenic[1] and social needs or whether they require bespoke models of prison-based support. Lastly, veteran prisoners, when they are released from custody, will have to deal with the additional

[1] Bonta and Andrews (2007) define criminogenic needs as *'dynamic risk factors that are directly linked to criminal behaviour'* (2007:5). They note that these needs can *come and go*, unlike static risk factors, which only change in one direction, usually an increased risk, and are unresponsive to intervention. Bonta and Andrews go on to list seven main criminogenic needs, detailing their major risk/ need factor, their indicators and their intervention goals. These major risk/ need factors include substance abuse, family and marital relationships, absence of prosocial recreational activities, poor performance or low satisfaction with school or work, pro-criminal attitudes, social supports for crime, and antisocial personality patterns.

stigma of being an ex-prisoner. Evidence needs to be obtained on how best to assist military veteran prisoners to prepare for their integration back into the community, given that for some they will have already experienced difficulty 'transitioning' from one 'way of life' to another.

This study will add to the current limited research on veterans in prison while addressing these uncertainties. In particular, it will examine whether veteran prisoners form a unique prison sub-group, with different health, social and criminogenic needs, when compared to prisoners with no history of military service. Specifically, this study aims to:

1. Identify whether veteran prisoners in Scottish prisons have different mental health, substance misuse and/ or social welfare needs when compared to the non-veteran Scottish prison population.
2. Explore what veterans in Scottish prisons perceive to be the causes of their imprisonment and how they perceive their experience of imprisonment.
3. Identify whether there are common vulnerability/ risk factors which are specific to veterans in Scottish prisons but not found in the Scottish non-veteran prison population.
4. Identify whether veterans have a common or idiographic pathway that led to their incarceration.
5. Identify what veterans in Scottish prisons believe is required to address their mental health, substance use, criminogenic and social needs.

In addressing the above, through quantitative analysis, a number of hypotheses will be tested:

1. The mental health of veterans in prison does not differ from the mental health of veteran prison staff.

2. The substance use, including alcohol use, of veterans in prison does not differ from the substance use of veteran prison staff.

3. Veterans in prison and veteran prison staff have the same past personal and military experience and exposure to combat and trauma.

4. The mental health of veterans in prison does not differ from the mental health of prisoners with no military experience.

5. The substance use, including alcohol use, of veterans in prison does not differ from the substance use of prisoners with no military experience.

6. Excluding military service, the socio-demographic characteristics and childhood history of veterans in prison are the same as that of prisoners with no military experience.

In summary, this introduction has briefly set out the context regarding the purpose and function of the UK's military services, describing the reasons why people may join the UK Armed Forces and explored what is required to obtain military veteran status. It has detailed the recent changes in UK military provision, including the downsizing of service and, as a consequence, the move from military life to civilian life following termination of military service. The difficulty that some veterans experience when transitioning from military to civilian living has been described and it has been noted that some commentators are concerned about a potential rise in the numbers of veterans in prisons. Due to a paucity of research there is uncertainty as to why veterans may end up in prison and this uncertainty continues when examining how best to support veteran prisoners. This study aims to address these uncertainties.

1.5 Guide to chapters

Drawing from the wider literature, Chapter 2 provides context to the research by summarising veteran and military personnel's experience of having poor mental health

and their engagement in criminality. The chapter then provides a systematic and more detailed review of the literature, comparing the mental health, alcohol and drug use of veteran offenders with other veterans before examining the influence that these clinical presentations and their treatment have upon veteran contact with criminal justice services.

Chapter 3 discusses the challenges that researchers can experience when conducting research in a prison environment, focusing on the roles I adopted and the relationships I formed with 'gatekeepers' to facilitate access to prisons and prisoners. The chapter then explains the theoretical paradigm used in the study, providing a rationale for this before describing the methodological processes implemented during the different components of the study.

Chapter 4 describes the research settings, methods used in the recruitment of participants, and how data was collected for each of the study's three components. It also details how data was analysed and provides an overview of ethical issues that arose and how these were addressed.

Chapters 5 to 7 present the research findings, with Chapter 5 detailing the quantitative findings following the statistical analysis of between and within group comparisons on a range of survey questionnaires. Questionnaires examined themes such as; education; marital status; employment; early childhood years; health and wellbeing; offending history; and military service.

Chapters 6 and 7 describe the qualitative findings following Interpretative Phenomenological Analysis of a focus group (Chapter 6) and one-to-one interviews (Chapter 7). In Chapter 6, two super-ordinate themes are identified and discussed: Group Identities and The Needs of Veterans. Chapter 7 describes a single super-ordinate theme: The Experience of Prison.

Chapter 8 discusses the findings and considers these in relation to the research aims detailed in Chapter 1. It draws upon the wider literature, and uses the qualitative findings from Chapters 6 and 7 to enhance and enrich understanding of the quantitative findings of Chapter 5. Study limitations are identified and reflected upon.

Chapter 9 completes the thesis by offering a brief summary and conclusion to the study. Additionally, implications for policy, practice and future research are highlighted with consequent recommendations.

Chapter 2 - Systematic Literature Review

2.1 Introduction

This chapter, following systematic searching of literature, presents a narrative summary of 16 papers that enhance understanding of the complexities that poor mental health and substance use can bring to the lives of veterans, providing insight into whether, and if so how, these health problems influence offending behaviour and contribute to imprisonment. This is followed by a commentary that draws together the main findings of the narrative summary. The purpose of this is to offer an opinion as to whether veterans with mental health, drug or alcohol problems have a greater risk of contact with criminal justice services when compared with veterans without these health difficulties or with non-veterans. Before this, however, a contextual overview is provided which discusses the wider literature in relation to military personnel or veterans and how poor mental health relates to offending and imprisonment. The provision of this contextual overview supports the interpretation and understanding of the narrative summary and commentary.

Before proceeding, however, a caveat must be acknowledged. Much of the literature in this field of study originates from the USA, therefore, when interpreting its findings, both within the contextual overview and the narrative summary, acknowledgement must be made to the 'dominant voice' of this geographical region. This has the potential to minimise the influence of findings from other parts of the world and can introduce bias when considering the welfare and health needs of military personnel or veterans from the UK.

2.2 Contextual overview

2.2.1 Poor mental health within military and veteran personnel

As a phenomena, military personnel experiencing mental health difficulties is not new (Jones and Wessely, 2005; Nash, Silva and Litz, 2009) and can affect active service and ex-service personnel (Klein, Alexander and Busuttil, 2012). In Chapter 1, it was noted that the transition from military to civilian living can be problematic for veterans with poor mental health (Iversen, Nikolaou, *et al.*, 2005), with some dying by suicide (Kaplan *et al.*, 2007; Kapur *et al.*, 2009; Zivin *et al.*, 2007). Others with combat experience may use drugs (Prigerson, Maciejewski and Rosenheck, 2002) or develop PTSD (Kulka *et al.*, 1990; Phillips *et al.*, 2010), which diminishes function and increases mental and physical disability (Goldberg *et al.*, 2014) and can increase risk-taking and impulsive behaviours (James *et al.*, 2014). Veterans in the UK are, however, more likely to experience other mental health conditions, such as depression or alcohol use, than PTSD (Iversen, Dyson, *et al.*, 2005).

The association between alcohol use and military personnel is longstanding, with Wagley (1944) commenting during the Second World War on the number of military offenders with alcohol problems. In contemporary times, alcohol use continues to be regarded as an issue for military personnel. In professional soldiers[2] (Browne *et al.*, 2008; Wilk *et al.*, 2010); and military reservists (Jacobson, Ryan and Hooper, 2008) a relationship has been established between excessive alcohol use and combat exposure. More specifically, being exposed to war atrocities, or experiencing a threat of injury or near death, has been strongly associated with alcohol misuse (Wilk *et al.*, 2010), although deployment to a theatre of war in the absence of other mediators does not necessarily lead

[2] Usually referred to as Regulars.

to an increase in alcohol consumption (Trautmann *et al.* 2015). In the UK, excessive use of alcohol is more common in UK military personnel than in the general population (Fear *et al.*, 2007) and is regarded as the most common mental health[3] problem in active and recent UK veterans (Iversen *et al.*, 2009); with up to 18% of military personnel or veterans meeting the criteria for probable alcohol abuse (Iversen *et al.*, 2009). Alcohol misuse is also strongly associated with combat deployment, exposure to trauma and with post-deployment violent offending (Elbogen *et al.*, 2014; MacManus *et al.*, 2013).

While alcohol misuse is common across veteran age groups, some younger veterans are also misusing drugs (Hill and Busuttil, 2008), perhaps to gain relief from, and cope with, the psychological consequences of combat exposure (Kulka *et al.*, 1990; SAMH, 2009; Back *et al.*, 2014). However, the misuse of drugs, like the misuse of alcohol, is not a new phenomenon with, for example, substance misuse occurring in military personnel during the Vietnam War (Kulka *et al.*, 1990). Interestingly, many Vietnam military personnel stopped their substance use following discharge (Robins, Davis and Nurco, 1974). Although small numbers of veterans continued using after their return to civilian living (Shaw *et al.*, 1987), this seems to have been because they had returned to their pre-enlistment drug use (Robins and Slobodyan, 2003) rather than the drug use being military-related. In UK veteran populations, the misuse of drugs is less well investigated with much of the examination on substance use focusing on alcohol rather than drugs (The Howard League for Penal Reform, 2010b). Despite this, drug misuse problems in UK veterans have been identified, for example, in homeless veterans populations

[3] In the UK mental health legislation excludes alcohol or drug misuse/ dependence as a mental disorder (Scottish Executive, 2005; Department of Health, 2008). Treatments for drug and alcohol problems are, however, delivered by mental health services in both Scotland and England. Further, the Scottish Government recognises the relationship between substance misuse and poor mental health (Nowell, 2014), as does English mental health legislation. Alcohol and drug misuse/ dependence are also recognised as features of substance / addiction disorders in both DSM-V (American Psychiatric Association, 2013) and ICD-10 (World Health Organisation, 2010) diagnostic manuals.

(Johnsen, Jones and Rugg, 2008) and veterans in prisons (The Howard League for Penal Reform, 2011b), and is raising concerns in UK service providers (Hill and Busuttil, 2008).

Governments have attempted to address the priority health needs of veterans, although this has not always been successful or well received. In the USA, for example, veteran healthcare provision has been found to be of a higher quality than health provision to the general population (Asch *et al.*, 2004), yet barriers to accessing services have been identified, such as being stigmatised by healthcare professionals (Hoge *et al.*, 2004). In the UK, despite veterans receiving priority access to health services (Department of Health, 2007), healthcare services appear to have failed to meet the mental health needs of veterans. Where services are available to veterans, only half of those who can access such a service choose to do so (Murphy, Iversen and Greenberg, 2008), and this is mostly through contact with General Practitioners (Iversen, Dyson, *et al.*, 2005), with veterans suggesting that accessing health services causes them to feel that they are being stigmatised by their peers (Gould, Greenberg and Hetherton, 2007; Greenberg *et al.*, 2007) and by healthcare professinals. Healthcare staff, in particular, have been identified by veterans as being ignorant or insensitive to the health needs of ex-military personnel (Murphy, Iversen and Greenberg, 2008). Veterans could, therefore, be choosing not to engage with healthcare services because of a fear of being stigmatised. Experiencing stigma does not, however, appear to be associated with veteran help-seeking behaviour, or their utilisation of mental health services, and it may, instead, be that the failure to access healthcare support is caused by the individuals' inability to recognise their own need for healthcare (Sharp *et al.* 2015).

2.2.2 Criminality within military and veteran personnel

Hakeem's 1946 paper provides a historical perspective on whether engagement in military service created future criminals. Hakeem noted, that shortly after the Second World War, there was a call for "special" courts to be convened to address the crimes of offending veterans. Hakeem, a researcher who studied the relationship between military training and crime, reported that many of his peers argued that the 'needs' of veterans were 'special' because they occurred as a consequence of what they encountered during military service and that veterans could not be held responsible for their criminal acts. Upon examination, however, Hakeem found that many of those veterans who had committed crimes had pre-existing criminal records, which were obtained prior to commencing military service. His findings negated the argument that the 'needs' of these offending veterans were as a result of their military service and in doing so countered demands being made for 'special' treatment.

More recently, Bouffard's (2003) study of Vietnam War veterans found that engaging in military service reduced future criminal behaviour. This finding, however, has not remained consistent with Craig and Connell (2013), suggesting that military service no longer offers the 'desistance' effects that had been found previously in ex-military personnel and veterans. Further, Galiani and colleagues identified a relationship between military service and engaging in future criminal behaviour (Galiani, Rossi and Schargrodsky, 2010). Their longitudinal study of Argentinian conscripts found that conscripted military service, particularly those engaged during periods of war, increased the likelihood of service personnel obtaining future criminal records. However, this did not appear to be a direct causal relationship with Galiani and colleagues suggesting that future criminal behaviours were possibly due to conscription delaying entry into, and impacting on, employment opportunities. When controlling for such demographic and

socio-economic factors, veterans, historically, are no more likely to be incarcerated in prison than non-veterans (Culp *et al.*, 2013).

Lastly, with regards to veterans and their engagement in criminality: veterans should not be regarded as a homogenous group. Greenberg and Rosenheck (2009), suggest that there are different 'veteran types' and some veterans, defined by, for example, their era of military service, specific socio-demographic factors, or their mental and physical wellbeing, are at a greater risk of imprisonment when compared with other 'veteran types'. Further, it may be that the "*quality*" of the person, for example, their intellectual ability, their employment options, and their motivation for joining, at the point of their recruitment into military service influences the risk of future incarceration (Greenberg, Rosenheck and Desai, 2007). The suggestion is that the potential for future offending appears to be dependent on the personal characteristics of the individual (Craig and Connell, 2013), influenced by the time period in which the person lives, and the societal challenges they are exposed to, and not on the military service (Bouffard, 2005). It may be that 'unique times' in societal and therefore military history may ultimately influence the number of veterans who go on to offend post-military service.

2.2.3 Veterans in prison

The number of veterans in prison, and the accuracy of collating this information, differs depending on the country being examined. For example, in the USA historical figures for the number of veterans in prison are available (Culp *et al.*, 2013), ranging from 21% of prisoners being veterans in the mid-1980s to around 10% in 2004 (Mumola, 2000; Noonan and Mumola, 2007). UK figures offer less certainty however. Recent UK figures suggest that around 3.5% of the current total of approximately 80,000 prisoners in England and Wales are veterans (DASA, 2010a; Bray *et al.*, 2013) and this figure is

similar to figures quoted between 2001 and 2004 by the UK Government (HM Government, 2010b). These counter a much higher figure of 8.5% reported by the National Association of Probation Officers (NAPO) in 2008. Others have suggested that none of the proposed figures are likely to be accurate because they are based on statistical extrapolation and conjecture (The Howard League for Penal Reform, 2011b) and that the exact number of veterans in prison is likely to be unknown (Treadwell, 2010).

While there are proposed figures for the USA and for England and Wales, within Scotland, an accurately defined figure does not exist. In Scotland, the Scottish Prison Service (SPS) does keep a record of prisoners who voluntarily disclose their veteran status however, disclosure of veteran status is optional for prisoners and there is no statutory obligation for the SPS to routinely collect this data when disclosure occurs. Explanations for not identifying the veteran status of prisoners have been commented on in other jurisdictions. Brown (2008), when criticising American criminal justice agencies' processes, suggests two reasons. Firstly, those who manage criminal justice services believe that veteran status is not a critical factor in the routine operation of their service. Secondly, and perhaps more controversially, Brown suggests that recording data that highlights veterans contact with criminal justice systems may be politically damaging, concluding that "*without criminal justice agencies agreeing to allow data collection of veterans processed it will be nearly impossible to develop veteran support structures*" (2008:8). Brown's explanations and conclusion seem relevant when applied to a Scottish context: there appears to be uncertainty within the SPS as to whether a prisoner's veteran status will make a difference to their management in prison and secondly, if there are large numbers of veterans in Scottish prisons this could impact negatively on the reputation of both UK and Scottish Governments, as well as tarnish society's positive image of the military. Yet without the implementation of transparent

and robust data recording systems, and the commitment and recognition from Scottish political bodies and criminal justice services that collecting veteran data has a positive purpose, the need for appropriate policies and systems for supporting veterans who offend cannot be examined and, if required, developed.

In summary, veterans can experience a range of mental health problems, including alcohol and drug misuse. Despite experiencing these health difficulties, there appear to be barriers that hinder veterans obtaining support, such as feeling stigmatised by peers and health staff. With regards to criminality and offending: veterans are not a homogenous group and the factors that cause their offending may be unique to the individual veteran. Lastly, there is also uncertainty over the number of veterans in UK prisons and without the means of identifying veterans in criminal justice services it is difficult to implement appropriate support services.

2.3 Narrative summary of findings from a systematic review of the literature

To explore the literature in greater depth, a protocol driven (Taylor *et al.*, 2012) systematic review was attempted examining whether veterans with mental health and/ or substance misuse problems have an additional risk of contact with criminal justice systems when compared with veterans who do not have such problems (see Appendix 1 for an abridged copy of protocol's inclusion and exclusion criteria and search strategy). Overall, there was a paucity of research in this study area. Further, due to the heterogeneity of the literature identified, a systematic analysis of findings was not possible. Instead, a narrative summary of the studies that met inclusion and quality criteria, as described in Appendix 1, is detailed under the following three domains:

- Veteran offenders who have mental health, drug or alcohol problems compared with other veteran types (6 studies reviewed);

- The influence mental health, drug or alcohol problems have on veteran contact with justice systems (6 studies reviewed), and;

- The influence intervention and treatment of veterans with mental health, drug or alcohol problems have on contact with justice systems (4 studies reviewed).

See Appendix 2 for Tables which detail the main findings of the studies reviewed.

2.3.1 Veteran offenders who have mental health, drug and alcohol problems compared with other veteran types

Studying veterans of the Vietnam War, Shaw and colleagues (Shaw *et al.*, 1987) examined whether mental health problems, and specifically PTSD, were related to criminal behaviour. They postulated that if a relationship with PTSD existed, then an increased prevalence of PTSD would be found in incarcerated veterans. In a well-designed, albeit small study, Shaw and colleagues found no difference between incarcerated and non-incarcerated veterans for PTSD diagnosis. Additionally, they found no difference between the two groups for alcohol misuse but did, however, find that incarcerated veterans had higher rates of antisocial personality disorder, drug use and adjustment disorder. This was despite both groups having similar pre-military adjustment problems and military experiences, including combat-related stress following deployment.

While Shaw and colleagues found no relationship between PTSD and imprisonment, their small study of Vietnam veterans is somewhat overshadowed, due to a greater sample size, by Kulka *et al*.'s (1990) seminal, and *"methodologically rigorous"* (Schlenger *et*

al., 2015), study of trauma and the Vietnam War generation. Further, Kulka and colleagues' findings on the association between PTSD and criminal justice contact differ from those reported by Shaw and colleagues. In Kulka *et al.*'s large study, veterans with a diagnosis of PTSD were significantly more likely to have: involvement with criminal justice services; multiple arrests, and be convicted of a felony crime. Only where veterans reported obtaining a single arrest was the figure proportionally greater in non-PTSD diagnosed veterans. However, Kulka *et al.*'s (1990) findings for PTSD have been questioned. It has been suggested that the diagnostic process used by Kulka *et al.* to confirm PTSD [criteria according to DSM-III-R (American Psychiatric Association, 1987), which was also used by Shaw and colleagues] diagnosed those who had the presence of symptoms but no impairment daily functioning as having PTSD (McNally, 2007) and subsequent studies of this population group have not found similar PTSD prevalence (CDC, 1988).

In addition to their PTSD findings, Kulka *et al.* (1990) also found a relationship between substance misuse and offending. Veterans with a diagnosis of substance misuse, including alcohol misuse, had greater contact, and a greater frequency of contact, with criminal justice services compared with veterans without a substance misuse diagnosis. Kulka and colleagues' findings, for both PTSD and substance misuse, suggest that once a veteran with a mental health problem had contact with criminal justice services, they progressed on to have multiple contacts. However, there is a final caveat to Kulka and colleagues' findings. Their study provides findings for veterans from the age of 18 years who reported having criminal justice service contact, however this inclusion criteria risks involving participants who had justice service contact before entering military service and/ or before they had a diagnosis of PTSD or substance misuse. Nonetheless, despite Kulka *et al.*'s study experiencing some methodological challenges, given its level of

influence, in particular in expanding treatment and research on PTSD (McNally, 2007) it would be remiss to dismiss the study's findings for both PTSD and substance misuse.

Focusing on a more recent conflict era, Black and colleagues' (Black *et al.*, 2005) population based survey of first Gulf War era veterans investigated the prevalence of incarceration and its associations with deployment type, which included an examination of mental health. While the reporting of the study failed to describe the study design in detail thus reducing the overall quality assessment of the study, Black and colleagues found that depressive disorders, alcohol misuse, symptoms of PTSD and anxiety disorders were significantly more evident in those veterans who reported a past history of incarceration. Further, those Gulf War veterans who reported previously being incarcerated were more than two times more likely to experience depression or anxiety, two and a half times more likely to misuse alcohol, and more than three times more likely to have PTSD, compared with never incarcerated veterans. Interestingly, adding to both Shaw *et al.* (1987) and Kulka *et al*.'s (1990) findings on substance misuse, Black and colleagues found that the use of illegal drugs prior to active service was also significantly associated with veterans reporting a period of previous incarceration and also with being incarcerated after deployment to the Gulf War.

Black *et al*.'s (2005) findings suggest the existence of a relationship between mental health conditions and incarceration in veterans but also strongly indicate that pre-military criminal behaviours are linked to later post-military offending. Similar to the other articles discussed, these findings are, however, not without caveats. Firstly, an 'ever incarcerated' status could have included imprisonment pre-military enlistment (and pre-occurrence of mental health difficulties), and, as acknowledged by Black and colleagues, 'ever incarcerated' data would have included participants detained but never charged.

Secondly, imprisonment could have occurred while still an active member of the military and in this context may have been used to enforce military discipline rather than represent an act of punishment for the engagement of criminal behaviour. For example, the ethos of military prison for UK Armed Forces, for which the Ministry of Defence (MoD) defines its correctional facility as a 'training centre' rather than a prison for some of the personnel transferred there, focuses on the improvement of discipline and morale leading to an enhancement in the person's military capability (Ministry of Defence, no date).

When comparing incarcerated veterans with other marginalised vulnerable veteran groups, differences in mental health, drugs and alcohol problems continued to be identified. McGuire *et al.'*s well-designed and methodologically robust study examining jailed and homeless veterans (McGuire, Rosenheck and Kasprow, 2003) found that clinically assessed psychiatric illness was significantly greater in the incarcerated group: as were a number of specific clinical diagnoses, such as mood disorders, personality disorders and psychotic disorders. Only PTSD was found to be more common in the homeless veteran group, countering what was reported by Kulka *et al.* (1990) and Black *et al.* (2005). However, McGuire *et al.* also found that incarcerated veterans reported misuse of alcohol and drugs more commonly than the homeless group and this finding is consistent with the other studies previously discussed.

The two remaining studies in this section, both of which achieved a quality assessment score of 7 out of 8 using the method developed by Loney *et al.* (1998), compare statutory collected health data with local government collated offending data, contrasting the health needs of those veterans who had contact with criminal justice systems with veterans who had no contact. Erickson *et al.* merged data from their local Veteran Association (VA) health databases with the database from their local Department of

Corrections to identify veterans who had been imprisoned within a year of hospital discharge (Erickson *et al.*, 2008). Erickson and colleagues found, in keeping with the majority of other empirical findings, that the incarcerated group were significantly more likely to have adjustment disorder, anxiety disorder, major depression, personality disorder, PTSD and schizophrenia. They were also substantially more likely to have a diagnosis for drug misuse, alcohol misuse and for co-occurring disorders. Erickson *et al.* found, however, that, despite the presence of a range of mental health problems in the incarcerated group, only major depression, drug misuse and alcohol misuse were independent predictors of veteran incarceration.

The influence that substance misuse has on veteran incarceration has also been noted by Pandiani and colleagues (Pandiani, Rosenheck and Banks, 2003). Using arrest rates to identify the impact and relationships that mental health and substance misuse problems have on criminal justice involvement, Pandiani *et al.* found, for both single and multiple arrests, that veterans with substance misuse or substance misuse co-occurring with mental health problems had a significantly greater elevated risk of arrest (up to five times greater for those with substance misuse and two and a half times more likely for dual diagnosis) compared with veterans who were recipients of medical care only. Of note, however, is that the risk of arrest to veterans with mental health issues and no substance misuse did not differ from those veterans without mental health, drug or alcohol problems. The inference from Pandiani and colleagues' findings, and to a lesser degree Erickson *et al.*'s (2008), is that increased contact with criminal justice services occurs when veterans have substance misuse problems rather than poor mental health. It should, however, be noted that Pandiani *et al.*'s use of arrest rates as a method of recording criminal justice involvement has its own limitations: not everyone arrested is guilty of committing an offence.

In summary, all six studies found differences in mental health and/ or substance use in veteran populations who had contact with criminal justice services compared with veterans who did not. The presence of PTSD varied, being evident in incarcerated veterans and linked to their offending but also found in non-incarcerated veterans. Additionally, while mental health problems were more evident in veteran groups who had criminal justice contact, the indication from the studies reviewed is that substance misuse increases the risk of veteran contact with criminal justice services compared with veterans without this problem, whereas most mental health problems do not.

2.3.2 Influence of mental health, drug and alcohol on veterans' contact with criminal justice services

Six studies, all of which scores 6 or more out of 8 using Loney and colleagues (1998) methods of quality assessment, provide insight into the influence that mental health, drugs and alcohol use has on veterans' contact with criminal justice services. The first (Rosenheck *et al.*, 2000) examined the incarceration rates of veterans who had contact with treatment services over a 3-year period. Using probabilistic population estimation, Rosenheck and colleagues suggested that 25% of all veterans who attended treatment services with a dual diagnosis of substance misuse and a mental health disorder were incarcerated at some point during the 3-year period. This compared with 21% of veterans with a substance misuse diagnosis who had contact with support services. Of the 4000 veterans who contacted services with a mental health problem, only 11% had been imprisoned during the time period. Rosenheck and colleagues found a similar pattern when calculating annualised estimated incarceration rates; 13% of veterans with a dual diagnosis and 12% of veterans with a substance misuse problem were imprisoned per year. Less than 4% of veterans with mental health problems were incarcerated annually during the study period examined. Similar to studies discussed in section 2.3.1 it would

seem that, from Rosenheck *et al.*'s findings, veterans with mental health problems are least likely to be incarcerated compared with veterans with substance misuse problems.

How the mental health of military veterans from different conflict eras (Iraq/ Afghanistan Wars, the Persian Gulf War, and the Vietnam War) influences incarceration rates has been the focus of one large study (Fontana and Rosenheck, 2008). Veterans of Iraq/ Afghanistan Wars who had received outpatient treatment for PTSD, were found to have less PTSD, drug or alcohol misuse and were significantly less often incarcerated compared with veterans from both the Persian and Vietnam wars, although no difference in PTSD diagnosis was found when comparing mental health hospital inpatient located veterans from the different war eras. Likewise, the inpatient Iraq/ Afghanistan group's rate of incarceration did not differ from veterans who had served in the Persian Gulf War, but both groups incarceration rates did significantly differ from the Vietnam inpatient group. The Vietnam inpatient group also had greater alcohol and drug dependence. The findings from Fontana and Rosenheck's study suggest that more recent veterans are less likely to experience substance misuse problems, less likely to have ongoing problems with PTSD and less likely to experience incarceration irrespective of war/conflict eras. This raises the question as to why this would be so. Are war era related differences attributable to; conflict theatre exposure; different leadership and methods of training and preparedness; availability and timely access to mental health treatment or to differences in the type of person recruited in to the military? For example, are modern soldiers more resilient; or is it a combination of these and other influencing factors (MacManus *et al.*, 2014).

While most of the studies reviewed used the presence of PTSD in their analysis of its relationship with criminal justice contact, Calhoun *et al.* found that it was PTSD severity

that provided the strongest association with arrest history whereas exposure to traumatic events such as combat exposure and childhood punishment had no relationship with veteran arrests (Calhoun *et al.*, 2004). Furthermore, while they also identified relationships between being arrested and other mental health problems (depression, feelings of hostility) and alcohol and drug use, similar to other studies already reviewed, it was only current substance misuse and PTSD symptom severity that increased the odds of being arrested, and for PTSD severity the frequency of arrests. It may be that in studies where PTSD does not differ between incarcerated and non-incarcerated veterans (Shaw *et al.*, 1987), or is not found to be present in incarcerated veterans (McGuire *et al.*, 2003), that this is because any underlying presentation is not severe enough to have an association with, or influence on, criminal justice contact.

The remaining three studies in this section recruited homeless veterans as study participants. Copeland *et al.* (2009) found a strong relationship between homelessness and a history of past imprisonment in military veterans with a diagnosis of bi-polar disorder. They also identified that, in this mentally unwell sample, binge drinking and substance use significantly influenced their risk of incarceration. The relationship and influence of alcohol and drugs on homeless veteran offending has been identified elsewhere. Wenzel *et al.* (1996) also recruited homeless veterans and specifically targeted those who had substance misuse problems. In their examination of the service needs of veterans with dual diagnosis, they found that a larger proportion of veterans with a dual diagnosis reported having at least one criminal conviction, whereas participants with no mental health or substance misuse diagnosis were least likely to report having a conviction. Benda, Rodell and Rodell (2003) also studied homeless veteran substance users and identified which factors differentiated non-offender homeless veterans from those homeless veterans that were nuisance offenders and those committing felony

offences. Interestingly, mental health or the misuse of drugs or alcohol were not the only factors that differentiated between homeless veteran offenders and non-offenders. Benda and colleagues also found that having robust coping abilities, poor self-worth, few friends or social contacts, and veterans believing that they had no control over what happens to them, also discriminated between homeless veterans that offend and those who do not. This is not surprising given that poor self-esteem, social isolation and poor locus of control are all linked to poor mental health (Solomon, Mikulincer and Avitzur, 1988; Kawachi and Berkman, 2001; Mann *et al.*, 2004), irrespective of whether a person has a history of military service.

2.3.3 Influence of clinical interventions on veteran contact with criminal justice services

As would be expected, accessing clinical treatment for mental health, drug or alcohol problems, improves health and wellbeing but it also influences the occurrence of illegal activity and veteran contact with criminal justice services, although processes that result in these changes are not always linear. For example, McLellan and colleagues studied the relationship between income source and methadone maintenance treatment in a substance-dependant veteran population, finding that more than half of the study's 165 participants obtained income from illegal activity (McLellan *et al.*, 1981). McLellan and colleagues examined a small sub-sample of 36 participants for whom illegal activity provided almost half their income. While their method of estimating illegal income may have been subjective, McLellan and colleagues found that following treatment the income they obtained from illegal activity significantly reduced with a corresponding increase in work-related earnings. As well as suggesting that the ability to self-support financially improved personal wellbeing and psychological adjustment, the authors concluded that reducing substance use through clinical intervention reduced criminal

behaviour. This reduction in criminal behaviour correspondingly increased their employment options, which then further reduced participants' engagement in illegal activity.

While McLellan and colleagues' (1981) study demonstrates the relationship between clinical intervention and a reduction in offending, it is worth asking whether the study's use of veterans as study participants was predicated by convenience rather than a specific choice to examine veteran offending. This raises the question as to whether the study's findings are unique to a veteran substance-using population or whether the outcome would be the same if the participant group were substance-dependent non-veterans. This consideration extends to Siegal and colleagues' more recent study on the provision of treatment to substance-misusing veterans (Siegal, Li and Rapp, 2002). In this robustly designed study, for which the quality evaluated strongly using the CASP critical appraisal checklist for cohort studies (CASP, n.d.), Siegal and colleagues found a significant difference in the number of new arrests between veterans who received case management in addition to treatment as usual and veterans that did not receive case management. They suggested that the length of time engaged in aftercare support was significantly predictive of the occurrence of future legal problems. Interestingly, despite demonstrating a relationship between the provision of ongoing support and a reduction in criminal justice contact, the authors concluded that where further criminal activity occurred, this was related to the severity of participants' previous offending rather than their current substance use. Simply put: their past criminal activity led to their future criminal activity.

Nonetheless, it also seems equally evident that if a veteran can stop his or her substance addiction he or she is less likely to experience future contact with criminal justice services. Hser and colleagues, as part of a methodologically robust longitudinal

study on cocaine dependent veterans, found at 12-year follow-up that half of their study participants had achieved 'stable recovery' (maintaining absence from cocaine for more than 5-years) (Hser *et al.*, 2006). When comparing veterans with a stable recovery with veterans from the study who continued to use cocaine, they found that the stable recovery group reported, in addition to less psychological distress, depression, anxiety, and obsessive compulsivity, and lower levels of daily alcohol and drug use, significantly less criminal justice involvement. Ending their dependence on cocaine improved their mental wellbeing and reduced their propensity to commit crime.

The final study for review is perhaps more interesting for the low numbers of veterans with mental health and/ or drug or alcohol problems it found, rather than finding, as would be expected, that treatment improves health and, less expected, reduced offending. Pandiani and colleagues examined veteran involvement with criminal justice services before and after they received either veteran specific or non-veteran specific community-based health interventions (Pandiani, Ochs and Pomerantz, 2010). The first point to note is that the number of veterans charged prior to clinical intervention was very small. Of those veterans with a diagnosis of mental disorder only, 5% of those who attended veteran specific services and 8% of those who visited non-veteran specific services had received a criminal charge preceding healthcare contact. Similar to patterns described earlier in this review, proportionally more veterans with substance use disorders than mental health disorders had contact with justice authorities before care provision. Of those veterans with substance use disorders, 11% of those engaging with veteran specific care service and 21% of veterans contacting non-veteran specific services had a criminal charge before contact. While the study does not describe how other confounding factors were controlled for or potentially influenced findings, post-treatment, for both veteran specific

and non-veteran specific treatment providers, participants experienced significant reductions in criminal charging when compared to pre-treatment status.

As stated, perhaps the most interesting finding from Pandiani *et al.*'s (2010) study is the very low percentage figures reported for numbers of veterans with both a mental health diagnosis and a criminal charge. Prior to accessing healthcare services, only 6% (n=109) of 1872 participants with a diagnosed mental health disorder and 9% (n=42) of 495 veterans with a co-occurring disorder had been charged prior to engaging in clinical intervention. Veterans with a diagnosis of substance use disorder did have a higher rate of pre-clinical service criminal charges compared with the other two diagnostic groups but this too only accounted for 15% (n=107 out of 713) of the diagnostic group. Most participants with mental health, substance use disorders or a dual diagnosis had not received a criminal charge. It is important to recognise, however, that this does not mean that they did not engage in criminal activity: they may have done so but were never caught, or if caught, never charged.

2.4 Discussion and commentary on the narrative summary

Systematic searching of the literature for the periods 1939 to November 2011 (Taylor *et al.*, 2012) identified 16 studies, all based within the USA, that illuminate relationships between mental health, alcohol or drug problems and veteran contact with criminal justice services. Few of the studies had a principal aim of examining veteran mental health and offending. However, all studies identified differences in criminal justice involvement between either veterans with mental health, drug or alcohol problems and veterans without these problems, or veterans that had received treatment for these problems. From this, through a deductive process, cautious inferences can be made regarding whether

mental health, drug or alcohol problems contribute to veterans having contact with criminal justice services and whether such problems increase the risk of said contact.

While there is heterogeneity across the studies, many of the studies identified differences in rates of arrests or incarceration between veterans with mental health problems and those without. It should be noted that, for many of the studies reviewed, the numbers of veterans with mental health or offending problems were often small or consisted of small proportions of the total sample. Studies directly comparing incarcerated or ever incarcerated veterans with never or non-incarcerated veterans found that personality disorder, adjustment disorders, anxiety disorders, mood disorders, schizophrenia and other psychotic disorders, and PTSD were all present in greater numbers in incarcerated veterans than non-incarcerated veterans. Conversely, one, albeit small study (Shaw *et al.*, 1987) found no difference in the prevalence of PTSD between incarcerated and non-incarcerated veterans and another (McGuire *et al.*, 2003) found combat-related PTSD more prevalent in their non-incarcerated group. Given Calhoun *et al.*'s findings (2004) a possible reason for this is whether Shaw *et al*. and McGuire *et al.*'s studies participants did not have PTSD symptoms severe enough to be associated with veteran incarceration, particularly, as more recent studies have continued to suggest a relationship between PTSD and offending behaviour (Elbogen *et al.*, 2012), and particularly violent offending (MacManus *et al.*, 2013; Elbogen *et al.*, 2014).

Studies identifying mental health problems as predictors of risk of incarceration were limited. One study, Erickson *et al.* (2008), identified veterans with major depression as being nearly twice as likely to be incarcerated as a veteran without major depression. Depression was also found to be a highly statistically significant discriminating factor between veteran offenders and veteran non-offenders (Benda *et al.*, 2003). PTSD severity

also independently predicted history and frequency of arrest (Calhoun *et al.*, 2004). Nonetheless, despite mental health predictors of incarceration being identified, and that differences in mental wellbeing between incarcerated and non-incarcerated veterans were found, Pandiani *et al.*'s (2003) large study, which counters the 'predictors of risk' findings of the other studies reviewed, found that veterans with mental health problems were no more at risk of single or multiple arrests than their mentally well control group. It was only when substance use was present with mental health problems as co-occurring conditions that the risk of arrest increased.

Both substance misuse and substance misuse co-morbid with mental health problems were found to greatly elevate the risk of criminal justice contact by as much as five times for both single and multiple arrests (Pandiani *et al.*, 2003). Indeed, all 16 studies provide details of the influence, impact, or relationship substance use, and in most studies alcohol misuse, have on veteran offending, arrest or incarceration, either as a single diagnosis or as a dual diagnosis with mental health problems. As a reminder, Wenzel *et al.* (1996) found that proportionally, when compared to other groups within their study, more veterans with substance misuse disorders, either as a dual or single diagnosis, committed at least one crime, and McGuire *et al.* (2003) noted that 62% of their incarcerated group had a diagnosis of drug misuse or dependence. More recent studies, post 2011, corroborate this. For example, substance misuse in Iraq and Afghanistan-era US veterans has been strongly associated with post-deployment criminal arrest (Elbogen *et al.*, 2012), incarcerated American veterans continue to report high levels of drug and alcohol use and dependence (Tsai *et al.*, 2013) and in UK veterans, violent offending was found to be strongly associated with alcohol misuse (MacManus *et al.*, 2013). Likewise, both alcohol misuse and drug misuse were found to differentiate between veteran offenders and veteran non-offenders (Benda *et al.*, 2003), and both were found to be independent

predictors of incarceration (Erickson *et al.,* 2008; Calhoun *et al.,* 2004; Copeland *et al.,* 2009). Equally, military personnel are not the only sub-group within society that consumes drugs or alcohol excessively. Locally, in Scotland, there is growing concern regarding alcohol consumption and its impact on wider society (York Health Economics Consortium, 2010), and on the numbers admitted into Scottish prisons with alcohol difficulties (Parkes *et al.,* 2010), of which only a small proportion are likely to be veterans. What does appear to be clear from the studies reviewed is that veterans who received treatment decreased their substance use, which also reduced their rates of offending (Hser *et al.,* 2006; Siegal *et al.,* 2002; Pandiani *et al.,* 2010).

Despite the range of findings summarised in section 2.3, because of the differing populations studied, the methods used and the presence of some inconsistencies in findings, it is impossible to confirm that veterans with mental health problems are at a greater risk of contact with criminal justice services than their mentally well counter parts. Many of the studies did demonstrate that more veterans with mental health problems appeared to be arrested or incarcerated, or were more likely to be, than veterans without mental health problems, yet people with serious mental health problems are significantly more likely to be arrested (Fisher *et al.*, 2006; Fisher *et al.*, 2011) than people without such problems. It may be that where veterans have contact with criminal justice services it is as a consequence of their mental health problem rather than their veteran status, albeit recognising that, for some, engagement in military service, specifically combat deployment, can cause mental illnesses such as depression or PTSD (Cesur, Sabia and Tekin, 2013).

Accordingly, while it cannot be stated with statistical certainty that veterans with mental health problems are more at risk of criminal justice contact than their mentally

well veteran colleagues, it can perhaps be inferred that as a consequence of their mental health problem their risk will be greater (Fisher *et al.*, 2011). This risk will not be present in all veterans who have mental health problems or for all mental illnesses: like other people who have mental illness the risk of committing a crime may be attenuated where substances misuse is absent (Fazel *et al.*, 2009). As MacPhail and Verdum-Jones (2013) note, criminal behaviour is driven by personality disorders, antisocial associates and environments, and various neurocognitive impairments, manifesting as impulsivity, which is attributable to substance misuse. Mental illness, without the presence of substance misuse, is not likely, therefore, to increase the risk of offending relative to people with no mental illness (Somers, Cartar and Russo, 2008). It would therefore seem fair to conclude that criminal behaviour is not driven by whether a person is a veteran nor has a mental illness but by other factors that are present and to which poor mental health may contribute to.

Substance use, with or without the presence of mental illness, does, however, increase the risk of criminal justice involvement (Somers, Cartar and Russo, 2008) but as Thomson eloquently states "*…there is no simple relationship between substance abuse and crime* […] *situational and individual factors can act with pharmacological effects to produce aggression and offending behaviours"* (Thomson, 1999:654). Substance misuse has been shown to influence violent offending in military personnel, such as alcohol misuse influencing the severity of domestic assault (Martin *et al.*, 2010). However, with the exception of regular binge-drinking and marijuana use, veteran and non-veteran use of drugs, and their rates of alcohol and drug misuse and dependence, have been found to be similar (Wagner *et al.*, 2007).

The key question is whether veteran substance use increases their risk of offending compared with those veterans who do not misuse substances. Being mindful of the heterogeneity of the studies reviewed, a number of studies identified substance use as an independent contributory risk factor to criminal justice contact. While the absence of formal statistical analysis prevents stating with certainty that veterans with drug or alcohol misuse are at greater risk of criminal justice contact than non-drug or alcohol using veterans, an opinion based on the studies reviewed can however be offered. One can construe, given the number of studies finding a relationship between substance misuse and criminality, that veterans with substance misuse, in isolation or co-occurring with mental health problems, appear to have an increased risk of criminal justice contact when compared with veterans who do not misuse substances. Furthermore, veterans who receive treatment for substance misuse appear to lessen their risk, although it is hard to discern if the outcome would be replicated in a non-veteran substance misusing population. This raises a further question: do veterans who misuse drugs or alcohol differ from substance misusing non-veterans.

2.5 Chapter conclusion

In scrutinising the literature that focuses on veteran mental health and wellbeing and their offending behaviour, this chapter has provided a contextual overview to the research area being addressed within this study. It concludes that some veterans have mental health problems and some misuse alcohol or drugs, all of which can be associated with past military service and combat exposure, and that governments have attempted to facilitate access to services that support the needs of veterans. These services are not well utilised, however, with veterans feeling stigmatised by their peers or negatively judged by support professionals.

Being exposed to military service does not directly lead to criminal behaviour; instead, for some people, engaging in military service appears to mitigate against current and future criminal behaviour. Veterans can however be found in prison, and in the UK there remains some uncertainty as to how many prisoners veterans account for. There is also uncertainty as to whether veterans with mental health, drug or alcohol problems are at a greater risk of contact with criminal justice services compared with veterans without such problems. A systematic searching of literature from the last 70- years identified 16 studies that provide evidence that addresses these questions. The inference from the studies is that the evidence to support whether the risk of contact with criminal justice services is greater for veterans with mental health problems than those veterans without is mixed but does appear to be greater when substance use is present.

Having provided a contextual overview for this study, the next two chapters (Chapters 3 and 4) describe the methodology and methods used in the study to address the aims detailed in Chapter 1. Findings for the study are then presented in Chapters 5 to 7.

Chapter 3 - Conducting prison-based research – the challenges, the research paradigm used, and the methodology

3.1 Introduction

Understanding the range of challenges that can occur when conducting research in a prison environment is essential when it comes to planning and designing a study. There are constraints, both intentional and unintentional, that researchers must be mindful of when thinking about research questions being asked, the philosophical underpinnings of the research methods and the practicalities of how the study is carried out. The chapter begins by summarising how researchers can be viewed by the prison system, its staff and its prisoners. It then discusses how key people can influence the process of obtaining access to, and how research is conducted within, a prison environment. To discuss these, I will be drawing upon the wider literature to help explain my own experiences while conducting this study, highlighting some of the challenges encountered. The chapter will then detail the research paradigm adopted within the study, providing a theoretical framework for the methodological approaches utilised. To address the research questions posed, this methodological framework consisted of three linked parts incorporating both qualitative and quantitative components. Chapter 4 describes the detail of the research methods; however, the rationale for adopting these methods and the philosophical stance underpinning each component is explained within this chapter.

3.2 Research in a prison environment

Prisons exist because they are seen as a requirement by society and thus their function and purpose are at society's behest. As such, they should be open to investigation and wider scrutiny. Morgan reminds us that prisons "*have existed since time immemorial"* (1997:1141) and that the legal purpose of prisons is to hold people in custody, applying coercion to conform, and to provide punishment through the loss of liberty. They are primarily custodial environments that have a responsibility for confining people sent there (Byrne, 2005). These people are often regarded as vulnerable (Peternelj-Taylor, 2005; Dalen and Jones, 2010) with complex and unmet needs (Anthony and Mcfadyen, 2005; Rickford and Edgar, 2005; Edgar and Rickford, 2009). Prison also has a rehabilitative purpose (Watson *et al.*, 2004) where, according to Byrne, the mission is to provide the "*three c's: custody, control and care*" (Byrne, 2005: 227). While operational functions that address a prison's mission are open to public inspection, what a prison does not have as a core function is the need to facilitate external research '*within its walls*' and when research has been conducted it has not been without trouble (see Byrne, 2005 for a brief summary).

Some prison administrators may be hesitant to allow research to take place where they have little control over what is being examined, or how the research results will be presented. Prison administrators may perceive independent researchers as being dangerous, with no allegiance to the prison system or prisoners (Trulson, Marquart and Mullings, 2004) and who are therefore unconcerned about the impact their study findings have on the organisation and the people it is responsible for. This is despite some researchers acknowledging that negative reporting of prison research by the media may expose prisoners to "*double stigmatisation*" (Dalen and Jones, 2010): stigmatised

because they are in prison in addition to how they are presented when research findings are communicated.

Some researchers also acknowledge concerns about using prisoners and accessing prison systems to conduct studies. Waldram (2009) notes that prisoners are not 'embraceable' research participants, with members of the public [including researchers] often holding disparaging view about prisoners, assuming they will be uncooperative and difficult to work with. He suggests that a prison system, through its raft of regulation and systems, constrains rather than enables studies to be carried out. However, Waldram reminds us that prisons are not just venues for the 'warehousing' of prisoners: people can change, for better or worse, when in prison, and prison has a direct influence on this. It is for this reason, in my opinion, that researchers should use their skills to inform and challenge existing knowledge on what happens within prisons. But equally, when conducting prison-based research it is essential to find the optimal balance between what is practicably possible in terms of research design while still being ethically justifiable: something that requires both an understanding of the prison system being examined and knowledge of research ethics (Dalen and Jones, 2010).

3.2.1 Insider and outsider

Waldram (2009) suggests that being an 'outsider' can be beneficial when conducting prison-based research but being viewed by an organisation as an 'outsider' can, for reasons described in section 3.2, also hinder initial access. In this context 'outsider' is the diametric of 'insider'; 'insiders' being members of a specific group or collective with monopolistic access to certain kinds of knowledge, with 'outsiders' regarded as non-members (Merton, 1972). For a researcher to address the "*omnipresent fear*" (Trulson, Marquart and Mullings, 2004:458) of prison managers (an all-encompassing fear of

research being conducted anywhere in their prison and at any time), and obtain access to study participants and other data, the researcher needs to bridge this insider/ outsider divide. In turn, the researcher has to learn the cultural and social nuances of the organisation and both adapt and adhere to the organisation's requirements (Byrne, 2005) while also being able to demonstrate a range of interpersonal and research skills, such as research credibility, consistent good communication and flexibility (see Trulson, Marquart and Mullings, 2004).

When this research project was initially proposed I believed I had 'insider' status and that this would be advantageous. I had been an employee of the SPS for many years and had operated in many of the prisons where the research was to be carried out. I understood the cultural and social nuances of the SPS across its different structural levels and believed this pre-existing relationship would remove any potential fear that the organisation had with regards to conducting the research (Bonner and Tolhurst, 2002). Moreover, recognising that access can often be eased if the researcher has a strong credibility (Patterson, Mairs and Borschmann, 2011), and can use known contacts (Trulson, Marquart and Mullings, 2004), I aimed to use the continued positive regard I was held in by the organisation for my previous work and the broad range of middle and senior management contacts I had. During the initial engagement with the SPS to discuss the research (its aims, methodology and the practicalities of how to carry it out), during the first few months of the study, feedback continued to support the idea that I was seen as being 'one of them' (Tshabangu, 2009; Carling, Erdal and Ezzati, 2013). I was regarded as someone who understood the purpose and functions of the organisation and its' staff, could be trusted and, as such, the study questions being asked were seen by the SPS as worthy of examination. The 'insider' status also proved helpful in fulfilling the SPS research and ethics requirements by knowing who to contact and liaise with, and the

appropriate culturally specific language to use when describing and agreeing the research methodology. It assisted in obtaining SPS approval for access to a majority of prison institutions and both staff and prisoners for research purposes.

Traditionally, researcher 'insider' status has been regarded as the antithesis of researcher 'outsider' status (Dwyer and Buckle, 2009; Kerstetter, 2012). Others, however, view this as a continuum (Breen, 2007), or believe researchers are able to adopt either status depending on context (Bonner and Tolhurst, 2002) and work with the 'space in between' (Dwyer and Buckle, 2009; Kerstetter 2012). As Kerstetter (2012) notes, within this 'multidimensional space' the researcher's identity, cultural background, and relationship to study participants influences how they are positioned.

On reflection, I now believe I operated in this 'space in between', adopting both 'insider' and 'outsider' status depending on context, but never fully being one or the other (Dwyer and Buckle, 2009). Initially, I had clear 'insider' status with former senior colleagues I knew and had previously worked with. Yet, the 'insider' status was neither absolute (I was no longer a prison employee) nor never-ending. The 'insider' status waned as the study progressed into its second and third year and the prison organisation evolved: it had obtained new senior staff, new organisational structures, new prisons and new priorities. Equally, at study commencement, and despite my prison service history, I had 'outsider' status with many of the local prison staff and prisoners whom I had had no previous contact or working relationship with. Such 'outsider' status is inherently characterised by feelings of distrust (Emmel *et al.*, 2007). I was unknown to many of the local prison staff and, where known, my previous employment at a senior management grade identified me as being different from uniformed staff and therefore was regarded as having different goals, motivations and interests. To prisoners I was always an

‘outsider’; there were socio-cultural differences and I had no incarceration history. To those staff and prisoners who had military service I was also regarded as an ‘outsider’ because I had no previous military service.

Despite the ‘insider’/ ‘outsider’ dichotomy that I experienced when applying for study approval and accessing participants, and the realisation that I was operating in the ‘space in between’, what became apparent was that, fundamentally, access required a research study that the SPS deemed worthy of being undertaken. Further, it needed people who were motivated by the aims of the research as these were the people who were interested in assisting with or participating in the study. Nonetheless, processes were required that developed trust between myself and study participants and those who controlled access to the study participants (Unnithan, 1986; Breen, 2007; Sveen, Sarriegi and Gonzalez, 2008; Waldram, 2009; Scourfield, 2012), particularly where those who controlled access had no vested interest in the study topic.

3.2.2 Gatekeeping, access and recruitment

Accessing vulnerable populations for the purpose of research can be challenging (Liamputtong, 2006) and increasingly so when the vulnerable population is incarcerated (Peternelj-Taylor, 2005). Ethical and administrative approval, as well as obtaining security clearance from an organisation, does not guarantee access as access is still controlled locally by prison staff (Peternelj-Taylor 2005) and prison staff are literally gatekeepers: they guard gates (Waldram, 2009). Moreover, obtaining approval to access an institution does not necessarily mean that a researcher will obtain access to the necessary data to make the research successful. Researchers have to obtain access, maintain access and access meaningful data (Trulson, Marquart and Mullings, 2004), and much of this involves developing and maintaining effective relationships.

Conducting research in a prison environment requires initiating and developing relationships with gatekeepers at multiple levels of an organisation's structure. Broadhead and Rist (1976) introduced the term 'gatekeepers' to define the small, but key, group of organisational staff who decide whether a research study can take place within their organisation, help facilitate access into the organisation and provide access to data collection. However, the more gatekeepers there are, the more obstacles there are that have to be overcome (Wanat, 2008). Broadhead and Rist recognised that obtaining entry via a gatekeeper is often contingent on 'reciprocity' – what benefits does the researcher and the research offer the organisation as a whole and to the individual gatekeepers (Broadhead and Rist, 1976)? They recognised that gatekeepers are concerned with how the organisation is going to be perceived publicly and the impact or influence the research will have on the operation of the organisation, such as, its impact on staff through the use of them as a resource in the research, potential conflict between staff, and changes in morale. In correctional settings, because of the differing priorities and interests of gatekeepers, reciprocal relationships have to be developed utilising different approaches and the exchange of different 'goods' (Unnithan, 1986). For example, at an organisational level, the association with research may address a specific business concern; whereas, prison staff gatekeepers may receive increased knowledge and status for assisting with the study. Developing these reciprocal relationships often requires direct face-to-face contact where the researcher can connect personally with the gatekeeper and where the researcher and the gatekeeper can develop a shared goal, making the gatekeeper an ally in the research process (Patterson, Mairs and Borschmann, 2011) without them feeling overburdened with research demands that compete for their time.

In this study, the Chairperson of the SPS' Research and Ethics Committee, who was also Chair of the Veteran in Custody In-Reach Steering Group of which I was a member,

was the first gatekeeper to be accessed. A previous and current working relationship with this person, and the knowledge that the organisation was already interested in the research area being proposed mediated, with little difficulty, the receipt of official organisational approval. These discussions, however, also shaped the nature of the research question and the methods employed, for example where and with whom the research would be conducted. This relationship with the Chair of the Veteran in Custody In-Reach Steering Group also initiated the assigning of a member of uniformed staff to provide national support in accessing individual prisons. The role of this member of staff was to encourage participation and support from an identified member of uniformed staff from each of the local prisons. It initially appeared that the national officer would have a strong influence over how access would be achieved and I regarded the individual as having a key gatekeeping role and, as such, invested time establishing rapport. However, it was the local uniformed support officers, in their role as local gatekeepers for their respective prison establishments, which ultimately had a central role in defining whether access was obtained and meaningful data collected. Where difficulties with access occurred, this appeared to be as a consequence of the Veteran in Custody Support Officer (VICSO) role being forced upon the member of staff where they believed they had too little time to commit to the role as they addressed competing priorities.

The widespread geographical locations of many of the prisons, and therefore the prisoners, influenced the study design. For example, the spread of prisons across all of Scotland was the reason for using survey questionnaires to obtain quantitative data. It also had an influence on forming relationships where the location of some prisons limited the opportunity for face-to-face communication with many of the local support officers. This limited initial contact to telephone and email communications following formal introductory emails from the Chair of the Research and Ethics Committee and the

national lead officer assigned to support the study. In retrospect, this lack of face-to-face contact prevented access to a number of prison establishments and through this process the importance of being able to make personal contact was clear (MacLean, 2010). Where I was able to directly meet with the local support officers to discuss the purpose and intended outcomes of the research study and common areas of interest (Wanat, 2008) it was easier to establish rapport and trust and thereby to obtain access to that establishment. Once VICSOs knew what the study involved, how it impacted upon them and what it was trying to achieve, it became easier to enter prisons and obtain assistance. It was also easier to facilitate access to research participants as a number of VICSOs in their role of gatekeepers had strong positive relationships with potential participants and were able to use this relationship, if they were 'on-board' with the study, to assist me in establishing credibility with participants (Clark, 2010), decreasing the influence of the prisoners' perception of me as an outsider.

This said, initiating and maintaining access to a prison establishment was not without some difficulties. Getting the 'first hit' can be the hardest task within a study and can become a process of trial and error (Sveen, Sarriegi and Gonzalez, 2008) with requests made by me sometimes being met with many of the neutralising responses identified by Wolff (2004) and Wanat (2008). These responses included 'passing request's upstairs' for guidance or a decision, requesting more information before deciding, and also 'forgetting'. The last named being, to me, the most frustrating but effective resistance strategy deployed. I not only experienced prison staff 'forgetting' following my requests for information, but I also turned up to establishments only to be told that access had not been cleared or that prisoners had not been informed of my visit and were engaged in other activities because staff 'forgot' they were informed of my attendance.

Despite there being a period of researcher uncertainty as to how the request [for information, entrance to a prison, or access to a prisoner] is going to proceed (Scourfield, 2012), forgetting eventually conveys to the researcher an answer of 'no' while the gatekeeper still appears cooperative (Wanat, 2008). In this respect, because an element of chance is present when trying to initiate and maintain access, persistence is required on the part of the researcher (Sveen, Sarriegi and Gonzalez, 2008) as is the need to be self-reflective and emotionally resilient with access to supporting networks. This can help to deal with what may appear to be continual rebuffs or blocked access (Patterson, Mairs and Borschmann, 2011). Equally, where there are continual blocks to access, the researcher should look to change gatekeeper(s) if they are able to (MacLean, 2010), while also focusing more attention on those gatekeepers with whom trusting relationships have been developed and who are committed to the study. These are the gatekeepers that are likely to provide a researcher with the most useful information (Sveen, Sarriegi and Gonzalez, 2008) and access to meaningful data, as I experienced in this study. Much of the access to prisons and prisoners that I obtained was facilitated through a small number of VICSOs who were very committed to their role and/ or motivated by the study aims, and with whom I had developed a strong relationship with.

The above provides insight into the challenges that can occur when conducting research in a prison environment. The remainder of this chapter will examine the philosophical and theoretical underpinnings of the models and methodology used in the study and the rationale for these.

3.3 Research paradigms

A number of research paradigms exist to inform the disciplined inquiry of human subjects. These are often characterised by how they seek to address the basic

philosophical nature of the questions posed, e.g. is the overarching philosophical stance ontologic or epistemologic (Polit and Beck, 2012). In conducting disciplined inquiry, researchers often adopt one of two broad paradigms: positivism or constructivism. Whilst not absolute, the two paradigms correspond to different methods of developing and gathering evidence to enhance understanding of the phenomenon under study. Positivism is most closely aligned to quantitative research methods and constructivism is associated with qualitative interpretive research techniques. Understanding the philosophical underpinnings of the above two paradigms are beneficial when proceeding to discuss a third paradigm: the pragmatism paradigm.

This third paradigm, often associated with mixed-method research studies (Polit and Beck, 2012) and the most popular with mixed-method researchers (Teddlie and Tashakkori, 2010), assumes that knowledge arises out of the actions and consequences identified from within the study rather than any antecedent conditions. This gives key importance to the problem or question being examined and the adopting of a 'what works' or best fit model to address the problem. As Creswell (2003) notes, pragmatism is not committed to any single system of philosophy of study. Nor should it be seen as holding its own philosophical stand-point but rather as a set of philosophical tools that can help address the problem (Biesta, 2010). Researchers are free to choose whichever methods and procedures best meet their needs. This may involve collecting and analysing data from both quantitative and qualitative methods and being able to draw from the philosophical underpinnings of both research methods [assuming that doing so proves to be the best method of gaining the greatest understanding of the phenomenon being studied (Creswell, 2003; Wright and Losekoot, 2012)]. As Polit and Beck note, pragmatist researchers believe that it should be the research question that drives the inquiry and not the research methods used, concluding that *"Pragmatism is, as the name*

suggests, practical: whatever works best to arrive at good evidence is appropriate" (2012:604).

Polit and Beck (2012) list five benefits of mixed-method research.

- Combining both qualitative and quantitative approaches can be seen to be complementary through the combining of two fundamental components of human communication: language and numbers.
- Practicality in being able to use whatever methodological tools that best address the question(s) posed.
- The ability to build incrementally upon both quantitative and qualitative findings: qualitative findings generating hypotheses that can be tested quantitatively, and quantitative findings that need clarification through qualitative methods.
- Enhanced validity of results when multiple and differing types of data support the hypothesis or model being tested.
- The ability for researchers with experience in either quantitative or qualitative study to collaborate and combine their expertise.

Further, Creswell and Plano Clark (2011) suggest that there are a range of research problems that are suited to mixed-methods research. These include problems where the use of one data source would be insufficient to address the whole question or where a second method can enhance the findings of the first; and, where results need further explanation or the exploratory findings need to be generalised. Creswell and Plano Clark also suggest that mixed-methods research suits studies requiring the use of specific theoretical approaches to answer different research questions, or where the overall research needs to be addressed through multiple research phases.

Mixed-methods tend to be used because researchers have posed at least two types of research questions, each requiring differing types of data and approaches; such as posing

confirmatory questions (seeking to discount and narrow down options to reach a focused point) and explanatory questions (seeking to explain the phenomena rather than describe it). This is the nature of the questions posed within this study, which required both quantitative and qualitative inquiry in order to obtain greater knowledge of the area of study.

3.4 Mixed method design

Mixed-method approaches can allow for creativity and an emergent approach to design, nonetheless, there are a number of recognised design typologies (Polit and Beck, 2012). This study adopts an explanatory design approach, where the qualitative analysis from second and third data sources are used to help explain the findings of the first data source, enriching the overall understanding of the phenomenon being explored. The explanatory design therefore largely dictates the data analysis and interpretation process, with analysis and interpretation occurring after each stage, with a subsequent integration of findings. As such this study is designed with a predefined sequencing of processes. Sequential designs are not sequential based on timing alone. For a design to be sequential, as well as data collection, it also concerns the ordering of the data analysis and interpretation (Creswell and Plano Clark, 2011). Within this study, data was collected sequentially, quantitative followed by qualitative, although, only minimal analysis and interpretation of findings from the quantitative data occurred before qualitative data collection. However, full analysis and interpretation of quantitative data took place before in-depth analysis of the qualitative data was started.

When designing mixed-method research, a decision has to be made as to whether quantitative or qualitative approaches are to have equal weighting or whether one approach is to be dominant (Polit and Beck, 2012). Where a source is deemed to provide

supplementary data, this is justification for a dominant weighted approach but there are several other reasons why priority decisions are made, including the researcher's philosophical orientation and skills, and who the intended audience is (Creswell and Plano Clark, 2011). It can also be strongly influenced by specific study design, such as the sequential approach adopted in this study, where dominance is given to quantitative data and qualitative data is being used to help explain the quantitative findings and broaden understanding of the research area. Using Morse's (1991) notation system this is a QUAN→qual+qual study, whereby the quantitative approach is dominant over, and occurs before, the qualitative approaches, which when occurring run concurrently. Overall it can be defined as a sequential, quantitative dominant (QUAN→qual+qual) explanatory design that incorporates a nested sampling design, whereby a subset of participants who were involved in the quantitative data collection are used when gathering qualitative data. Nested sampling was used for pragmatic reasons: the quantitative data collection process made it easier to identify suitable participants for the qualitative component of the study.

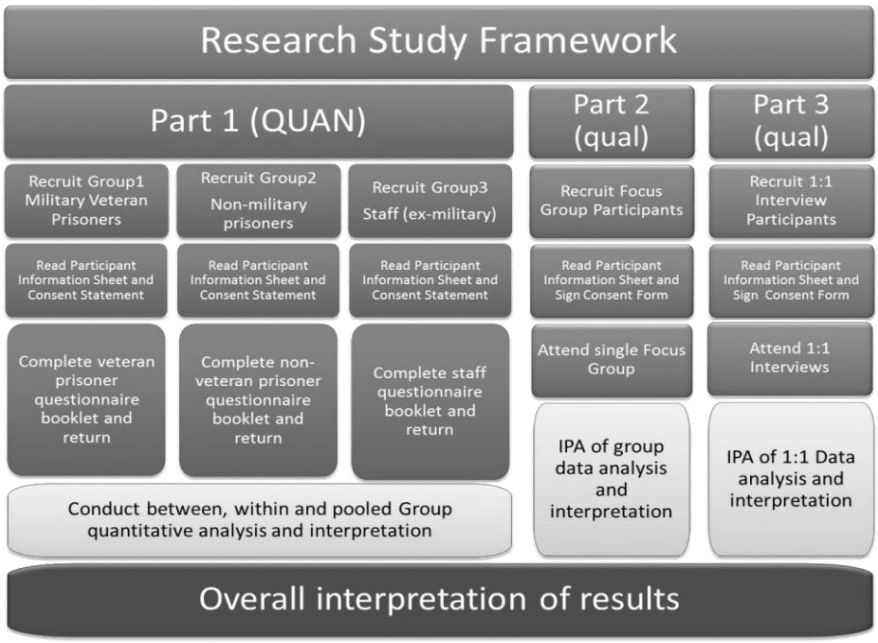


Figure 3-1: Study Methodological Framework

3.4.1 Part 1: Quantitative component using survey methods

A common distinction between types of quantitative research studies is whether they are experimental or non-experimental (Polit and Beck, 2012). This component of the study offered no intervention or treatment; instead, it was interested in exploring relationships between different, but related subject groups with a focus on veteran mental health, social wellbeing and imprisonment. It was, therefore, a retrospective, non-experimental, observational, cross-sectional, comparative study that examined relationships between a range of dependent and independent variables. These variables are discussed in detail in Chapter 4. The study comprised of three distinct participant groups, however, there was no three-way comparison, with comparisons instead limited to two sets of paired groups. Group 1 (veterans in prison) was compared with Group 3 (non-imprisoned veterans) and with Group 2 (non-veterans in prison). Groups 2 and 3 were not directly compared as the scope of the study did not include examining for similarities and difference between non-veteran prisoners and non-imprisoned veterans. In addition to identifying relationships between variables through the use of descriptive and inferential statistical analysis, the study aimed to identify risk factors associated with veteran mental health and offending. The study also incorporated two case-control designs (one is nested) allowing for the examination of imprisonment and post-traumatic stress disorder (PTSD).

A case-control design can be used to identify risk factors by comparing one group who have a 'condition' with a group who do not, and by then looking back over time to identify how the characteristics of the two groups differ (Breslow, 2005). Brief examination of the quantitative component of this study suggested that the use of a case-control design was not an obvious option, but this was not so. Data from Group 1 and Group 3 was able to be used in a case control design and while it would be more complex

directly comparing Group 1 and Group 2, there was no direct group comparison between these two groups. Instead, data for Groups 1 and 2 were combined to create 'caseness'. The following examples clarify the rationale for adopting this approach. Using questionnaire responses from Groups 1 and 3 and having defined the outcome of interest as 'veteran imprisonment', the case group consisted of veterans in prison (Group 1) and the control group consisted of veterans not in prison (Group 3). These two groups were then compared against a range of exposures to test their influence on imprisonment. The second case-control example used the combined data from Groups 1 and 2 to identify what factors influenced the presence of PTSD with the presence of a diagnosis for PTSD used to define group 'caseness'.

3.4.2 Part 2: Qualitative component using Interpretative Phenomenological Analysis (IPA)

There are a wide variety of approaches within qualitative inquiry, each often associated with specific disciplines, e.g. anthropology, philosophy, psychology, and sociology. Some adopt interpretative approaches which can require participant observation (Wright and Losekoot, 2012). Within this study, the qualitative component adopted an interpretative inquiry that focused on the lived experiences of military veterans who were incarcerated using Interpretative Phenomenological Analysis (IPA). This approach, first described by Smith (1996), sits within the research traditions of phenomenology and hermeneutics (Smith, Flowers and Larkin, 2009), but also owes a debt to symbolic interactionism's construction of individual meaning within personal and social worlds (Smith, 1996; Smith and Osborn, 2007). When combined with quantitative methods it can provide an insight into macro level broad models that have been identified. For example, providing a micro level exploration of participants' beliefs and actions can

enhance understanding of the macro level models that involve relationships between cognitions and behaviours (Smith, 1996).

The process of IPA

IPA adopts an idiographic ethos, which combines both phenomenological and hermeneutic insights. Phenomenological because it attempts to 'get close to' the personal experiences of participants, but doing so requires an interpretive effort on the part of both the researcher and the participant being studied. As Smith, Flowers and Larkin note *"without the phenomenology, there would be nothing to interpret; without the hermeneutics, the phenomenon would not be seen"* (2009:37). IPA does not seek to find a single truth or answer but instead seeks to provide a legitimate and coherent account that demonstrates attention to the words of the participant (Pringle *et al.*, 2011). IPA is committed to the examination of how people make sense of their life experiences within their personal and social worlds (Smith and Osborn, 2007). It purports that when people engage with a life experience they begin to reflect on the significance of what is happening. The researcher engages with these reflections (Smith, Flowers and Larkin, 2009), informed and shaped by philosophical knowledge of phenomenology, hermeneutics and idiography as it relates to IPA's method of inquiry. These terms will now be defined and explained.

Phenomenology is the study of 'experience'. The founding principle of this mode of inquiry is that the experience should be examined in the way that the event takes place (*how it occurs*) and in its own terms. Dastur (2000) describes, from a phenomenological stance, an event as something that is not expected, that arrives unexpectedly, as a surprise, which then moves a person towards a previously unanticipated future. He suggests that it provides the difference between past and future and that this difference ensues because of the sudden occurrence.

To assist in understanding the concept of experience, Smith *et al.* (2009) summarise the conceptual thinking of Husserl, one of the founding philosophers of phenomenology. Smith and colleagues (2009) remind us that Husserl sought to reason that if a person was accurately able to know their own experience of a given phenomenon, and if the person was able to do so with such "*depth and rigour*" (2009:12), this would then allow the person to become aware of the essential qualities of the experience. If this could occur, Husserl conceptualised that the essential features of the experience would surpass the appearance of this awareness and in doing so be able to illuminate a given experience for others. Yet, in order for a person to become aware of the phenomenon they are experiencing they would need to be able to disengage from their active participation within the world, and their 'taking-for-granted' of the experience of being an active participant. According to Smith et al., for Husserl, to be phenomenological a person needs to be able to stop and consciously reflect on what he or she is seeing, thinking, remembering, or wishing. The person needs to be able to separate out and put to one-side, or to use Husserl's term 'bracket', their taking-for-granted engagement with the world so he or she can focus attention, and be able to describe and reflect, on how they are perceiving their world. Within IPA, the concept of bracketing and the systematic and attentive examination of the subjective lived experience are integral parts of the inquiry process. So too is the process of reflection: there is a need to think reflectively to identify areas of potential bias before and during the practice of bracketing and during the process of interpretation.

Heidegger's thinking on both phenomenology and hermeneutics has also been influential in the practice of IPA. Smith and colleagues (2009) remind us that Heidegger was a student of Husserl but diverged from Husserl's conceptualisation of phenomenology by adopting a greater hermeneutic emphasis and it is the theory of

hermeneutics that influences IPA. Practitioners of IPA recognise that "…*human beings can be conceived of as 'thrown into' a world of objects, relationships and language…. that our being in the world is always perspectival, always temporal and always in relation to something*" (Smith, Flowers and Larkin, 2009:18). They recognise that humans are subjective in thinking and exist in a forever changing inter-relational world. Thus, as people focus to make meaning out of their own unique experiences, the IPA researcher can only engage interpretatively to best understand a person's relationship to and within the world they live, and how their meaning materialises. It is this need for interpretation that links with hermeneutics: hermeneutics is the theory of interpretation.

Hermeneutics looks at what was reported to have happened and to refine this to what might actually have happened in the context of the event. This often involves several levels of interpretation, or double hermeneutics (Smith and Osborn, 2007; Smith, 2011). It involves the interpretation of the meaning of what has been said, which is in itself an interpretation by the researcher of what the participant was intending to communicate. This, however, is limited by the researcher's interpretation of the participant's 'life-world' bounded by the researcher's 'life-world' (Wright and Losekoot, 2012). The double hermeneutics associated with "subject-subject" (participant-researcher) relationships may assist in explaining, where two people are culturally related, why some can interpret the experiences of others better than the person can interpret their own experience (Rennie, 2012). However, whenever interpretation is required, this act is never without presuppositions, or using Heidegger's terminology 'fore-conception'; the researcher's, reader's or analyst's prior experiences, values and prejudices. In this respect, no matter how hard the researcher attempts to limit their own biases, bounded rationality (being limited by their own 'life-world') and the difficulties in understanding the 'life-world' of the participant and their own life experiences and prejudices will lead to preconceptions

and subconscious bias (Wright and Losekoot, 2012). Such biases may be unknown at the point of initiating interpretation of the experience, for example through the reading of an interview transcript, and only come to awareness after engaging with the text in a more in-depth way (Smith, 2007).

Smith, Flowers and Larkin (2009) note that Heidegger's relationship between interpretive practice and a person's 'fore-structure'[4], of which fore-conception is a component, causes a need to re-evaluate Husserl's notion of bracketing. They assert that bracketing can only ever be partially achieved as each new level of engagement brings about recognition of our preconceptions. As such, the interpretative process is dynamic, multifaceted and multileveled with the phenomena (*the event or thing*) directly influencing the interpretation, which thereby influences our fore-structures, and in turn our interpretation. This confirms the complex relationship between what is being interpreted and the interpreter (Smith, Flowers and Larkin, 2009) and is linked to the concept of the hermeneutic circle. The hermeneutic circle describes both the relationship between the *"…different aspects of the object the interpreter is interpreting …. [and] describes the relationship between the interpreter and the object of interpretation"* (Smith, 2007:5). The hermeneutic circle refers to the dynamic relationship between the part and the whole, at a series of levels, where the understanding of one part requires a look at the whole and where to understand the whole one has to look at the constituent parts.

The third influence on IPA is idiography. In contrast to nomothetic research, study which focuses on obtaining knowledge and making claims at large group or population

[4] Heidegger theorises that every interpretation has to begin with the mental structure (personal knowledge, experience, prejudices and biases) that the interpreter (researcher) brings to the object or person's experience being interpreted. This is fore-structure.

levels idiography concentrates on individuals and studies their uniqueness. Within IPA, Smith, Flowers and Larkin (2009) describe idiography as being interested in the 'particular' which operates at two distinct levels. Firstly in terms of detail and, therefore, the depth of analysis, and secondly, understanding the particular experiential phenomena as it is understood from the perspective of the person who experiences it. It is as a consequence of this idiographic ethos that Smith and colleagues note that IPA research uses small purposively-selected and carefully situated samples that can provide, if required, detailed single case analysis before proceeding to make broader claims. They also draw a note of caution, however, by stating that researchers should be mindful not to conflate their interest with the 'particular' as being exactly the same as having a focus on the individual. The complexity of understanding the phenomenological view of experience requires both an understanding of the uniqueness of individual experience in terms of context and perception, but also of the experience's relatedness. Experience is best understood as '*in-relation to'* the phenomena and not the property of a person as such. Understanding, however, according to Smith *et al.*'s (2009) summary of Heidegger, is not merely obtained by a certain method of reading or careful critical reflection; nor is it a conscious action or the collection of neutral facts about how someone has lived. Understanding is a synthesising activity that requires a self-interpretatory act by the researcher of their state-of-being in relation to the person's perception of the experience, and how both the researcher and the person being studied engage and fit within the world (Wright and Losekoot, 2012).

Conducting IPA studies

IPA studies are conducted using small samples. Participants are selected because they represent a perspective rather than a population (Smith and Osborn, 2007; Smith, Flower and Larkin, 2009) and are usually a homogenous group that clearly fit the specificities of

the research question (Smith and Osborn, 2007). Smith and Osborn go on to confirm that there is no right sample size when conducting IPA inquiry. Instead it will often depend on a number of factors such as the richness of the individual cases; the commitment to the depth of analysis required; and associated research constraints, for example, the length of time given to complete the study, or the length of interviews. Longer more detailed interviews require a longer time to analyse but provide more detailed information. While there are reports of studies involving up to 12 participants (see Smith, 2011) there is a recent trend for IPA studies to be conducted on very small numbers of participants, usually around five or six, to ensure that there is commitment to a detailed interpretative account of the cases included. Ultimately, this approach sacrifices breadth for depth (Smith and Osborn, 2007).

While it is possible to collect data suitable for IPA analysis using a variety of methods, most studies are conducted using semi-structured interviews (Biggerstaff and Thompson, 2008). Once rapport has developed between the researcher and participant, the aim is to engage in dialogue that has the flexibility to deviate from a defined script. Following participant responses permits a deeper probing of new and interesting areas that arise during the conversation. During semi-structured interviews, the order of questions and how they are posed is less important than allowing the discussion to follow the participant's area of interest or concern (Smith and Osborn, 2007). Pairing conversational dialogue with the opportunity for deeper probing into areas of interest that arise during the conversation permits access to the psychological and social world of the participant. The researcher must however, be mindful that the participant must be perceived as the experiential expert on the subject being discussed and should therefore be afforded the maximum opportunity to tell their story.

Smith's (2007) description of IPA analysis adopts an iterative and inductive cycle whereupon, through a process of examination and repeated re-examination, understanding of the experience and its meanings occur. The researcher moves from awareness of the specifics to an inferred broader knowledge and awareness. This cyclical action is helpful when there are several transcriptions to be examined and new material does not appear to fit with an existing emerging picture. To address dissonance between accounts, the researcher must return to the earlier transcribed material to re-examine whether something has been missed or misunderstood (Biggerstaff and Thompson, 2008). A range of strategies and a six-step heuristic framework (see Figure 3-2) that can be utilised during analysis have been proposed by Smith, Flowers and Larkin (2009). They stress that there is room for deviation as the route taken is rarely linear, involving complex processes that are often conceptually challenging, and are clear that there is no right or wrong method of conducting IPA analysis. New innovative approaches can be identified and used when engaging with the analytical process. Nonetheless, the heuristic framework does provide useful guidance for the novice IPA researcher.

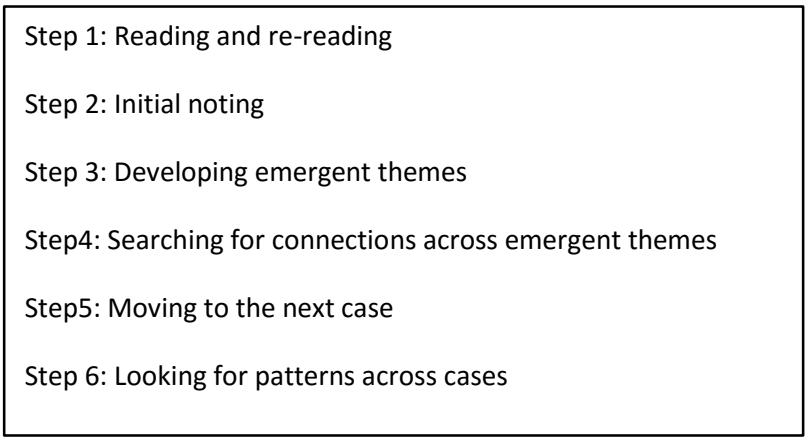


Figure 3-2: IPA six-step analysis framework (Smith, Flowers & Larkin, 2009)

Smith (2011), in developing a guide to help identify and appraise the quality of IPA research publications, has also defined a range of skills required to engage in good IPA.

As a novice IPA researcher, developing and practising these skills ensures quality analysis. It also permits the researcher to demonstrate rigor and transparency within the approach they have taken. The researcher can achieve this by commenting on how interpretations were applied, explaining how themes emerged, and detailing how ideas, meanings and themes disagreed or moved apart (divergence), or how they come together or reached uniformity (convergence) within their study.

3.5 Chapter conclusion

This chapter has discussed the challenges of conducting research in a prison environment and how the 'insider'/ 'outsider' status of the researcher can influence obtaining research approval and access to prisons, prisoners and, ultimately, research data. In addressing the challenges of obtaining access, it summarised the role gatekeepers can take in facilitating and sometimes blocking access to an organisation or study participants and how the researcher can assist in fostering a positive researcher – gatekeeper relationship while also actively observing for actions indicative of resistance. It also draws to attention how attempting to conduct research in such environments can have an influence on the forming of research questions, the design of a study and the methods used to find answers.

The second half of the chapter has provided a rationale for adopting the pragmatic research paradigm and the mixed-method approach. This research study posed confirmatory and explanatory questions that required using both quantitative and qualitative approaches. The chapter has summarised the benefits in using the mixed-method approach in addressing the study aims, detailing the advantages of combining both positivistic quantitative and constructivist / interpretivist qualitative methods when research questions dictate the need for combined methodologies. It also defined the

structural QUAN→qual+qual design of this particular study and provided details of the processes of analysis for both quantitative and qualitative methodologies, providing practical as well as philosophical reasons for these.

The next chapter will build upon the methods discussed above. It will provide a comprehensive account of the methods used in recruiting participants, collecting and analysing data and addressing ethical considerations for both the quantitative (Part 1) and qualitative (Parts 2 and 3) components of this study.

Chapter 4 - Study methods and ethics

4.1 Introduction

This chapter provides an account of the methods used to conduct this study, detailing the participant recruitment processes and study locations, questionnaires used, and methods of analysis. It also summaries the ethical decisions made during study design and implementation.

As a reminder, the aims of this study were to:

1. Identify whether veteran prisoners in Scottish prisons have different mental health, substance misuse and/ or social welfare needs when compared to the non-veteran Scottish prison population.
2. Explore what veterans in Scottish prisons perceive to be the causes of their imprisonment and how they perceive their experience of imprisonment.
3. Identify whether there are common vulnerability/risk factors which are specific to veterans in Scottish prisons but not found in the Scottish non-veteran prison population.
4. Identify whether veterans have a common or idiographic pathway that led to their incarceration.
5. Identify what veterans in Scottish prisons believe is required to address their mental health, substance use, criminogenic and social needs.

This research study consists of both quantitative and qualitative data gathering and analysis separated into three distinct, but linked, constituent parts. Part 1 is a quantitative study that compared responses from prisoners who were ex-military with those prisoners

who have had no previous military experience and to ex-military prison-based staff through the use of survey questionnaires and self-report measurement scales. Parts 2 and 3 of the study used qualitative data obtained from a focus group discussion (Part 2) and four 1:1 semi structured interviews (Part 3) with veteran prisoners, with the latter involving participants who had experienced mental health and/ or substance misuse problems. Qualitative analysis of the data was carried out using IPA. In this aspect of the research, the 'phenomenon being explored' is the perceived impact imprisonment has on veterans with complex health needs, their perspectives on being a veteran in custody and their impact on the prison system, what they believe contributed to their imprisonment, and what they think will assist them in their preparation for eventual transition from prison to the community.

Before proceeding to describe, for each component part, the design, methods used, sampling, recruitment and analysis processes, the overarching ethical considerations raised by the study are detailed. Those ethical considerations that are specific to each component part, however, will be addressed during the discussion of each respective component part.

4.2 Ethical considerations

4.2.1 Consent

When conducting research in a prison environment, obtaining clear unambiguous consent from participants is paramount. Research participants who are prisoners are, by their very status, confined, have restrictions placed upon them, and have a loss of control or reduction in autonomy in aspects of their decision-making. Prisoners may agree to participate in research for the 'wrong' reasons. They may do so because low literacy can impede understanding of the consent process and participant information sheets, or

because they want to demonstrate to prison staff positive behaviour which can influence decisions on their future. They may also consent because they believe the research will enable them to access previously unavailable treatment (Carr, Amrhein and Dery, 2011). As Edens *et al.* (2011) emphasise, two key aspects of consent is that it is voluntary and informed. A participant must have had disclosed to him relevant information that is understandable so that the person can make a competent decision to participate and have autonomy or freedom of choice to take part, withdraw, or not take part, without fear of coercion, enticement or undue influence by others. This being said, autonomous decision making with regards to research participation has been found to be the norm within a prisoner population (Eden *et al.* 2011).

Participant consent for this study was sought for each part of the study; however, the process for Part 1 differed from Parts 2 and 3. Obtaining informed consent does not always require obtaining a signature from participants (Roberts and Indermaur, 2003) and alternative methods were considered for Part 1. This resulted in a consent process for Part 1 that did not require the volunteer to provide a formal signature agreeing to their participation. Such a process has been adopted previously. For example, the waiving of the need for a signed consent form has been recognised in offender research when using postal surveys (Roberts and Indermaur, 2003). The consent process for Parts 2 and 3 adopted the more traditional approach of obtaining a signature after clarifying the volunteer's understanding of what participation involved. The specific consent processes for Parts 1, 2 and 3 are discussed in more detail later in the chapter.

4.2.2 Participants declaring previously undeclared mental health problems

This study involved the participation of prisoners, some of whom were diagnosed with mental health and substance problems, a group that is considered by some as

vulnerable (Dalen and Jones, 2010), but would also include prisoners with undiagnosed or unrecognised mental health difficulties. Orb *et al.* (2000) note that ethical dilemmas may arise during an interview and are difficult to predict, stating that "*an interview is usually equated with confidentiality, informed consent and privacy, but also by recurrence of old wounds and sharing of secrets*" (2000:94). Prior to study implementation, consideration had to be given to the possibility that some prisoners would seek to participate who had not declared or sought support for mental health or substance difficulties whilst in prison. To address this it was agreed that where this declaration, or request for support, was made to me, and where there was no evidence of acute psychological or emotional distress, the participant would be advised to make a referral to the prison health care team to discuss their healthcare needs. Additionally, it was agreed that if this was to occur during a focus group or interview, and assuming the absence of acute distress, the participant was to be asked if they wish to end their participation or continue to conclusion. Furthermore, it was agreed with the SPS that where there was evidence of acute distress during focus group participation or 1:1 interviews, irrespective of whether the participant had disclosed or not disclosed their heath needs, that person's participation would end and support from the local VICSO and mental health team would be sought.

4.2.3 Researcher safety and participant welfare

The study involved entry into a number of Scottish prisons and unsupervised contact with prisoners. As a prerequisite of obtaining access I had to conform to SPS policy, safety and security requirements, including basic security awareness training required to facilitate access to the prison environment. I was a former SPS employee and was aware of the personal and environmental risks and safeguards required to operate within a prison environment.

All participants were informed that participation did not influence access to prison or other support services, except where a prisoner experienced acute distress or an adverse reaction during a 1:1 interview or focus group. Their research packs did, however, provide details of health and welfare support services, including some that were veteran specific, which they could routinely access whilst in prison. Participants were also informed that no payment or reward for involvement in the research would be provided.

The current study pre-dated NHS Scotland's adoption of responsibility for healthcare in Scottish prisons. NHS research and ethics approval was, therefore, not required for this study. Approval was obtained from both the Scottish Prison Service's and the University of Stirling's School of Health Sciences' Research and Ethics Committees (received 8 December and 1 December, 2011 respectively, and amendment approval obtained 10 October 2012).

The remainder of this chapter will now describe each component part of the study.

4.3 Part 1: Quantitative survey design, method and sample

Part 1 of the research had two principal purposes. The first was exploratory, testing the following hypotheses:

1. The mental health of veterans in prison does not differ from the mental health of veteran prison staff.
2. The substance use, including alcohol use, of veterans in prison does not differ from the substance use of veteran prison staff.
3. Veterans in prison and veteran prison staff have the same past personal and military experience and exposure to combat and trauma.

4. The mental health of veterans in prison does not differ from the mental health of prisoners with no military experience.

5. The substance use, including alcohol use, of veterans in prison does not differ from the substance use of prisoners with no military experience.

6. Excluding military service, the socio-demographic characteristics and childhood history of veterans in prison are the same as that of prisoners with no military experience.

The second purpose was to generate data that can be compared against the qualitative data reported for parts 2 and 3 of the study. Although parts 2 and 3 used IPA as a method of analysis and involved an exploration of the meaning behind personal experiences, it is both possible and valuable to compare the evidence of the reported 'lived experience' with the findings from the quantitative analysis in order to gain a deeper understanding and address the research aims more fully.

4.3.1 Sampling and participant demographics

This component of the research involved three separate participant groups. In agreement with the SPS, all participants were male. Group 1 consisted of veterans incarcerated in Scottish prisons. Participants to this group were specifically targeted to take part in this phase of the study. Invites were sent, via local prison VICSOs, to prisoners, residing in those prisons that had agreed to participate, who had self-declared their veteran status to the SPS or their local VICSO. No formal verification of veteran status was made by the researcher or the SPS. While an attempt was made to target known veteran prisoners, it must be acknowledged that this did not comprise the total veteran prisoner population as many choose not to declare their veteran status to the SPS. This specific targeting of veteran prisoners combined with the opt-in method of recruitment, detailed below for Group 2, is typical of a purposive sampling approach.

Group 2 consisted of prisoners in Scottish prisons who had no military experience. The sampling process adopted for Group 2 was one of convenience and there was no specific targeting of non-veteran prisoners to support recruitment.

Both groups comprised of sentenced and un-sentenced/ untried male prisoners under the age of 65 years. Female prisoners were excluded from the study due to the very small number of female veteran prisoners in Scottish prisons and the potential for this to breach their anonymity. No other formal matching of groups for research purposes occurred. All prisoners were located in adult male prisons restricting the lower age to 21 years and the majority, more than 90% of Scottish prisoners, would have had a low or medium supervision level (Scottish Government, 2011). Eight adult male prisons from across Scotland provided the Group 1 study participants. For Group 2, participants were recruited from five adult male prisons, although individual participant locations were not recorded. Group 3 comprised of staff who were directly employed by the SPS who worked in offender management, leadership, policy or administrative roles, within publicly operated prisons or SPS Headquarters. All were male and between the ages of 21 and 65 years at the time of the study, who had previous military service. Initially, a target sampling approach was adopted with this group using local VICSOs' knowledge. This was amended to a snowball sampling approach to address problems with the recruitment process.

The UK definition of what constitutes a veteran was used irrespective of the nationality of the veteran who participated. Reservists or territorial personnel were excluded from participating during Part 1 as the study looked to examine the number of years the person had been in full active military service. For this reason the non-veteran participants in Group 2 excluded prisoners who had Reservist or Territorial Army

personnel experience and staff participants in Group 3 only included former fully enlisted military personnel.

4.3.2 Recruitment of participants

Given that veteran prisoners were dispersed across the Scottish prison estate, recruitment of participants to Group 1 was to be from all 13 adult male Scottish prisons. This, however, was restricted to 10 prisons due to difficulty obtaining local VICSO support from some of the smaller prison establishments. The initial plan for obtaining non-veteran prisoner participants, following agreement with the SPS, was to recruit from four large non-private Scottish prisons. During mid-2011, at the time of research proposal development, these prisons accounted for approximately 45% of the adult male Scottish prison population. This agreement was amended in 2012 to address recruitment challenges to allow for the recruitment of non-veteran participants from all adult male prisons, however not all prisons provided VICSO support to facilitate this, with only one additional prison agreeing to participate.

Prior to the study commencing I offered to visit all adult male prisons to discuss the research with prison senior management, VICSOs, and residential staff and to inform prisoners about the research. Eight prisons made initial arrangements for me to visit to speak with the VICSO and on one occasion to a small group of veteran prisoners. The VICSOs of a further two prisons made contact via the telephone to discuss the research and their potential involvement. Through the support of SPS and its VICSOs, the SPS electronic national record systems were used to identify prisoners who had voluntarily disclosed their previous military service. Additionally, VICSOs informed prison staff and other prison-based service providers of the study and requested that they inform any veterans they provided support to of the research. Posters advertising Part 1 of the

research were also provided to the SPS with a request that they be posted on residential location noticeboards in the prisons involved in the research.

In 2011, the SPS conducted a survey of 120 known veteran prisoners (Scottish Prison Service, 2011). This survey generated a response rate of 82%, a rate much higher than the normal SPS prisoner survey response of 62% (Scottish Prison Service, 2008, 2009). This high response figure was viewed by the SPS as being an indicator of veteran prisoners' willingness to engage in activities that were either veteran specific or may provide benefit to veteran prisoners. For this study, a simple *a priori* power calculation test on a proposed two-sampled t-test, setting power at 0.8 and with an Alpha rate of 0.05, indicated that a minimum of 64 participants were required for each group. The initial proposed plan was to recruit 120 veteran prisoner participants (Group 1) and 120 prisoners from the general prison population (Group 2) allowing for the submission of incomplete or defaced questionnaire booklets.

Given the high response rate to the SPS veterans' survey (Scottish Prison Service, 2011) and their average survey response rate (Scottish Prison Service 2008, 2009) it was reasonable to expect that at least 60% of veteran prisoners who had declared their veteran status to the SPS would participate and complete the questionnaire booklet. It was also envisaged that a further 25% of the veteran prisoners (a number between 35-40 prisoners) unknown to the SPS would participate after hearing of the study from their peers. These figures assumed that the SPS, at the time of study recruitment, had percentage rates for veteran prisoners similar to that found by Defence Analytical Services and Advice (DASA, 2010) for veterans in prison in England and Wales. When developing the study methodology it was recognised, however, that the number of veterans in prison comprised of a small percentage of the total prison population, that the number of veterans held in

custody fluctuates, and that not all veteran prisoners would wish to participate. It was also recognised that these issues could restrict or limit the availability of the total number of veteran participants to the study.

To obtain the required number of non-veteran prisoner responses, less than 4% of the general prison population from four large prisons would have had to complete and return questionnaire booklets. It was assumed that this low percentage target would be achieved through awareness raising of the study by VICSOs and by having easily accessible research packs. In practice, these assumptions were over optimistic and low recruitment to Groups 1 and 2 was encountered during the early recruitment phase. This resulted in amendments being made as to how awareness of the research and its aims were raised with potential participants, including VICSOs inviting me to veteran prisoner forums and other prisoner meetings to discuss the study. Changes were also made to the method of distributing research packs and how completed questionnaires were returned. The principal change required me to meet face-to-face with both veteran and non-veteran prisoners and directly provide them with research packs, following their request to participate, and to collect from participants or VICSOs the completed questionnaires which participants had sealed in envelopes. These revisions resulted in 77 veteran prisoners being recruited to Group 1 and 143 non-veteran prisoners being recruited to Group 2.

Group 3 consisted of SPS directly employed staff with a previous history of military service and no offending history. Working for the SPS confirmed that they had not received a prosecution for a criminal offence as a conviction bars a person for working within the organisation. Participants were initially recruited via poster and email advertising. Posters were placed in prison residential locations; however, this limited the

number of SPS staff exposed to them as many worked out with these areas. VICSOs also emailed their local prison staff informing them of the study but initial response numbers were low, as not all SPS staff had regular access to email communication during the timeframe of the study. Additionally, VICSOs were communicating directly with ex-Armed Forces colleagues informing them of the research and this did increase SPS staff awareness of the study. Such communication, however, was limited to only those ex-Armed Forces colleagues known to these staff and only those they had close or regular working contact with. It was this group that requested and received most of the research packs for Group 3 but few returned them.

During the recruitment phase the initial advertising process was insufficient in informing all potential veteran staff participants of the research. The SPS does not hold a central record of how many or which staff served in the military but there was an informal network with local knowledge within each of the prisons. Staff with military experience knew of other colleagues who had served. An attempt was therefore made to utilise this informal network and the recruitment process amended to include a 'snowballing' approach for the purpose of locating potential participants. Staff who had participated in the research were asked to inform their ex-military service colleagues of the research and whether they would be willing to receive an email communication providing further information. Where a positive response was received, an email containing information about the research was forwarded to them by their colleague. To remove any perception of implied coercion no information identifying the names of those staff members who agreed or refused when contacted were provided to me; however, this also prevented me from identifying whether this amendment to the recruitment process increased participation rates. The target initially was to recruit 70 veteran SPS staff and while it was recognised that achieving this could be problematic because it was unknown how

many SPS staff had military service, and the recognition that not all who did would volunteer to take part, 69 veteran staff were recruited into the study. This provided sufficient power for statistical analysis when comparing the veteran staff group with the veteran prisoner group.

4.3.3 Consent

Part 1 of the study is analogous to a "mail-shot" or "postal survey" approach, with questionnaire booklets being offered to all known veterans or following veteran request. The presumption was that those people who returned a completed booklet had consented to participate. Each participant was made aware of this consent process prior to participating in Part 1 of the study. A Participant Information Sheet detailing the purpose of the research and processes involved, and how consent would be obtained, was provided to all potential participants. This stated that implied consent to participate would be assumed once I had received the questionnaire booklet or the online survey submitted.

4.3.4 Data collection

There were separate research packs for veteran prisoners, non-veteran prisoners and the staff group. Research packs consisted of:

- A 'Participant Information Sheet' (Each group had its own specific information sheet. See Appendix 3 for an example).
- Information on how to give consent to participate in Part 1 of the study and the Consent Information Sheet (Appendix 4).
- Group specific questionnaire booklets (Appendix 5 for the veteran prisoner example).

After receiving approval from the SPS, I provided VICSOs with Part 1 research packs for veteran prisoner participants. The VICSO then disseminated the research packs to

known veteran prisoners within their establishment. The VICSO did this by either meeting with the veteran prisoner on a 1:1 basis or handing them out during their regular veteran prisoner group meetings. Later in the study, after attending their forum group meetings to discuss the research study, I was also directly involved in disseminating research packs to prisoners who had volunteered to participate.

Non-veteran prisoners volunteered to participate in the study by completing the questionnaire booklet. The research packs were located in residential areas where prisoners regularly congregated during prisoner association periods and in locations such as the prison library and education centre and were accessible without having to ask prison staff for assistance. However, many of these packs disappeared. The most likely reason for this was that the free availability of the packs provided access to postage stamps that were then used as a 'black market' currency within the prisons. After discussion with VICSOs changes were made to the process of providing research packs to Group 2 participants to prevent unrestricted access to the stamps and to ensure that packs were available to those who wished to participate in the study.

All participants were asked to work through and complete a single booklet containing a range of questionnaires and self-report measures. The Group 1 and 2 booklets (for veteran and non-veteran prisoners), albeit similar, were not identical, as they included demographic questions and self-report measurements relevant to their specific range of experiences. For example, only veteran participants were asked about their military service and combat experience. The veteran staff group were asked to complete an abridged version of the veteran prisoner questionnaire booklet, which excluded questions related to offending. Following feedback via the lead VICSO that some staff participants would have preferred to complete an on-line questionnaire, an amendment was made to

the study method to make available to SPS veteran staff an online version of their survey questionnaire booklet. The general themes covered by the questionnaire booklets were:

- General demographics
- Educational attainment and childhood experience
- Mental health and wellbeing, including alcohol and substance use, psychological trauma and personal resilience
- Offending histories and current reason for imprisonment (for prisoner groups)
- Military experience, including combat exposure (for veteran groups)

A number of these themes were addressed through the use of standardised questionnaires and self-report measures. Most have previously been used when researching veterans or prisoners, however not all have been formally validated for use with these groups. The questionnaires and self-report rating measurements used in the study are listed below followed by a brief summary of each.

- Global Assessment of Function (GAF) (American Psychiatric Association, 2000)
- General Self Efficacy Questionnaire (GSE) (Schwarzer and Jerusalem, 1995)
- Global Belief in A Just World Scale (GBJWS) (Lipkus, 1991)
- General Health Questionnaire 12 (GHQ12) (Goldberg, 1978)
- Patient Health Questionnaire 9 (PHQ9) (Kroenke, Spitzer and Williams, 2001)
- The Alcohol Use Identification Scale (AUDIT) (Babor *et al.*, 2000)
- Drug Abuse Screening Test 10 (DAST 10) (Bohn, Babor and Kranzler, 1991)
- Childhood Experience of Care and Abuse Questionnaire (CECA.Q3) (Bifulco *et al.*, 2005)

- The Short Form Buss-Perry Aggression Questionnaire (BPAQ-SF) (Bryant and Smith, 2001)
- Post-Traumatic Stress Disorder Checklist – Civilian Version (PCL-C) (Weathers *et al.*, 1993)
- Combat Experience Scale (CES) (Keane *et al.*, 1989) [veteran participants only].

The Global Assessment of Function Scale (GAF) (American Psychiatric Association, 2000) is a brief measure that integrates three different dimensions of individual functioning: psychological, social and occupational (Grootenboer *et al.*, 2011). Its purpose is to provide an easy and quick method of representing a patient's current level of functioning using a scoring range from 1 to 100, with lower scores reflecting greater levels of disability, loss of functioning and symptom severity (American Psychiatric Association, 2000). Some studies have demonstrated reliability (Jones *et al.*, 1995; Startup, Jackson and Bendix, 2002) while others have questioned this (Grootenboer *et al.*, 2011). Aas (2011) has suggested that there is inadequate guidance on how to use the scale which can influence how it is scored. However, it has been used within prison (Trestman *et al.*, 2007) and military (Schnurr *et al.*, 2003) populations previously.

The General Self Efficacy Scale (Schwarzer and Jerusalem, 1995) has been used in numerous research projects where it has been shown to be consistent and valid (Scholz *et al.*, 2002). It is a 10-item self-administered scale that measures perceived self-efficacy and the ability to cope with stressful life events. It has been used in both prisoner (Grieger, Hosser and Schmidt, 2012) and ex-military service (MacEachron and Gustavsson, 2012) populations.

Global Belief in a Just World Scale (Lipkus, 1991) is a 7-item measure developed by Lipkus in 1991 which rates the "*attributional process of whether people get what they*

deserve or deserve what they get" (Lipkus, 1991:1171) and has demonstrated good reliability when compared with other 'just world' measures (Hellman, Muilenburg-Trevino and Worley, 2008). Lipkus suggests that that people who believe in a just world tend to have a higher internal locus of control, are often more trusting and believe that personal and social justice exist.

The General Health Questionnaire (GHQ-12) (Goldberg, 1978) is a short self-completing 12-item measure of current mental health, focusing on the ability to engage in normal everyday functions. It provides a total overall score and it has been shown to be both valid and reliable (Goldberg *et al.*, 1997) being used extensively within both military (Fear *et al.*, 2009; Sundin *et al.*, 2012) and prison/ offender (HM Inspectorate of Prisons, 2007) populations.

The Patient Health Questionnaire-9 (PHQ-9) is a self-administered brief measure of depression severity which can also establish diagnosis (Kroenke, Spitzer and Williams, 2001). The severity measure can range from a score of 0 to 27 with each of the 9 items being scored from 0-3. A diagnosis of major depression can be made if five or more of the nine depressive symptom criteria have been present for at least 'more than half the days' for the preceding two-week period and if one of the symptoms reported is either depressed mood or anhedonia (loss of pleasure). For the purpose of this current study, the severity score and the five from nine symptom criteria, albeit, excluding the reporting of depressed mood or anhedonia, will be used. Validity of the questionnaire has been confirmed (Kroenke *et al.* 2001) and corroborated by others (Martin *et al.*, 2006). It has also been used with both prisoner (Horton *et al.*, 2014) and military populations (Iversen *et al.*, 2009; Cesur, Sabia and Tekin, 2013).

The Alcohol Use Identification Scale *(*AUDIT) is a self-report measure that consists of 10 questions focusing on recent alcohol use, alcohol dependence and alcohol related problems (Babor *et al.*, 2000). Babor *et al.* (2000) suggest scores of eight or more are recommended indicators for hazardous and harmful alcohol use. They also, however, suggest that a cut-off score of 10 will provide greater specificity in identifying those with and without hazardous or harmful use. It has strong validity and reliability (Hays, Merz and Nicholas, 1995) and has been widely used within both prison (Singleton *et al.*, 1998), including Scottish prisons (Parkes *et al.*, 2010; Graham *et al.*, 2012), and military / veteran (Rona *et al.*, 2010; Mattiko *et al.*, 2011) populations. For the purpose of this study, prisoner participants were asked to rate their alcohol use for the period prior to their current imprisonment.

Bohn and colleagues (1991) developed the Drug Abuse Screening Test 10 (DAST-10) to provide a brief measure of drug use. They suggest that a score of three or more correctly classified more than 93% of the patients in their study. A score of zero would indicate a person had no problems related to drug use, whereas a score of 9-10 would indicate a 'severe level' for problems relating to drug use. The DAST-10 has been shown to demonstrate satisfactory measures for reliability and validity (Yudko, Lozhkina and Fouts, 2007). The DAST-10 has been used with a veteran population (Norman *et al.*, 2010), whilst DAST-20, to which the shorter version has strong test reliability (Cocco and Carey, 1998), has been used previously with prisoners (Peters *et al.*, 2000).

The Childhood Experience of Care and Abuse Questionnaire (CECA.Q) (Bifulco *et al.*, 2005) is a self-report questionnaire that was developed to emulate the findings of an existing childhood experience of care and abuse interview measure (Bilfulco *et al.* 2005). The questionnaire assesses lack of parental care, in particular neglect and antipathy, as

well as measuring parental physical abuse and experiences of sexual abuse before the age of 17 years. Bilfulco *et al.* report that the CECA.Q has satisfactory reliability and validity. In 2011, version CECA.Q3 was developed (Bifulco, 2011) which added a measure of parental psychological abuse. In the current study, only questions regarding parental relationships, including psychological abuse, from CECA.Q3 (Bilfulco, 2011) were asked in detail. CECA.Q3 screening questions concerning sexual experiences and childhood punishment were used for data gathering as it was believed the severity questions could cause emotional distress to the study participants. I was unable to identify evidence that the measure had been used previously in either ex-military or offending populations.

The developers of the shortened 12-item Short Form Buss-Perry Aggression Questionnaire (BPAQ-SF) (Bryant & Smith 2001) argue that it is psychometrically superior to the original Aggression Questionnaire (Buss and Perry, 1992), whilst only having half the number of questions (Bryant and Smith, 2001). The shortened questionnaire still captures the four sub-domains, namely, physical and verbal aggressions and feelings of anger and hostility. Bryant and Smith (2001) state they used a 6–point scale in their shortened version instead of a 5-point scale that was used in Buss and Perry's original questionnaire. The current study, whilst using the shortened scale, used a 5-point measure. This is similar to the rating method used by Diamond and Magaletta (2006) when they tested the validity of the questionnaire in an American federal prisoner population.

The Post-Traumatic Stress Disorder Checklist – Civilian Version (PCL-C) (Weathers *et al.*, 1993) is a 17-item self-report checklist that assesses the DSM-IV symptoms of Post-Traumatic Stress Disorder (PTSD). It can be used to screen individuals for PTSD,

to assist with the diagnosis and to monitor change during and after intervention. There are three versions of the post-traumatic stress disorder checklist: one for military or ex-military populations, another for civilian populations, and the third which can be used to assess a specific stressful experience. In the current study, the PCL-C was used as it can be utilised with any population type, therefore allowing comparisons to be made between this study's veteran and non-veteran participants. The PCL has strong test reliability (Blanchard *et al.*, 1996) and has been used in military (Bliese *et al.*, 2008; Hourani *et al.*, 2012) and prison (Saxon *et al.*, 2001; Simpson *et al.*, 2007) populations. The PCL can be used to provide a single score for PTSD symptoms by summing the individual score for each of the 17-items resulting in a score ranging between 17 and 85. For research and diagnostic purposes, a cut-off score of 50 has been used by researchers (Blanchard *et al.*, 1996; Hoge *et al.*, 2004; Hotopf *et al.*, 2006) to distinguish between those with PTSD and those without. A PTSD diagnosis can also be determined by scoring the scale according to DSM-IV PTSD symptom criteria, for example, scoring 'moderately' or above for at least one item from questions 1-5, three items from questions 6-12, and two items from questions 13-17. Both scoring methods were used within this study and groups were compared against total scores, scores greater or less than 50, and using the diagnostic criteria method to distinguish a binominal yes/no score for diagnosis.

The 7-item Combat Exposure Scale (CES) is a validated measure (Keane *et al.*, 1989) that captures the frequency of exposure to various types of combat and has been widely used in the research of military and veterans (Killgore *et al.*, 2008; Wilk *et al.*, 2010; Van Voorhees *et al.*, 2012). Each item is rated on a 1-5 scale and then transformed using a weighted scoring key. Once each item score has been transformed the scores are totalled. A greater score represents greater combat exposure. Additionally, total scores can be

categorised on a 5-point range from light to heavy exposure to provide a second measure of combat exposure. Both measures were used in this study.

Additional questions relating to education, offending history and reason for incarceration were included in the general demographic section of the questionnaire booklet. These questions are similar to the demographic questions asked in the Scottish prison-based alcohol research (Parkes *et al.*, 2010) and those asked in the SPS bi-annual prisoner surveys. Postcode information detailing the general location of residence prior to incarceration was also requested from both veteran and non-veteran prisoner groups. Postcode data at the point of military discharge was also requested for both veteran prisoners and veteran staff groups. The intention was to use postcode data to identify the level of social deprivation associated with the residential locations of the study participants. This method of matching prisoner postcode data with areas of social deprivation has been carried out previously (Houchin, 2005). Finally, the veteran prisoner and staff groups were questioned on their military service and deployment experience.

Prior to the study commencing, the veteran questionnaire booklet was reviewed by a former member of the UK Armed Forces and comments for improvement of formatting and question content were sought and received. Then, after research and ethical approval of the study was obtained, each of the questionnaire booklets was completed by a volunteer participant to assess ease and accuracy of completion. No difficulties were identified at this time. As the three participants who piloted completion of the questionnaire booklets met group inclusion criteria and answered all the survey questions their data was included for analysis. Once wider data collection commenced, however, very few prisoner participants provided full postcode details limiting any comparison of geographical areas corresponding to the obtained postcodes. Additionally, the GAF scale

and parts of the CECA-Q3 questionnaire (questions on psychological abuse) were also poorly completed, limiting comparison between groups on these measures. A small number of participants also expressed difficulties with reading once they had started the survey and on these occasions a 'reader' (usually the VICSO, another prisoner who had completed the survey, or I) was chosen by the participant to assist in explaining some of the questions in the survey booklet. Such explanations, however, were not standardised. This would have resulted in different levels and types of guidance being provided to those participants who had difficulty interpreting some of the questions.

4.3.5 Confidentiality and data security

Lowman et al. (2001) note that "*The need for confidentiality arises in relationships where one party is vulnerable because of the trust reposed in the other and includes relationships where one party provides information to another because of the latter's commitment to confidentiality* (2001:2). Ensuring confidentiality is partially operationalised through the use of anonymity (Wiles *et al.*, 2008) although it also includes ensuring data is separated from identifiable individuals, storing coded data securely and ensuring those who have access to the data do not disclose what an participant has said that might then identify the participant (Wiles *et al.*, 2006). In this study, all questionnaires were anonymous and all raw data, transcripts and recordings were stored securely. On completion of the questionnaire booklet, prisoner participants were asked to seal the booklet in the envelope and return it to either the local VICSO, the officer's desk in their residential hall, or directly to me. Staff group participants who completed paper versions of the questionnaires were provided with stamped addressed envelopes and posted their own responses. Completed questionnaires were stored in a locked cabinet within a locked office on the University campus. Raw questionnaire data was loaded onto a password accessed university networked computer within an encrypted folder.

SPS staff who completed the online version of the questionnaire booklet were informed that no data entered into the survey would be stored or cached onto the local computer. They were informed that the server hosting the online survey would record IP addresses of the computers that accessed their website but these were securely stored by the service provider and could only be released following legal mandate. Participants were also informed that an IP address cannot, in itself, be used to identify the person completing the form as it is common for single IP addresses to be used for multiple web enabled devices. Access to completed surveys was restricted by password control to me as the survey administrator and completed online surveys were exported into the main SPSS data file.

4.3.6 Data analysis

Quantitative examination of the data obtained from the questionnaires and self-report measures was carried out comparing the results within and between groups. Separate analysis was conducted on all component questionnaires and measurement scales. Where a participant did not fully complete a component questionnaire or scale, this was removed from the statistical analysis, but all other completed questionnaires from the participant were included. Descriptive and inferential statistical analyses were carried out using the IBM's Statistical Package for the Social Sciences (SPSS) 19 computerised software package. The methods used to interrogate variables were determined by the type of scales used within the data collection tools and whether the distribution of individual measures' results were parametric or non-parametric.

Where non-parametric tests were used for analysis an attempt was made, within SPSS statistics software, to transform data with a skewed distribution using the Log10 transformation to permit the use of parametric tests. This is in recognition that parametric

tests, such as a *t-test*, on normal distributions are more accurate than non-parametric tests on non-normally distribution data. Logarithmic transformations are common in the normalising of variables in social sciences (Osborne, 2010). However, despite Log10 transformations the results still demonstrated skewed distributions. The transformed data was therefore rejected in favour of using the original untransformed data and analysed using non-parametric tests.

A test of significance set at $p<0.05$ for all tests was initially proposed; however, because of the large number of univariate analyses conducted, a *p*-value with an alpha (α) of 0.01 or less (usually regarded as being highly significant) was introduced. Nonetheless, this did not preclude a number of findings with an alpha between 0.05 and 0.01 being commented on. In addition to between-group statistical analysis, logistic regression was used to analyse whether military service and other identified variables contributed to the imprisonment of veterans and whether these influenced the presence of PTSD in prisoners. When developing models for logistic regression, variables with a $p\leq0.01$ and those whose significance was borderline ($p\leq0.05$) were included. Initial models proposed contained nine (examining imprisonment) and eight (examining PTSD) variables. The first model, for imprisonment, deviates from the 10 events per variable rule; however, it has also been suggested that using between five and nine variables poses little risk of type I or type II errors (Vittinghoff and McCulloch, 2007). Final models contain four and three variables respectively. An alpha threshold of 0.05 was used for significance testing when reporting logistic regression results.

4.4 Part 2: Qualitative design, method and sample for focus group

4.4.1 Participants

Part 2 of the study used focus groups for data gathering and adopted a purposive sampling model. Focus groups consisted of sentenced and non-sentenced veteran prisoners from Scottish prisons. As in Part 1 of the study, the UK definition of a veteran was adopted; veteran prisoners had to have been fully enlisted military personnel, including conscripted if not from the UK, in any branch of the military service, since 1970. Additionally, participation in the focus group was also open to former Reservist or Territorial Army personnel who had served at least one tour of duty in a combat or peace keeping zone since 1970. This was to allow for an examination of whether the perceived experiences of civilian living, military service and prison differed between reservists and regular service personnel. Such an examination, however, did not occur as only prisoners who had been regulars in the Armed Forces volunteered for Part 2 of the study.

4.4.2 Recruitment

It was planned that at least one, but no more than four, focus groups consisting of between 4-10 group participants would take place. The minimum number of participants required for Part 2 of the study was four and for pragmatic reasons, prior to commencing the study, the maximum number of focus group participants was to be capped at 40. Low participant response rates, cancellations and withdrawals meant that only one focus group, located in a single prison, took place but this was sufficient to allow IPA analysis. The focus group discussion was programmed to last approximately 90 minutes, with an additional 30 minutes allocated to complete introductions, demographic questionnaires and meeting closure but in reality the meeting was restricted to 90 minutes by SPS operational requirements. This however, proved sufficient to complete the discussion.

Prior to the commencement of Part 2, the local VICSO or designate was provided with Part 2 research packs. The VICSO was asked to forward a copy of the research pack to veterans who had indicated that they wished to participate after taking part in Part 1, hearing of the study via word of mouth, or via poster advertising. Part 2 research packs contained a Participant Information Sheet and a two part consent form.

4.4.3 Consent

Participation in Part 2 required signed informed consent and obtaining informed consent was a two-stage process. Stage 1 followed receipt of the research pack which summarised the research project and provided specific details of Part 2 of the study. Participants were asked to sign the first section of the consent form if they agreed to proceed further. At this point, participants were consenting to attend a focus group and have their names shared with the prison VICSO. There was no obligation to participate after signing the first section of the consent form and potential participants were able to withdraw. Stage 2 of the consent process involved meeting with me, immediately prior to commencing the focus group, and signing the second section of the formal consent form. Participants were also given a final verbal offer to withdraw prior to the groups formally proceeding.

4.4.4 Data collection

Data was gathered through the use of a facilitated focus group involving four participants. Although each participant was asked to complete a basic demographic questionnaire, the principal means of capturing data from focus group was through the recording of the group discussion on a portable digital recorder. The recording was transcribed verbatim maintaining the accented dialect of the participants to enable capture of colloquialisms, and group and cultural specific references, including slang and jargon.

Smith and Osborn (2007) note that transcribing for IPA is done at a semantic level where all the words spoken need to be recorded. This needs to be done with *"meticulous accuracy"* including mistakes, mis-hearings, pauses and other speech dynamics (Biggerstaff and Thompson, 2008:8) so one can make sense of the words used and of the person using them (Smith, 2007).

The general structure of focus group discussion was guided by a number of key questions, some of which included supplementary or follow up enquiries where required (Appendix 6). These key questions were supported by introductory and linking questions to facilitate a conversational approach, whilst moving from broad general discussions to the specific key areas of interest. Once the focus group had commenced, comments made or data provided could not be withdrawn from the study and participants were made aware of this prior to commencing.

After the focus group was completed, a backup digital audio file was transferred and placed in a password protected encrypted file and the original version entered into an NVivo password protected project file, which again was stored on a password accessed university networked computer. Transcribing of the focus group audio file was done by a contracted transcriber who had signed a confidentiality agreement before commencing. The transcribed records were up-loaded into NVivo and stored as described above.

4.4.5 Data analysis

Transcriptions from the focus group discussion were entered into NVivo software. Scrutiny of the qualitative data used IPA. IPA has traditionally been used whilst conducting 1:1 in-depth interviews and the methodology has been discussed in detail in Chapter 3. Within this research, the purpose was to explore and gain a greater understanding of how veterans in prison, when together in a group, perceive their

experience of incarceration. Using a group format acknowledges the 'in-group' status, or military identity, of veterans and the supportive nature of 'comradeship' to facilitate discussion (Hunt and Robbins, 2001). The aim of this approach was to encourage veteran prisoners to discuss their pre-prisoner military experience as well as their veteran prisoner experience. The use of IPA with focus groups is novel, and while the multiple voices and interactional complexity of the group may appear less suitable to this model of inquiry (Smith and Osborn, 2007), the potential benefits and challenges that this approach brings has also been identified (Tomkins and Eatough, 2010). Palmer and colleagues (2010) developed a protocol which they suggest other researchers can use as a prompt, rather than a 'recipe', when reflecting on focus group data. Tomkins and Eatough (2010) discuss methods of balancing the 'part-whole relationships' between the group and the individual, and the interplay between real time discursive and *post hoc* thematic sense-making, when analysing the data and constructing themes. The approaches and recommendations from both papers were used as a guide when analysing data from this study.

Transcribed data was entered into NVivo and the software was used to support annotation of the transcript, the initial analysis and identification of sub-themes. Limitations within the software, such as the inability to create tables of themes with transcript references, which have been commented on by others (Wagstaff *et al.*, 2014), however, prevented IPA from fully being carried out within NVivo. Manual analysis was then carried out grouping together and reviewing sub-themes and the development of sub-ordinate themes through to super-ordinate themes.

4.5 Part 3: Qualitative design, method and sample for 1:1 interviews

4.5.1 Participants

Part 3 of the study involved 1:1 semi structured interviews, regarded as the best method for collecting data for IPA studies (Smith and Osborn, 2007), with sentenced and un-sentenced prisoners, who had military experience and current mental health and/or substance use problems. A military experience cut-off date of 1970 was used to exclude veteran prisoners from participating who had served prior to this date. This cut-off date was used to exclude those veteran prisoners substantially over the age of 70 years from this part of the study minimising the unknown inclusion of participants with age related memory impairment. Doing so also excluded veterans who had been conscripted into UK National Service. The definition of what constitutes a military experience matched the veteran definition used for Part 2 of the study.

Within this study a veteran prisoner was deemed to have a mental health problem if he was currently receiving treatment, monitoring or support from the prison mental health service, prison addiction support service, or General Practitioner, irrespective of diagnosis. Veteran prisoners with a diagnosis of antisocial or psychopathic personality disorder, without a co-morbid Axis I mental health problem or substance use problem, were excluded. It is not unknown for veterans to have a diagnosis of personality disorder, including antisocial personality disorder (Bollinger *et al.*, 2000), nor is it uncommon to find antisocial personality disorder in an incarcerated population (Black *et al.*, 2010). The current recommendation, however, is for people with antisocial personality disorder who have a history of offending to engage in group-based cognitive and behavioural interventions that address their offending behaviour (NICE, 2010). Such programmes are

currently delivered in Scottish prisons, but are not the responsibility of, or delivered, by mental health or other healthcare services.

Veteran prisoners were deemed to have substance use problems if they had regular illicit drug use, drug dependence, and or were receiving harm reduction support or substitute prescribing. Substance use problems excluded the smoking of tobacco but did include alcohol problems and dependence and other psychological and behavioural problems associated with alcohol use. Participants had to have had a formal assessment whilst in prison confirming their difficulties with alcohol or drugs, or had to be engaged in, or waiting to begin, treatment or support within prison for problem drinking or substance use. The latter included contact in prison with statutory and non-statutory abstinence support services.

4.5.2 Specific ethical considerations

Part 3 of the research sought to specifically target participants with known health difficulties. To ensure prisoner welfare the local VICSO could raise a concern if they believed a potential participant was being put at risk if they entered the study. If a person was flagged as being a risk the Prison Governor, or their designate, was to be contacted to confirm whether the SPS had objections, on health and welfare grounds, to the volunteer participating. This process also acknowledged that the SPS had a veto, on grounds of security, on allowing a prisoner to participate in Parts 2 and 3 of the study. Although this appears to remove the rights of the individual for their voice to be heard, as Orb *et al.* (2000) note when discussing the principle of beneficence (doing good for others whilst doing no harm), a balance has to be found whereby the safety and wellbeing of the volunteer, other prisoners, prison staff and I had to be maintained. Nonetheless, no request was made by the SPS to exclude or remove a volunteer from the study.

4.5.3 Recruitment

Participants who met the Part 3 inclusion criteria were recruited from two SPS prisons. The intention was to recruit between 8 and 12 participants from at least four different prisons however several withdrawals and low recruitment numbers reduced participation to four prisoners taking part in 1:1 interviews. Each interview lasted approximately 60 minutes, with an additional 15 minutes allocated for introductions and completion of a demographic questionnaire.

The process for recruitment mirrored the process described for Part 2. The local VICSO or I then made Part 3 research packs available to those veteran prisoners who volunteered to participate. Part 3 research packs contained a Participant Information Sheet and a two-part consent form. The consent process was also similar to that described for Part 2 except in Part 3 participants were also consenting to having their names shared with the Prison Governor or their designate if additional security or welfare clearance was required.

4.5.4 Data collection

Prior to interview commencement, and following confirmation of consent, the participants were asked to complete a basic demographic questionnaire. Veteran prisoners then participated in a 60 minute, semi-structured, 1:1 interview (Appendix 9). All participants used pseudonyms to maintain anonymity. All interviews were digitally recorded and transcribed verbatim. The interviewer supplemented the recording of the interview with written comments and notes made during the interview. Participants were able to request to have their data withdrawn from the study for a period of 1-week post interview. No requests were received. The data management, transcribing of interview audio files and storage of files was as described in Part 2.

4.5.5 Data analysis

All transcribed interviews were entered into NVivo 9 software for coding and analysis support, and an IPA approach used to explore the lived experiences of the interviewees. As described in Part 2, the limitation of the NVivo software prevented IPA being wholly carried out electronically and required the inclusion of manual analysis to identify and develop sub-ordinate and super-ordinate themes.

4.6 Chapter conclusion

This chapter details the methods used for conducting this study, explaining how the quantitative and the two qualitative components of the mixed method design were implemented. It describes how participants were identified and recruited to the study and how data was obtained and analysed. It also acknowledges some of the ethical challenges of conducting research in a prison environment.

Prisons are environments where mundane and routine objects develop a value. Objects such as envelopes and stamps develop a worth and appeared to be taken by those who had no wish to participate in the study. New processes had to be adopted following discussion with local VICSOs that addressed these and the other challenges that arose.

It was not just routine objects that developed a worth: information also has a value in prison. Prisoners are wary of disclosing personal information; particularly where they believe the prison system (and on occasion other prisoners) will have access to this information. To address this concern, participant information had to be unambiguous and consent processes explicit for each of the study's component parts. It was also important to recognise the need for anonymity. The protection of participants' identities was

essential given the small number who took part in the study focus group and 1:1 interviews and the nature of the information they were sharing.

Further comments on the strengths and weakness on the study design and the methods used will be discussed in Chapter 8. The next three chapters report the findings for Parts 1, 2 and 3 of the study.

Chapter 5 - Findings for Part 1 of the study: Veteran and prisoner comparisons

5.1 Introduction

This chapter tests the hypotheses noted in Chapter 4. To recap, these include identifying whether veteran prisoners and veterans who work for the SPS have the same mental health problems and/or drug or alcohol use, the same socio-demographics and childhood histories, and whether these factors, excluding military service experiences, are the same for veteran prisoners and non-veteran prisoners. Analyses were carried out using univariate tests directly comparing a range of questionnaire responses. While the study used data from three groups, the analyses compared the data from Groups 1 and 3 and then Groups 1 and 2. The findings are reported in this order. Models, following logistic regression, are proposed to identify factors that influence veteran imprisonment and the presence of PTSD.

5.2 Respondent numbers

Group 1 consisted of veterans in prison. Group 2 comprised of prisoners with no prior military service, and lastly, Group 3 consisted of SPS staff that had prior military service and no offending history. Across the three groups there were a total of 289 respondents. Table 5-1 lists the number of respondents for each group.

Table 5-1: Number of respondents per group

Group	No. of respondents
Group 1: Veteran prisoners	77
Group 2: Non-veteran prisoners	143
Group 3: Veteran SPS staff	69
Total	289

Due to the methods used to distribute questionnaires, no note was taken of the numbers distributed within individual prisons, so it was not possible to estimate a response rate to the questionnaire survey. Further, given the small number of veteran prisoner responders for some of the prisons, and the need to ensure their anonymity, a breakdown of veteran prisoner respondent numbers per prison is not provided.

5.3 Comparison between veteran prisoners and non-imprisoned veterans

5.3.1 Comparison and summary of demographic features

Seventy-seven male veteran prisoners from eight Scottish prisons took part in the study. The 77 veteran prisoners were compared against 69 male SPS staff members who had previous military service. Table 5-2 provides a summary of general demographics for both groups.

There was a difference of almost 10 years in the mean age of both groups (SPS veteran staff group had an average age of 45 years [s.d. 9.7] compared with 36 years of age [s.d.10] for veteran prisoners). The veteran prisoner group were mostly found within the 20-39 age bands whereas the veteran staff group were within the 40+ age bands. SPS staff veteran participants were also more likely to be married or to report living with a partner whereas a majority of the veteran prisoner group were single or never married.

Although more veteran prisoners reported being separated or divorced compared with the SPS staff group, it was not possible to clarify whether the prisoner group regarded themselves 'separated' as a result of their incarceration.

There was no difference between the two groups on their educational attainment. The majority of both groups achieved school standard grade or equivalent exams. Although a greater proportion of staff group respondents reported achieving school higher grade (or equivalent exams) and degree/ professional qualifications, this did not reach statistical significance.

There were differences in who provided parenting to participants before the age of 17 years. While both groups reported a majority being raised by their birth mother, 19% of the veteran prisoners group reported being raised by a female figure other than their birth mother. This compared with 6% of the SPS veteran staff group. A similar pattern was found when looking at father-figures involved in parenting participants before the age of 17 years. Again, most SPS staff group respondents reported being raised by their birth father (94%), whereas more than a quarter (27%) of veteran prisoners reported being raised by a male figure other than their birth father. Both groups had respondents who reported having multiple mother and/or father parenting figures but these numbers were small. The veteran prisoner group reported a percentage rate twice that of the staff veteran group, as can be seen from Table 5-2, but there was no statistically significant difference in these figures. There was also a percentage difference in the proportion who reported being placed in a 'children's home'. This accounted for 13% of veteran prisoners compared with 3% of SPS veteran staff but this difference did not achieve a *p*-value of 0.01 or less.

Table 5-2: Group 1 and Group 3 demographics

	Veteran prisoners (Group 1)	Veteran staff (Group 3)	Pearson X^2	$p.^b$
Age band (%)	(*n= 77*)[a]	(*n= 68*)[a]		
• 20-29 years	35%	10%	33.418	<0.001
• 30-39 years	30%	7%		
• 40-49 years	22%	46%		
• 50+ years	13%	37%		
Marital status (%)	(*n= 77*)[a]	(*n= 67*)[a]		
• Married or living with partner	31%	79%	34.991	<0.001
• Single/ never married	51%	10%		
• Separated/ divorced or other	18%	10%		
Educational attainment	*(n= 76)*[a]	*(n= 67)*[a]		
• School leaving certificate or no qualification	20%	15%	3.236	0.36
• School Standard grade or equivalent	50%	40%		
• School higher or equivalent	18%	27%		
• Degree, professional qualification or equivalent	12%	18%		
Mother-figure before age of 17 (%)	(*n= 77*)[a]	(*n= 67*)[a]		
• Birth mother only	81%	94%	5.71	0.017
• Step, adopted, foster mother: female family, friend or other	19%	6%		
Raised by multiple mother-figures before age of 17 (% yes)	12%	6%	1.426	0.232
Father-figure before age of 17 (%)	(*no. 71*)[a]	(*no. 65*)[a]		
• Birth father only	73%	94%	10.255	0.001
• Step, adopted, foster father: male family, friend or other	27%	6%		
Raised by multiple father-figures before age of 17 (% yes)	11%	5%	2.02	0.155
Ever in a children's home (% yes)	*(no. 76)*[a] 13%	*(no. 67)*[a] 3%	4.794	0.029

a. The number of participants for each group that provided a response
b. Significance threshold set at p≤0.01

5.3.2 Adverse childhood experiences

A sub-component of the CECQ-3 questionnaire examines exposure to childhood physical and sexual assault. Participants were asked whether as a child or teenager they were repeatedly hit, punched, kicked or burned by a person in their family or in authority.

While 53% of the veteran prisoner group stated they had these experiences compared with 37% of the SPS veteran staff group, this difference failed to achieve significance (Fisher's Exact Test, p=0.065). Differences, nonetheless, were found when examining exposure to unwanted sexual experience before the age of 17 years. While the proportion who reported having these unwanted experiences were small, the differences were statistically significant. In the veteran prisoner group 18% of group participants reported having an unwanted sexual experience before the age of 17 years compared with 5% of the SPS veteran staff group (p=0.02). When questions on unwanted sexual experience were more specific, differences continued to be identified and achieved significance; were they *'forced or persuaded against their wishes to have sexual intercourse'* (Group1=16%, Group 3=0% p=0.001), or whether *'the unwanted sexual experience was with an adult or person in authority'* (Group 1=21%, Group 3=5%, p=0.01). For clarity, and as per CECQ3 guidance on scoring unwanted sexual experience responses, where a participant scored a response as 'unsure' this was scored the same as a 'yes' response.

Again using data obtained from the CECQ-3 questionnaire, analyses were conducted on whether respondents' key female and/ or male parenting figures were separated from them or died before respondents reached the age of 17 years. Although there appeared to be a percentage figure difference between the two groups for each of these, conducting Fisher Exact Tests found no statistical differences. Participants were also asked to rate their exposure to parental antipathy and neglect. Most participants provided ratings for their birth mother: 89% for the veteran prisoner group and 99% for the SPS veteran staff group. For father-figures, 97% of the SPS veteran staff group rated their birth father whereas in the veteran prisoner group 70% provided ratings for their birth father and a further 23% for their step father or mother's live-in partner. The remaining 7% of veteran prisoners provided ratings for other male family members or male friends that provided

parental responsibility for them. Mann-Whitney Tests were used to identify whether statistical differences occurred when comparing both groups' antipathy and neglect scores for both mother and father-figures. A statistically significant difference was identified (Table 5-3) between the two groups for father antipathy scores. Differences in mother neglect, mother antipathy and father neglect scores failed to achieve α threshold of 0.01; however, for mother antipathy scores (p= 0.04) and father neglect scores (p=0.02) this was marginal. Nonetheless, there is an indication that the veteran prisoner group experienced greater levels of mother and father antipathy and father neglect.

Table 5-3: Parental antipathy and neglect

	Participant group	N	Mean Rank	Sum of Ranks	Mann-Whitney U	*p.*[a]
Mother-figure total antipathy score from CECQ3	Veteran prisoner group	75	76.43	5732.00	1918	0.04
	Veteran staff group	64	62.47	3998.00		
	Total	139				
Mother-figure total neglect score from CECQ3	Veteran prisoner group	75	73.83	5537.00	2113	0.22
	Veteran staff group	64	65.52	4193.00		
	Total	139				
Father-figure total antipathy score from CECQ3	Veteran prisoner group	69	75.85	5233.50	1459	0.002
	Veteran staff group	62	55.04	3412.50		
	Total	131				
Father-figure total neglect score from CECQ3	Veteran prisoner group	69	73.33	5059.50	1633.5	0.02
	Veteran staff group	62	57.85	3586.50		
	Total	131				

a. Significance threshold set at p≤0.01

5.3.3 Military experiences

One participant from the SPS veteran staff group was an officer at the point of discharge from the military. All other veteran participants were non-officer class. Table 5-4 summarises which branch of armed service participants served in. A majority of both groups served in the Army with small numbers serving in the air force. Proportionally, a

greater percentage of the SPS veteran staff group served with the navy compared with the veteran prisoner group.

Table 5-4: Respondents branch of military service

	Veteran prisoners (Group 1) ***No.*** **(%)**	**Veteran staff group (Group 3)** ***No*** **(%)**
Army	65 (87%)	44 (66%)
Air Force	3 (4%)	7 (10%)
Navy	7 (9%)	16(24%)

Veteran prisoner group respondents commenced military service between the years 1965 and 2007 compared to 1966 and 2006 for the SPS veteran staff group. The number of years' completed service ranged from 0-41 years. The mean number of years' service for the veteran prisoner group was 5.7 years (s.d. 3.9) and 9.9 years (s.d. 7.2) for the SPS veteran staff group [*t-test* = -4.24, $p<0.001$]. It is suspected that the person who did not complete 1 year of military service took discharge during his basic training.

Table 5-5 provides a summary of the years of service broken into four-yearly bands. The groups' lengths of services differed ($X^2= 20.650$, $p<0.001$) with the veteran staff group enlisting for longer periods of service than the veteran prisoner group. Slightly less than 50% of the veteran prisoner group served less than four years whereas this period of service only accounted for 14% of the veteran staff group.

Differences in discharge type between the two groups were also identified ($X^2= 23.56$, $p<0.001$*).* Eighty-two per cent of SPS veteran staff participants reported obtaining an honourable discharge from their military service, whereas, 57% of the veteran prisoner

group's discharge was attributable to either medical or other discharge types[5]. Using the year 2013 as a fixed end-point, on average the veteran prisoner group had more recent military service. The veteran prisoner group obtained discharge from military service 13.8 years prior to 2013 compared with the veteran staff group which obtained discharge 18.9 years prior to 2013 (*t-test* = -3.348, *p*=0.001).

Table 5-5: Years in military service and discharge type

	Veteran prisoners (Group 1) ***No.*** **(%)**	**Veteran staff group (Group 3)** ***No*** **(%)**
0 to 4 years	34 (47%)	9 (14%)
4 to 8 years	24 (33%)	29 (44%)
8 to 12 years	10 (14%)	13 (20%)
12 plus years	4 (6%)	14 (22%)
	Veteran prisoners (Group 1) ***No.*** **(%)**	**Veteran staff group (Group 3)** ***No*** **(%)**
Honourable discharge	33 (43%)	54 (82%)
Medical discharge	15 (20%)	2 (3%)
Other discharge types	29 (37%)	10 (15%)

There were differences in their post-military employment (Table 5-6). More SPS veteran staff respondents reported obtaining full-time employment, training or education immediately after leaving military service whereas more veteran prisoners reported obtaining part-time/ casual employment or being unemployed. When combining full-time employment, part-time employment and training activities as a single employment criterion the difference was maintained. Only 15% of the veteran staff group reported being unemployed following discharge. The remainder reported being engaged in employment or training following discharge. This compared with 38% of the veteran

[5] Whilst participants were not specifically asked to define 'other discharge types' these can include general discharge, other than honourable discharge and judicial discharge, which can include dishonourable discharge.

prisoner group reporting that they had been unemployed following military discharge and 62% in some form of employment or training.

Table 5-6: Comparison of Group 1 and Group 3 employment post military

	Veteran prisoners (Group 1) *(no. 77)* [a]	**Veteran staff group (Group 3)** *(no. 67)* [a]	**Pearson X^2**	***p.*** [b]
Employment post military service • Full-time employment, training or education • Part-time, casual, voluntary employment or other • Unemployed	45% 17% 38%	76% 9% 15%	14.186	0.001
• Any employed or training • Unemployed	62% 38%	85% 15%	9.379	0.002

a. The number of participants for each group that provided a response
b. Significance threshold set at p≤0.01

5.3.4 Exposure to conflict theatres

Participants were asked to identify how many conflicts they had served in and which was the most recent (see Table 5-7). A small number of participants in both groups noted that they had not served in a conflict theatre. The 'Other' category mostly related to conflicts that occurred in various African countries, e.g. Sierra Leone, during the first decade of this millennium.

The number of conflict areas respondents were deployed to was also examined. Respondents were rated as being deployed to zero, one, two, or three or more conflicts. Chi squared test indicated that there was no difference between the veteran prisoner group and the veteran staff group on the number of conflict theatres participants were deployed to (X^2= 4.21, p=0.24). Further, examining whether participants were exposed to the most recent Iraq conflict or the conflict in Afghanistan, again, found no statistical difference between the two groups (X^2= 2.226, p=0.14).

Table 5-7: Comparison of Group 1 and Group 3 to conflict theatres

	Veteran prisoners (Group 1) ***No.*** **(%)**	**Veteran staff group (Group 3)** ***No*** **(%)**
None	10 (13%)	7 (10%)
Northern Ireland	13 (17%)	20 (30%)
Falklands	3 (4%)	11 (16%)
Gulf	8 (11%)	10 (15%)
Balkans	9 (12%)	1 (2%)
Iraq	17 (23%)	7 (10%)
Afghanistan	7 (9%)	7 (10%)
Other	8 (11%)	4 (6%)

Respondents' exposure to combat was examined using the Combat Exposure Scale (Weathers et al., 1993) which provides a weighted score to indicate the severity of a person's exposure to combat: the higher the score the greater the exposure to combat related activities, e.g. killing enemy combatants or witnessing comrades being killed or injured. There was no difference between the two groups in the severity of combat exposure [see Table 5-8]. The Combat Exposure Scale also incorporates a secondary method of measuring exposure to combat related experiences where individual scores can be assigned into one of five categories; 'light exposure', 'light to moderate exposure', 'moderate exposure', 'moderate to heavy exposure', and 'heavy exposure'. Analysing the data using category scores, albeit due to small participant numbers combing the latter two categories ('moderate to heavy exposure' and 'heavy exposure'), confirmed there was no difference in the level of combat exposure (X^2= 3.797, p=0.28) experienced between the two groups. Despite being deployed to different combat areas across different time periods, it seems that both groups were exposed to the same level and severity of combat.

Table 5-8: Mann-Whitney U analysis of Combat Exposure Scale total scores

	Participant group	N	Mean Rank	Sum of Ranks	Mann-Whitney U	*p.*[a]
Combat exposure scale total scores	Veteran prisoner group (Group 1)	75	71.80	5385.00	2265.00	0.576
	Veteran staff group (Group 3)	64	67.89	4345.00		

a. Significance threshold set at p≤0.01

5.3.5 Exposure to trauma

Despite there being no difference in the number of military deployments and exposure to combat there was a marked difference in PTSD scores when measured using the PTSD Checklist. Analysing these using a Mann- Whitney Test found the difference to be highly significant, with the veteran prisoner group scoring greater on the PTSD checklist than the SPS staff group (Table 5-9).

Table 5-9: Comparison of PTSD checklist total scores for Group 1 and Group 3

	Participant group	N	Mean Rank	Sum of Rank	Mann-Whitney U	*p.*[a]
PTSD Checklist score	Veteran prisoner group (Group 1)	75	87.2	6540	1035	<0.001
	Veteran Staff Group (Group 3)	63	48.43	3051		

a. Significance threshold set at p≤0.01

Using Fisher's Exact Test to analyse the PTSD Checklist's second scoring method (scores the presence of symptoms according to DSM-IV PTSD diagnostic criteria) also identified a significant difference between the two groups. Using this specific analysis a greater percentage of the veteran prisoner group had the presence of symptoms that matched the diagnostic criteria for PTSD. A third analysis was conducted using the PTSD Checklist which involved the creation of an arbitrary cut-off score to measure differences in symptom severity. As per other studies in this area of research (Blanchard *et al.*, 1996; Hoge *et al.*, 2004; Hotopf *et al.*, 2006), a score of 50 (out of 85) was used to differentiate

between those participants with high or low symptom severity: a score of 50 or greater indicates high symptom severity and a score of less than 50 indicates low symptom severity. Using Fischer's Exact Test, a highly significant difference was found between the two groups with the veteran prisoner group having more participants with a score of 50 or greater (47%) compared with the SPS veteran staff group (11%) (see Table 5-10 for the results of the 2nd and 3rd methods of analysis). In all three methods of analysing the presence of post-trauma symptoms, there were clear differences between the two groups. The veteran prisoner group had higher PTSD Checklist scores, and a greater proportion met the criteria for a PTSD diagnosis and experienced greater post-trauma symptom severity.

Table 5-10: Comparison of PTSD diagnosis and score greater than 50 for Group 1 and Group 3

		Veteran prisoner group (Group 1) (n=75)	**Veteran staff group (Group3) (*n=63*)**	***p.*[a]**
PTSD diagnosis	No Yes	30 (40%) 45 (60%)	53 (84%) 10 (16%)	<0.001
PTSD score >50	No Yes	40 (53%) 35 (47%)	56 (89%) 7 (11%)	<0.001

a. Significance threshold set at p≤0.01

5.3.6 Fairness, resilience and self-efficacy, and mental health and wellbeing

Both groups completed Lipkus' (1991) Global Belief in a Just World scale. Examination of groups' mean scores through independent *t-test* analysis found no difference (*t (141) =-1.273*, *p*=0.21). The SPS veteran staff group did, however, demonstrate greater self-efficacy when measured on the General Self Efficacy Scale (Schwarzer and Jerusalem, 1995). Analysed using the Mann-Whitney Test, the mean rank score for the SPS veteran staff group was 88.6 compared with a mean rank score of 56.21 for the veteran prisoner group: this difference being highly significant (*U*=1365, *p*<0.001).

Mental health and wellbeing was measured using Goldberg's (1978) General Health Questionnaire 12-item (GHQ-12) version and Kroenke *et al.*'s (2001) Patient Health Questionnaire (PHQ-9). A low GHQ-12 total score indicates little psychological distress whereas a high total score indicates the presence of psychological problems and high symptom severity. A high score on the PHQ-9 indicates the presence and severity of a depressive illness. Additionally, reporting the presence of five criteria from the nine individual criterions presented within the questionnaire can be used as a proxy indicator for the presence of symptoms consistent with having a diagnosis of major depression. Both methods of scoring the PHQ-9 were used.

The total scores of these measures were analysed for both groups using Mann-Whitney Tests. For the GHQ-12, the mean rank score was greater for the veteran prisoner group (mean rank 89) compared with the SPS veteran staff group (mean rank 51). This difference was statically significant (U=1166.5, p<0.001) with GHQ scores indicating that the veteran prisoner group had greater levels of psychological distress. Similar differences were found when comparing PHQ-9 questionnaires. Again, the veteran prisoner group's scores indicated a greater presence and severity of depressive symptoms compared with the scores of the SPS veteran staff group (U=1261.5, p<0.001). Further, 46% of the veteran prisoner group met the five from nine criteria, indicating the presence of major depression. This compared with 13% of the SPS veteran staff group (Fisher's Exact Test, p<0.001).

Feelings of aggression and hostility were measured using the Short Form Bus-Perry Aggression Questionnaire (BPAQ-SF) (Bryant and Smith, 2001). A Mann-Whitney Test was used to compare each group's questionnaire scores and significant differences between the two groups were found (U=947.5, p<0.001) suggesting the veteran prisoner

group had greater feelings of aggression and anger. However, due to a fault in a batch of questionnaires, only 49 from the 68 SPS veteran staff group fully completed this questionnaire. The fault resulted in a number of questionnaires only listing 11 of the 12 questions contained within the full measure.

5.3.7 Alcohol and substance use

Previous studies have found hazardous/ dependent alcohol and illicit substance use in veteran populations (Glass *et al.*, 2010; Back *et al.*, 2014). This study examined participants' use of alcohol using the Alcohol Use Disorders Identification Test (AUDIT). For the veteran prisoner group, their use of alcohol was examined for the period when they were last in the community. For the SPS staff veteran group, present day alcohol use was measured. Use of illicit substances was measured using the Drug Abuse Screen Test (DAST-10). Scores for both sets of measures were analysed using Mann-Whitney Tests and both found significant differences between the two veteran groups. Alcohol use scores for the veteran prisoner group were significantly greater than the scores for the veteran staff group (U=1037, p<0.001). This pattern was replicated for illicit substance use (U=1029, p<0.001) (see Table 5-11).

Categorising whether a participant was a hazardous/ dependent drinker (a score of 10 or more) also identified significant differences (Fischer Exact Test, $p<0.001$) between the two groups. A greater proportion of the veteran prisoner group met the scoring criteria for hazardous/ dependent drinking compared with the veteran staff group. Similarly, use of a conservative cut-off score of 3 out of 10 from the DAST-10, a score which indicates clinical intervention is required, identified more veteran prisoners who met this criteria compared with the veteran staff group (Fischer Exact Test, p<0.001) (Table 5-12).

Table 5-11: Comparing AUDIT and DAST-10 total scores

	Participant group	N	Mean Rank	Sum of Ranks	Mann-Whitney U	*p.*[a]
AUDIT Total Scores	Veteran prisoner group	73	81.79	5971.00	1037	<0.001
	Veteran staff group	59	47.58	2807.00		
	Total	132				
DAST-10 Total Scores	Veteran prisoner group	74	87.59	6482.00	1029	<0.001
	Veteran staff group	64	48.58	3109.00		
	Total	138				

a. Significance threshold set at p≤0.01

Table 5-12: Comparisons of hazardous/dependent drinking and DAST-10 score requiring an intervention

		Veteran prisoner group (Group 1) (n=75)	Veteran staff group (Group 3) (*n=63*)	*p.*[a]
AUDIT score ≥10, indicating hazardous/ dependent drinking	No	22 (30%)	42 (71%)	<0.001
	Yes	51 (70%)	17 (29%)	
DAST-10 score of 3 or more out of 10	No	33 (44%)	64 (100%)	<0.001
	Yes	41 (56%)	0 (0%)	

a. Significance threshold set at p≤0.01

5.3.8 Variables that independently influence veteran imprisonment

Logistic regression analyses using SPSS were conducted to identify which variables independently influenced, and to what degree, veteran imprisonment. One hundred and thirty-one participants from Group 1 and Group 3 were included in the analysis. Fifteen participants were excluded due to missing data. The veteran imprisonment variable was coded as 'yes imprisoned' and equal to 1; whereas, 'no imprisonment' was equal to 0. Two models were developed using variables that had demonstrated either significant ($p \leq 0.01$) and near significant ($p \leq 0.05$) differences between the two group comparisons, or had been identified in previous research as having an influence on veteran imprisonment (Shaw *et al.,* 1987; Kulka *et al.,* 1990; Benda *et al.,* 2003; Calhoun *et al.,* 2004; Erickson *et al.,* 2008; Copeland *et al.,* 2009). Model one included the variables: AUDIT score, DAST-10 score, marital status, mother antipathy scores, father antipathy

scores, father neglect scores, parented by non-birth mother, parented by non-birth father, and employment status post military discharge.

Results from model one (Table 5-13), where variables were entered into the model in a stepped procedure, found the full model at Block 9 to be statistically significant against the constant only model (X^2= 76.78 [df=9], p<0.001) with the Hosmer-Lemeshow goodness-of-fit statistic indicating that the model fitted the data (X^2= 6.15 [df=8], p=0.63). When examining the overall amount of variation in the dependent variable when explained by all the independent variables in the model, *Nagelkerke's* R^2 of 0.64 indicated a moderate relationship of 64% between the predictors and the prediction. Prediction success within the overall model was 82% (84% for no imprisonment and 81% for yes imprisonment). The *Wald* criterion demonstrated that the AUDIT score, DAST-10 score, marital status and being raised by non-birth mother all significantly influenced whether a veteran was imprisoned. The remaining variables in the model had no significant influence. For both AUDIT and DAST-10 scores, the *EXP(B)* values indicated that for each one-point increase in test-score the odds ratio for imprisonment increased by 1.07 times for AUDIT and 2.25 times for DAST-10. For marital status, if a veteran reported living alone (being single, divorced or widowed) he was just over three times more likely to be imprisoned. Being raised by a mother-figure other than the person's birth mother resulted in the person being 12 times more likely to be imprisoned. However, the robustness of the latter finding warrants caution given the large confidence interval for this variable. It is likely that this finding was influenced by the variable's small sample size.

Table 5-13: Veteran Imprisonment - Logistic Regression Model 1

	Model 1					
Variable	***β***	***Wald***	***Sig.[a]***	***EXP (β)***	***95% C.I. for EXP (β)***	
					Lower	***Upper***
AUDIT score	0.074	4.344	0.037	1.077	1.004	1.154
DAST-10 score	0.811	6.564	0.010	2.250	1.210	4.184
Marital status – not married or cohabiting	1.190	4.125	0.042	3.286	1.043	10.356
Mother-figure antipathy score	-0.028	0.422	0.516	0.972	0.894	1.058
Father-figure antipathy score	0.008	0.033	0.855	1.008	0.928	1.094
Father-figure neglect score	0.033	0.649	0.420	1.034	0.953	1.121
Raised by non-birth mother	2.504	5.608	0.018	12.237	1.540	97.251
Raised by non-birth father	0.784	0.911	0.340	2.158	0.445	10.477
Employment / non-employment post military discharge	0.784	1.297	0.255	2.189	0.568	8.435

a. Significance threshold set at $p \leq 0.05$

In model two (Table 5-14), the non-significant variables have been removed. In doing so the full model continued to be statistically significant when compared against the constant (X^2= 85.676 [df=4], $p<0.001$), the Hosmer-Lemeshow statistic continued to indicate a good fit between the model and the data (X^2= 4.354 [df=8], p=0.824), and there was little difference in the *Nagelkerke's* R^2 score (0.642 or 64%). There was also little difference in the overall model prediction success with model two also achieving 82% (86% for no imprisonment and 78% for yes imprisonment). All four variables (AUDIT score, DAST-10 score, marital status, and raised by non-birth mother), as demonstrated by the *Wald* criterion, continued to indicate significant influence on likelihood of veteran

imprisonment. Removing the non-significant variables from the revised model made little change to the *EXP(B)* values for AUDIT, DAST-10 variables and slightly increased the *EXP(B)* value for the marital status variable. It also had a greater increase in the *EXP(B)* value on the raised by non-birth mother variable increasing the odds ratio to 14.2 times. In summary, the revised model continued to show that an increase in AUDIT and DAST-10 scores continued to increase the likelihood of imprisonment. It demonstrated that veterans who were single, divorced or widowed were nearly four times more likely to be imprisoned when compared to veterans who were married of cohabiting. They were also 14 times more likely to be imprisoned if they were raised by a mother-figure other than their birth mother but, as with model one, this finding must be interpreted with caution given the reported confidence interval and the variable's small sample size.

Table 5-14: Veteran Imprisonment - Logistic Regression Model 2

Model 2						
Variable	***β***	***Wald***	***Sig.[a]***	***EXP (β)***	***95% C.I. for EXP (β)***	
					Lower	***Upper***
AUDIT score	0.063	4.029	0.045	1.065	1.001	1.133
DAST-10 score	0.731	5.994	0.014	2.076	1.157	3.727
Marital status – not married or cohabiting	1.417	8.363	0.004	4.125	1.579	10.776
Raised by non-birth mother	2.652	8.825	0.003	14.183	2.465	81.579

a. Significance threshold set at $p \leq 0.05$

5.4 Comparison between veteran prisoners and non-veteran prisoners

5.4.1 Non-veteran prisoner demographics and comparison with veteran prisoners

As mentioned in section 5.2, the veteran prisoner group (Group 1) consisted of 77 male participants and the non-veteran prisoner group (Group 2) consisted of 143 male participants. A summary of general demographics comparing Group 2 participants with Group 1 is provided in Table 5-15.

Both groups had the same age profile: the mean ages of both groups were similar and there was no statistical difference when comparing the two groups across age bands. There was no significant difference in marital status: the single or never married category accounted for more than 50% of both groups. There were no differences in employment experiences prior to entering prison: the largest proportion of both groups identified themselves as being unemployed prior to incarceration. More than a third of the non-veteran prisoner group reported leaving school with either no formal qualifications or a school leaving certificate. This compared with one in five of the veteran prisoner group. This was reversed when comparing the next educational category (school standard grade or equivalent) with a majority (50%) of the veteran prisoner group noting that they had achieved this qualification compared with a third of non-veteran prisoners. Overall, 80% of the veteran prisoner group obtained some form of educational qualification compared with 64% of the non-veteran prisoner group. Despite these differences, statistical significance was not achieved, albeit only marginally failing to do so (p=0.02).

Table 5-15: Group 1 compared with Group 2 for demographics

	Veteran prisoners (Group 1)	Non-veteran prisoner (Group 2)	Pearson X^2	*p.*[b]
Mean age (range)	36yrs (22-64yrs)	35yrs (21-62yrs)	.	.
Age band (%)	(*n= 77*)[a]	(*n= 142*)[a]		
• 20-29 years	35%	39%		
• 30-39 years	30%	28%		
• 40-49 years	22%	24%	1.002	0.8
• 50+ years	13%	9%		
Marital status (%)	(*n= 77*)[a]	(*n= 142*)[a]		
• Married or living with partner	31%	35%		
• Single/ never married	51%	54%	2.030	0.36
• Separated/ divorced or other	18%	11%		
Educational attainment	*(n= 76)*[a]	*(n= 136)*[a]		
• School leaving certificate or no qualification	20%	36%		
• School Standard grade or equivalent	50%	32%		
• School higher or equivalent	18%	24%	9.527	0.02
• Degree, professional qualification or equivalent	12%	8%		
Employment pre prison sentence	*(n= 77)*[a]	*(n= 143)*[a]		
• Full-time employment, training or education	33%	29%		
• Part-time, casual, voluntary employment or other	22%	15%		
• Unemployed	45%	56%	2.559	0.28
• Any employed or training	55%	44%	2.207	0.14
• Unemployed	45%	56%		
Mother-figure before age of 17 (%)	(*n= 77*)[a]	(*n= 143*)[a]		
• Birth mother only	81%	97%		
• Step, adopted, foster mother: female family, friend or other	19%	3%	15.476	<0.001
Multiple mother-figures before age of 17 (% yes)	12%	16%	0.778	0.38
Father-figure before age of 17 (%)	(*n= 71*)[a]	(*n= 134*)[a]		
• Birth father only	73%	87%		
• Step, adopted, foster father: male family, friend or other	27%	13%	10.255	0.018
Multiple father-figures before age of 17 (% yes)	11%	13%	0.196	0.66
Ever in a children's home (% yes)	*(n= 76)*[a] 13%	*(n= 143)*[a] 32%	9.423	0.002

a. The number of participants for each group that provided a response
b. Significance threshold set at p≤0.01

When examining early parenting experiences, for group participants before the age of 17 years, differences were found. A majority of both groups reported that they were raised up to the age of 17 years by their birth mother; however, only 3% of the non-veteran

prisoners group reported being raised by a female figure other than their birth mother compared with 19% of the veteran prisoners group. A less pronounced difference was found when looking at father-figures involved in care before the age of 17 years. More of the non-veteran prisoner group reported being raised by their birth father (87%) compared with 73% of the veteran prisoner group, a result which just failed to achieve significance (p=0.018). There was no difference between the groups when examining whether participants had been raised by multiple mother or multiple father-figures.

Where participants had been raised by multiple mother or father-figures, it accounted for approximately one in ten of both Group 1 and Group 2 respondents. When examining the experiences of participants who had been removed from the family home, a significant difference was found between the groups: nearly a third of non-veteran prisoners reported spending time in a 'children's home' compared with around one in eight from the veteran prisoner group.

5.4.2 Adverse childhood experiences

Childhood exposure to physical assault, such as experiencing repeated hitting, punching, kicking or burning by a parent or person in authority or of being forced, including by an adult or person in authority, into an unwanted sexual experience before the age of 17 years were also examined using Fisher's Exact Tests. Proportionately more veteran prisoners (18% compared with 12%) reported unwanted sexual experiences, however, the difference did not achieve significance. For physical assault, around half of both groups reported being assaulted as a child or teenager with no statistical difference between the two groups identified.

There were no differences between the groups regarding their experiences of either separation from, or death of, key female or male parenting figures before the respondent

reached the age of 17 years. Where separation from a parent or parental death had taken place, numbers were very small and the profile for both groups was similar. Examining participants' experience of parental antipathy or neglect did find differences between the two groups. Similar to the veteran prisoner/ SPS veteran staff group comparison described earlier, most participants provided ratings for their birth mother. As described previously, 89% of the veteran prisoner group provided ratings for their birth mother. This compared with 93% of the non-veteran prisoner group. For father-figures, 70% of the veteran prisoner group provided ratings for their birth father, 23% for their step-father or their mother's live-in partner, and the remaining 7% for other male family members or male friends. In the non-veteran prisoner group, 83% provided ratings for their birth father, 10% for their step-father/ mother's live-in partner and 7% rated other male family members or other male figures.

Table 5-16: Comparing Group 1 and Group 2 for parental antipathy and neglect

	Participant group	N	Mean Rank	Sum of Ranks	Mann-Whitney U	*p.*[a]
Mother-figure total antipathy score from CECQ3	Veteran prisoner group	75	117.61	8821.00	4229	0.04
	Non-veteran prisoner group	136	99.6	13545.00		
	Total	211				
Mother-figure total neglect score from CECQ3	Veteran prisoner group	75	116.91	8768.5	4281.5	0.05
	Non-veteran prisoner group	136	99.98	13597.5		
	Total	211				
Father-figure total antipathy score from CECQ3	Veteran prisoner group	69	108.4	7479.5	3284.5	0.01
	Non-veteran prisoner group	121	88.14	10665.5		
	Total	190				
Father-figure total neglect score from CECQ3	Veteran prisoner group	69	103.78	7161.0	3603	0.12
	Non-veteran prisoner group	121	90.78	10984.0		
	Total	190				

a. Significance threshold set at p≤0.01

Mann-Whitney Tests were used to identify whether differences occurred between groups for both mother and father-figures antipathy and neglect scores. No differences between groups were identified for the father-figure neglect scores, suggesting that both groups experienced the same level of father neglect. As can be seen in Table 5-16, however, there were statistically significant differences between the two groups for father antipathy scores. Mother antipathy scores and mother neglect scores failed to achieve a significance level of 0.01 or lower. In these measures the veteran prisoner group had greater scores indicating greater levels of experiencing father antipathy. They also experienced higher levels of mother antipathy and neglect despite these findings not achieving significance.

5.4.3 Offending histories

Three quarters of the non-veteran prisoner group had been in prison before compared with 64% of the veteran prisoner group, although this difference was not significant. Nearly a half of veteran prisoners stated that while in prison they mixed with non-veteran prisoners most or all of the time. Only around 5% of veteran prisoners stated that they did not mix with other non-veteran prisoners (Table 5-17).

The majority of both groups (83% veteran prisoner group and 92% non-veteran prisoner group) had been convicted of an offence and were serving a sentence in custody as a consequence. The remaining participants had been remanded to custody and were awaiting trial or sentencing. Length of sentence differed between the two groups, as did offence type.

Table 5-17: Veteran prisoners who mix with non-veteran prisoners

Mix with non-veteran prisoners	Per cent
None of the time	5.2
Some of the time	37.7
Unsure	11.7
Most of the time	14.3
All of the time	31.2
Total	100.0

Comparing sentence length found significant statistical differences between the two groups (p=0.005). While the majority of sentenced prisoners for both groups were serving sentences of less than four years duration, 46% of the veteran prisoners group were serving a sentence of more than four-years compared with 25% of the non-veteran prisoner group (see Figure 5-1). A similar pattern was observed with regards to offence type. Offences were classified as being violent or non-violent. In addition to offences that are clearly violence related, i.e. homicide or serious assault, offences were also deemed violent if they included crimes of a sexual or indecent nature and handling or carrying an offensive weapon. A greater percentage of veteran prisoners (68%) committed a crime involving violence compared with the non-veteran prisoner group (53%), although this relationship between veteran prisoner group and offence type failed to demonstrate significance (p=0.04).

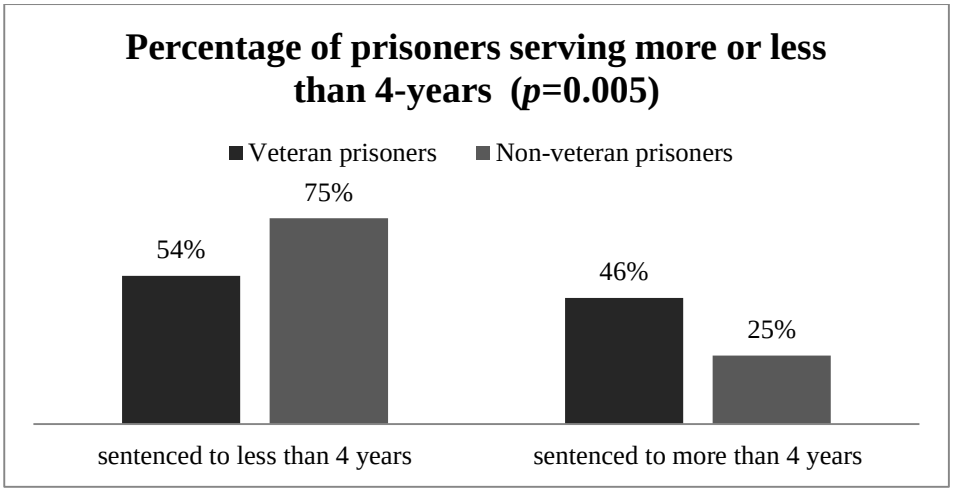


Figure 5-1: Comparing length of sentence for Group 1 and Group 2

5.4.4 Fairness, resilience and self-efficacy, and aggression

Examination of the mean scores obtained from Lipkus' Global Belief in a Just World Scale through independent *t-test* found no difference between the veteran prisoner group and the non-veteran prisoner group. Indeed, the mean scores of all three groups were similar; veteran prisoner group M=20.08 (s.d.=7.14), non-veteran group M=21.01 (s.d.=7.38), and the SPS veteran staff group M=21.6 (s.d.=7.24), and were similar to mean scores from Lipkus' original paper (Lipkus, 1991). Additionally, *t-test* analysis of General Self Efficacy Scale mean scores found no differences between the two prisoner groups indicating that both prisoner groups expressed the same levels of self-efficacy ($t(213) = 0.831$, $p = 0.407$). While the veteran prisoner group scores on the Short Form Bus-Perry Aggression Questionnaire appeared to show that they experienced greater feelings of anger and hostility, a Mann-Whitney test found that this just failed to reach significance ($U = 3885$, $p = 0.04$).

5.4.5 Psychological wellbeing, mental health, and PTSD

It is recognised that across the globe poor mental health is an issue in prisons (WHO, 1999; Blaauw, Roozen and Van Marle, 2007) and in section 5.3.6 it was identified that

the veteran prisoner group had poorer psychological health and were more likely to be depressed when compared with the SPS veteran staff group. Mann-Whitney analysis of GHQ-12 scores comparing the veteran prisoner group with the non-veteran prisoner group's psychological wellbeing also found a significant difference between the two groups with the veteran prisoner group having poorer psychological health than prisoners from the group with no past military experience (U=4058, p=0.002). Despite this difference in psychological health, there did not appear to be a difference when analysing PHQ-9 data for the presence of symptoms of depression or the presence of criteria suggesting a diagnosis of major depression. A Mann-Whitney test on PHQ-9 scores (an indicator of symptom severity) found that while the veteran prisoner group's mean rank score was greater than the non-veteran prisoner group's mean rank score (188.55 compared with 102.11), suggesting a greater presence of depressive symptoms in the veteran prisoner group, the test statistically failed to achieve significance (U=4500.5, p=0.06). Fisher's Exact Test on the PHQ-9 scoring for the presence of major depression also failed to show any relationship with either group (p=0.181) suggesting that both groups scored similar for the presence of major depression.

Post-traumatic Checklist scores for both groups were also analysed using the Mann-Whitney test. Results identified a highly significant difference between the two groups (U=3481, p<0.001) with the veteran prisoner group's scores being greater than those of the non-veteran group. The veteran prisoner group had a mean rank of 125.59 compared with the non-veteran prisoners' mean rank of 93.48, suggesting that the veteran prisoner group experienced a greater number of PTSD symptoms. The veteran prisoner group and the non-veteran prisoner group were also compared using both the alternate PTSD Checklist scoring for PTSD diagnosis and the 'cut-off' score comparison method. Analysed using Fisher's Exact Tests, both achieved significance, confirming that the

veteran prisoner group had greater PTSD symptom presentation and PTSD diagnosis when compared to the non-veteran prisoner group. Table 5-18 provides a summary of the test results.

Table 5-18: Comparing Group 1 and Group 2 PTSD diagnosis and PTSD score greater than 50

		Veteran prisoner group (Group 1) (n=75)	Non-veteran prisoner group (Group2) (*n*=134)	*p.*[a]
PTSD diagnosis	No	30 (40%)	86 (64%)	0.001
	Yes	45 (60%)	48 (36%)	
PTSD score >50	No	40 (53%)	98 (73%)	0.006
	Yes	35 (47%)	36 (27%)	

a. Significance threshold set at p≤0.01

5.4.6 Alcohol and substance use

Studies have examined the use of alcohol (Jacobson, Ryan and Hooper, 2008; Iversen *et al.*, 2009; Schumm and Chard, 2012) and drugs (Martin *et al.*, 2010; Prigerson, Maciejewski and Rosenheck, 2002) in military populations and studies have commented on substance and alcohol use of prisoners (Fazel, Bains and Doll, 2006; Sirdifield *et al.*, 2009). This study sought to identify whether the use of substances differed between prisoners who had a history of military service and prisoners with no previous military experience. AUDIT and DAST-10 measures were used to identify whether veteran prisoners and non-veteran prisoners had the same or different substance use. Both measures were analysed using Mann-Whitney tests and no differences for either measure were found. For AUDIT scores the mean rank for the veteran prisoner group was 108.12 and the mean rank for the non-veteran prisoner group was 95.3, suggesting the veteran prisoner scores were greater, although this difference was not statistically significant (U=4006.5, p=0.129). For the DAST-10, the pattern was reversed with the non-veteran prisoner group having a mean rank of 107.81 and the veteran prisoner group having a mean rank of 95.8 (U=4314.5, p=0.159). The non-veteran prisoner group scores were

greater but, again, there was no significant difference. Further, using Fisher's Exact Tests, no differences between the two groups were found when examining whether or not respondents were hazardous/dependent drinkers (AUDIT score of 10 or more) (p=0.26), or whether they required intervention for illicit substance use (DAST-10 score of 3 or above) (p=0.281). The results for the AUDIT and DAST-10 analyses suggest that drug and alcohol use for both groups was similar.

5.4.7 Variables that independently influence the diagnosis of PTSD

To identify which variables independently influenced the presence of a PTSD diagnosis, logistic regression analyses was carried out using SPSS software. The total number of participants included in the analysis was 187. From Groups 1 and 3, 33 cases were excluded from analysis due to missing data. As discussed earlier PTSD diagnosis was ascertained using the diagnosis scoring method from the PTSD Checklist questionnaire. The variable was split into 'no diagnosis' which equalled 0 and 'yes diagnosis' which equalled 1. Again, two models were developed: the first model using variables that previous studies have demonstrated influence PTSD development, e.g. exposure to childhood sexual abuse or physical violence (Sareen *et al.*, 2013), military service (Kulka *et al.*, 1990; Magruder and Yeager, 2009), neglectful parental approaches (Widom, 1999), hazardous alcohol consumption [can increase exposure to serious accidents or violence – see Rehm *et al.*, (2004)], self-efficacy (Ginzburg *et al.*, 2003; MacEachron and Gustavsson, 2012) and committing a violent offence (Evans *et al.*, 2007). The second model only included the variables that were identified as being significant influencers in model one. Table 5-19 and Table 5-20 summarise findings from both models.

Results from model one, where variables were entered into the model using a stepped procedure, found the full model at Block 8 to be statistically significant against the constant only model (X^2= 45.26 [df=8], p<0.001), with the Hosmer-Lemeshow goodness-of-fit statistic indicating that the model fits the data (X^2= 8.29 [df=8], p<0.41). However, it should be noted that a *Nagelkerke's* R^2 of 0.288 indicates a weak relationship of 29% between the predictors and the prediction. Nonetheless, prediction success within the overall model was 70% (79% for predicting no PTSD diagnosis and 59% for yes PTSD diagnosis). The *Wald* criterion demonstrated that experiencing physical violence before the age of 17 years from a parent or authority figure, being exposed to a forced sexual experience before the age of 17 years, having a veteran status, and a general self-efficacy score below group median were all significantly associated with having a PTSD diagnosis. Parental antipathy, parental neglect, committing a violent offence and being a hazardous drinker had no significant association with a diagnosis of PTSD. *EXP(B)* values shown that being physically hit by parent or authority figure before the age of 17 years increased the likelihood of having a PTSD diagnosis, as measured by the PTSD checklist, by nearly three-fold. Being a veteran increased the odds ratio by just over 2 times greater than if the prisoner was not a veteran. A self-efficacy score below the group median also increased the odd ratio two-fold. The greatest association was being exposed to a forced sexual experience before the age of 17 years, which increased the likelihood of a PTSD diagnosis by eight times.

Table 5-19: PTSD Diagnosis - Logistic Regression Model 1

	Model 1					
Variable	***β***	***Wald***	***Sig.[a]***	***EXP (β)***	***95% C.I. for EXP (β)***	
					Lower	***Upper***
Child hit pre 17	0.999	7.328	0.007	2.716	1.318	5.599
Forced sex experience pre 17	2.091	8.782	0.003	8.090	2.030	32.242
Veteran status	0.832	5.546	0.019	2.298	1.144	4.614
Parental antipathy	0.339	0.606	0.436	1.403	0.598	3.292
Parental neglect	0.268	0.456	0.500	1.307	0.601	2.842
Violent offence	-0.089	0.065	0.799	0.915	0.460	1.819
Hazardous drinker from AUDIT	0.415	1.314	0.252	1.514	0.745	3.079
General self-efficacy below score of 30	0.744	4.691	0.030	2.104	1.073	4.125

a. Significance threshold set at p≤0.05

Model two removed the non-significant variables from the model. In doing so the full model continued to be statistically significant when compared against the constant (X^2= 50.72 [df=4], p<.001), the Hosmer-Lemeshow statistic continued to indicate a good fit between the model and the data (X^2= 5.878 [df=7], p<0.554), and there was negligible change to the *Nagelkerke's* R^2 score, which now was 0.296 or 30%, and continued to indicate a weak relationship between the predictors and the prediction. When rounding was applied, there was a small change in the overall model prediction success to 71% and a slight change in prediction accuracy for both yes (reduced to 58%) and no diagnosis (increased to 81%). A self-efficacy score below the group median no longer had an association with PTSD. Three variables (child hit, forced sexual experience pre-17 years age, and veteran status), as demonstrated by the *Wald* criterion, continued to indicate a significant association with PTSD diagnosis. Removing the non-significant variables from model two did marginally change *EXP(B)* values. In model two, being physically hit by a parent or authority figure before the age of 17 years increased the likelihood of

having a PTSD to almost four times that of a person not hit by a parent or authority figure as a child. The odds ratio for being a veteran also increased to nearly three times greater than that of a non-veteran. There was a slight reduction in *EXP(B)* value for the variable 'exposed to a forced sexual experience before the age of 17 years'. In model two, a PTSD diagnosis was just over seven times more likely if a person was exposed to a forced sexual experience before the age of 17 years when compared with participant who did not experience this.

Table 5-20: PTSD Diagnosis - Logistic Regression Model 2

	Model 2					
Variable	***β***	***Wald***	***Sig.[a]***	***EXP (β)***	***95% C.I. for EXP (β)***	
					Lower	***Upper***
Child hit pre 17	1.347	17..09	0.000	3.845	2.039	7.252
Forced sex experience pre 17	2.016	8.481	0.004	7.505	1.933	29.142
Veteran status	1.043	9.611	0.002	2.836	1.467	5.483
General self-efficacy below score of 30	0.636	3.828	0.050	1.889	0.999	3.572

a. Significance threshold set at $p \leq 0.05$

5.5 Chapter summary and conclusion

5.5.1 Findings summary

Compared with the veteran SPS staff group, the veteran prisoner group were younger, more likely to be single or never married, and less likely to be raised by their birth mother or father. They were also more likely to have been forced to have an unwanted sexual experience before the age of 17 years and experience antipathy from their father-figure and possibly from their mother-figure. Differences were also noted with regards their military experience. The veteran prisoner group had more recent service but spent less

time engaged in the military and on leaving the military fewer veteran prisoners received an honourable discharge. The veteran prisoner group were also less successful in obtaining employment or training post military discharge. There was, however, no difference between the two veteran groups in the number of times they were deployed to conflict theatres nor was there a difference in combat exposure. Despite this, the veteran prisoner group presented with greater PTSD Checklist scores, had a greater proportion meeting PTSD diagnosis, and experienced worse post-trauma symptom presentations. They also scored greater for the presence of psychological distress, the presence of depression and had greater feelings of anger and less self-efficacy. The consumption of alcohol and the use of illicit drugs were also greater in the veteran prisoner group compared with the veteran staff group. Being raised by a female other than the birth mother, drug use, alcohol consumption and marital status, specifically being single or living alone all independently influenced the risk of veteran imprisonment.

Comparing the veteran prisoner group with the non-veteran prisoner group identified more similarities than differences. For example, both groups had the same age profile and there were similarities in their exposure to parental apathy and neglect, their exposure to childhood physical and sexual abuse, their marital status, and their employment pre-prison. Additionally, there were no differences found with regards to their self-efficacy, resilience or feelings of anger and hostility, nor did either group score as more depressed than the other or use more alcohol or illicit drugs. There were differences in who raised them before the age of 17 years, with fewer veteran prisoners being raised by their birth mother and more non-veteran prisoners having spent time in local authority care as a child. The two groups also had different sentence lengths with veteran prisoners serving longer prison sentences and appeared to have committed more violent offences, however, the latter failed to meet the strict alpha threshold. The veteran prisoner group did,

however, have greater scores for psychological distress and for PTSD across all methods of scoring their psychological trauma.

When analysing which variables had an influence on the presence of a PTSD diagnosis, being exposed to an unwanted sexual experience at an early age and being physically assaulted by a parent or person in authority greatly increased the likelihood of this diagnosis. What is also important to highlight here is that veteran status also increased the likelihood of a PTSD diagnosis, yet, as discussed earlier in this summary, comparison between the two veteran groups did not identify any combat or conflict related differences in military experience that might contribute to the occurrence of PTSD.

5.5.2 Conclusion

As mentioned in Chapter 4, one of the principal aims of this study was to test a number of hypotheses. The findings from this chapter provide answers to a number of these. Firstly, there were differences in mental health and wellbeing when comparing veteran prisoners and veteran prison staff. Veteran prisoners had scores indicating a greater presence of mental health difficulties and challenges to their wellbeing which differed from veteran staff across a number of measures, including PTSD. There were also clear differences in both alcohol and illicit substance use between the two veteran groups. Finally, there were also significant differences between the two groups in their length of military service and their experience of employment post discharge, but not in their exposure to conflict theatres or combat.

Hypotheses specific to veteran prisoner and non-veteran prisoner comparison were also addressed. The mental health of the two prisoner groups differed but not in all areas examined. For example, there were differences for PTSD but not for depression. There

were no differences in the use of alcohol or illicit substances when comparing the two prisoner groups but there were differences in socio-demographic characteristics, childhood history and offending.

The next two chapters will build on the results discussed here by providing insight following the interpretive phenomenological analysis of data provided by military veteran participants, some of whom had mental health difficulties, and their experiences of their military service and prison custody.

Chapter 6 - Findings for Part 2 of the study: IPA of focus group

6.1 Introduction

This chapter presents the findings following IPA of one focus group transcript of a discussion with four veteran prisoners. The analysis sought to identify what veterans perceived of their experiences of living in the community post-military service, their experiences of imprisonment, and views on their future transition from prison back into the community. They were asked about their key needs to identify whether, in their opinion, addressing these would improve the health and social welfare of veterans and reduce the likelihood of future offending. Whether the use of a focus group influenced how participants perceived their veteran identity, when discussing their experiences, was also explored. This piece of analysis examined how they perceived their identity, and the identity of other veterans, when in prison. Focusing the discussion and subsequent interpretative analysis on these topics addresses a number of the study aims; specifically, what veterans perceive to be the causes of their imprisonment and their experiences of being detained in prison; whether they have common pathways to imprisonment and common vulnerabilities that contribute to this; and what they believe is required to achieve social wellbeing and address their criminogenic needs.

The analysis is presented across two super-ordinate themes: 'Group Identities' and 'The needs of veterans'. Each of these super-ordinate themes 'parents' a number of sub-ordinate themes. When reporting the findings, quotations have been italicised. Changing the names of focus group participants maintained anonymity. Occasionally, separate but

related sections of dialogue have been combined removing irrelevant text. Where this has occurred […] has been inserted to represent the removal of text. Square brackets have also been used to link text addressing the same topic but from different speakers. Quotations have been transcribed keeping the language used by participants, including the use of words and grammar specific to this population group. Maintaining the original language and dialect presents a more accurate portrait of group participants and their lived experiences. I have, however, occasionally added text to assist with clarity or translation, also contained within square brackets.

6.2 Focus Group: participant portraits

Seven veteran prisoners completed Part 1 of the consent form volunteering to participate in study focus groups. Six were from one prison and the seventh from another. The latter had to be excluded from the study as no other volunteers came forward from this prison and he could not be moved to the other prison to facilitate participation. Of the six remaining volunteers, two failed to attend on the day of the focus group. Four participants took part in a single focus group and were aged between 26 and 40 years. All had served in the Army, with lengths of service ranging from 2 to 5 years, between 1996 and 2007, and three were honourably discharged. The fourth received a medical discharge following an acute short-lasting mental health problem. Two declined to state which military theatres they had served in, although their focus group contributions inferred that they had been deployed to a conflict zone. The remaining two acknowledged that they had been deployed to at least one area of conflict. None were married but three of the four reported having children. Only one had been in full-time employment prior to his imprisonment. All had been convicted and three were serving sentences from crimes associated with violence. Only one was serving a ‘long-term’ sentence of more than four

years. None of the four attributed their experiences of military service as a cause of their past or current offending. Appendix 7 summarises focus group participants' demographics and other key characteristics.

6.3 Super-ordinate theme 1: Group Identities

This super-ordinate theme examines focus group participants' perceptions of their identities as both veterans and prisoners, with them comparing and contrasting these with prison staff, some of whom had also served in the Armed Forces. Before this, the theme examined whether using a group format in data collection encouraged the expression of a military identity and supportive comradeship. This provided insight into how they agreed and disagreed with one another, how they provided support or critical feedback, and whether they expressed individualised and unique experiences, or collective and similar ones. This super-ordinate theme has two sub-ordinate themes. The first is 'unit and unity', and the second is 'the staff side of the fence'. Each sub-ordinate theme has its own sub-themes derived from the analysis of the focus group transcript (Figure 6-1) (Appendix 8 provides a specimen of emergent themes to sub-theme to sub-ordinate theme development using a component of 'unit and unity' as an example).

6.3.1 Theme 1.1: Unit and unity

Theme 1.1 addresses the use of the group format as a method of obtaining both individual and collective experiences from its participants. It examines how these experiences were expressed, how participants engaged with each other, and what their actions and comments implied. It also examines their position as an individual in the group and their part in developing the group as a single entity while looking at how group identity was formed. The theme then examines the group's view that veteran prisoners are different from non-veteran prisoners proceeding to then examine both conscious and

subconscious expressions and realisations that they were not different from other prisoners. There are two sub-themes within this sub-ordinate theme; 'Unity' and 'We are They'.

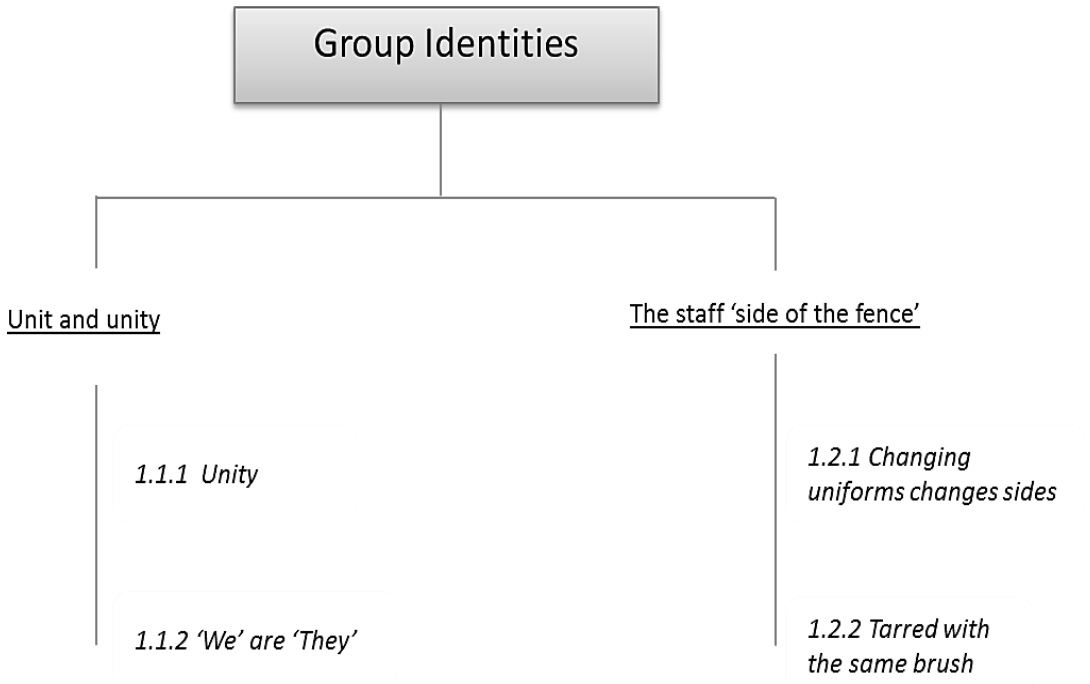


Figure 6-1: Super-ordinate theme 1: Group Identities

Sub-Theme 1.1.1: Unity

In addition to speaking from a common point of view or using common language, there were numerous examples of participants offering narratives as though they were coming from a single person. While different participants were speaking, and despite participants often starting or finishing each other's sentences, the narrative remained coherent as though it was being voiced by one person. They may have had similar past experiences or points of views, yet the way they communicated these inferred that not only did they share similarities in their experiences but also applied similar meaning to these. They appeared to speak with a 'unified voice'.

Adam:	*But when a first came oot* [of the Army]
Brian:	*ma life just went doon* [down] *hill completely.*
Adam:	*(sigh) Aye.*

[…]
Adam: *Just somebody to help ye wi* [with],
Craig: *…guide ye,*
Adam: *…gies ye* [gives you] *a wee, mare information, what's available oot there.*

The above examples conveyed not just a shared experience but also a shared meaning or expectation. The first demonstrated the frustration and anguish at the negative impact leaving the Army had on both Adam and Brian. The second inferred a shared understanding of the benefits of receiving additional support and guidance prior to discharge from prison and the transition back to civilian living. Even where the flow of the spoken word was less structured there was still commonality in how the response was expressed, for example repeating words the other person had used. Not only was the point that was being expressed clear for each contributor, the meaning being conveyed was also clear inferring a shared understanding.

Brian: *If they're better … Probably look at ye as if, like…*
Adam: *Yer* [you're] *looked doon oan* [on] *as if, as if they're well they're better than you.*
[…]
Adam: *It just follows you everywhere.* [Legacy of skills learned in the army]
Craig: *Disnae* [doesn't] *need to be in prison fur that tae follow ye.*

There were also examples where participants spoke at the same time and their simultaneous responses, whilst initially appearing unstructured, led to a convergence of meaning. In the following extract, for example, both participants were frequently speaking over each other yet without initially realising that both were attempting to convey the same point. This becomes evident when Craig eventually makes his concluding statement and Brian offers agreement.

Craig: *It's aw aboot* [about] *even (said together)…*
Brian: *brings people (said together) in yer heid* [head] *it's bringing ye all that wee bit closer…*

Craig: *Aye it's…*
Brian: *Yous can loosen up a wee bit mare* [more] *and get to know each other a bit mare an…*
Craig: *The socialising, the Army (said together – also Adam starts to talk)…*
Brian: *It brings the guys (said together), the guys, the guys (said together)…*
Craig: *the socialising (said together). The Army, maist* [most] *part of it is doon tae alcohol.*
Brian: *Mmmm.*

With the group looking to speak with one voice and working hard to be a cohesive single entity, they had to express 'sameness'. Each worked, at a conscious and subconscious level, to portray a uniformity of experience and identity to not just myself as the researcher but also to each other so that they felt, and made others feel, accepted as part of the group. At a subconscious level, group participants would use the same words as each other to convey similarities of the meanings they applied to their experiences. In the quotation below, Brian used the phrase 'wrang decision' when he speaks about his decision to leave the Army and though he had not finished speaking Craig interjects. Craig used the same phrase to convey that he had made the same mistake.

Brian: *For me it was the wrang* [wrong] *decision…*
Craig: *Still the wrang decision at the time but a knew it was wrang….*

The group also demonstrated this uniformity through the expression of 'insider' language and on one occasion an 'insider' joke made by Craig: a joke that meant nothing to me as an outsider but had a common meaning to the veteran group members.

Interviewer: *People are generally smiling at that statement…*
Group: *(Laughs)*
Interviewer: *which means it resonates; it means something to yous, is that specific to military or…*
George: *Aye.*
Craig: *Improvise, adapt and overcome.*
Adam: *It's just a saying in the Army.*
Craig: *Aye, just one of those wee stupid things, wee stupid things that probably carries through aw the Army, aye.*

At a conscious level, to convey their 'sameness', members of the group appeared to voice similarities in life experiences. Adam spoke of his difficulty settling into civilian life followed by Craig who described a similar experience but also added marital acrimony. Brian offered agreement followed by Adam who confirmed that after leaving the Army his marital relationship ended. Craig then reaffirmed that they had had the same experience.

Adam:	*A got oot and a just couldnae settle. A hated everybody, came oot and a just […] every joab* [job] *a tried to get a couldnae settle into a joab […] a never lasted in a joab because a went from job to job.*
Craig:	*Ah've been through ma divorce an everything fi ah've been oot, a huvnae* [have not] *really settled in really…*
Brian:	*Mmm*
Craig:	*…and the work a huv hud* [have had] *it's been like casual roofing work stuff like that, ah've no really settled.*

[Shortly after]

Adam:	*… a got oot fur ma, fur ma daughter, a didnae want tae get married when a wis in the Army because a wis too young, an a got the choice a… it's either us or the Army so a got oot an a ended up falling oot wi ma ex two years later.*
Craig:	*Same situation as me basically.*

Throughout the discussion there was evidence of collective statements being used by participants. Adam and Brian, for example, used inclusive statements to convey focus group affiliation and to nurture group identity and cohesion. They also used these collective statements as a means of identifying inside and outside group identities when discussing their experiences of imprisonment. To them, the in-group consisted of veterans in prison, whereas, the out-group referred to other prisoner types. The quotations below provide examples of this. In both the word 'we' is used as the collective or inclusive term. In the first example the use of 'we' infers positive attributes to the focus group

participants. It suggests that they accepted responsibility for their offending. The second example suggests that they as a group of veterans are the same, and that they are the same as other veterans in prison but are different from, and better than, other non-veteran prisoners (albeit, this view changed as the discussion progressed). Brian specifically refers to prisoners who misuse substances, the inference being that he believed that veteran prisoners do not misuse substances.

Adam: *But that's us, we put wurselves* [ourselves] *here.*
[…]
Brian: *We generally dinnae* [don't] *associate wi them.*

Brian's attempt to unify the group by stating that group participants were different from other prisoner types was, however, presumptuous. He failed to consider that focus group participants may themselves have had issues with substance misuse. This presumption provided insight into how the group addressed disagreements so as to maintain group unity and foster group identity. During the discussion there was a brief period where George did not contribute and appeared to disengage. He was invited by the interviewer to answer whether he agreed or disagreed with the discussion his peers were having about whether they differed from prisoners who misused substances. George's response could be construed as 'sitting on the fence' where he offered both agreement and disagreement.

George: *A agree wi some of the things that have been said but a fiercely disagree wi some of the stuff that's been said anaw* [as well].

Despite stating his strong disagreement, George did not want to define himself as being different from the others in the group. In his next comment, while acknowledging his previous substance misuse problems, he limited his expression of being different to other members in the group.

George: *Well they people* [substance users] *that they're talking aboot, a wis probably wan* [one] *o they people…*

Rather than making an absolute statement, by including the word 'probably' he softened his response. This introduced uncertainty to the group as to whether he was or was not 'one of they people'. Nonetheless, despite George tempering his view, participants engaged in backtracking responses to appease George, seemingly to lessen any perceived tension within the group and to suggest to him that they continued to be similar.

Brian: *Ah've nuhin* [I've nothing] *against any o them but, ah've nuhin against them know what a mean.*

This interaction appeared to influence how George engaged during the remainder of the discussion. When discussing topics with strong collective agreement George was actively involved. For the most part, though, he was content to express disagreement or displeasure at questions and statements made by me in my role as interviewer but did not appear to offer disagreement towards comments made by other group participants. Instead he limited what he said or, when invited to respond, offered neutral, non-confrontational replies.

Interviewer: *Anything a challenge or nothing a challenge?*
George: *Just what the guys are saying, basically that's it.*

After George's disagreement and subsequent appeasement by other participants, there was a further example of two group participants disagreeing. The quotation below starts with Adam reflecting that when seeing the prison doctor he expects to receive *"something"* [medication]. Craig butts in with his statement suggesting he experienced no difficulty being prescribed medication, whereas, for Adam (and Brian) there had been a difficulty. There was no discussion between the participants comparing their different experiences. Instead, Craig remained silent and for a period of time appeared to disengage

from the discussion. The inference here is that Craig chose to not disagree, opting instead to withdraw from the discussion briefly to prevent group tension and conflict from reoccurring. His action suggests that he believed it was better to remain quiet and not offer his counter experience for the purpose of ensuring continuity of group cohesion.

Adam:	*So when, when, when you go an see the doctor or a nurse an ye want something…*
Craig:	*The doctor will gie ye it… but it's getting (said together)…*
Adam:	*But half the time (said together) the doctor will no gie ye it but…*
Brian:	*Naw.*

While Craig offered no challenge to the different opinions expressed, Brian demonstrated examples of changing his opinion to match the prevailing discussion. Doing so ensured he was not seen by others as having different opinions from the dominant view being expressed. For example, Brian had agreed that everything in the Army rotated around the use of alcohol and that it was used to *'loosen up a wee bit mare'* so people could get to know each other better. His inference was that everyone in the Army consumed alcohol. George then confirmed he had never used alcohol and shortly after Adam suggested that some people do not drink. Brian then switched his opinion to mirror Adam's point of view agreeing that some people in the military did drink but chose not to.

Adam:	*It's like anything, some people drink, like he* [George] *doesnae drink, some people still in there* [the Army], *in that environment, other boys will drink but they'll no drink, ye get some people that drink mare than others.[…] Same as oot here.* [civvy street]
Brian:	*Some people just go awr* [over] *there just to socialise wi the guys, they'll drink but ur* [are] *no drinking.*

Other group members made tentative statements that appeared to be checking for group agreement and seeking affirmation before confirming their point of view. For example, Adam, when discussing how easily veterans settled into prison life, suggested why he

thought this was, but then sought validation from other group members by turning his statement into a question.

> *Adam:* *A hink ye just, aye, ye just adapt tae yer environment, din't ye* [don't you]*?*

In the absence of disagreements as the discussion progressed group cohesion was evident. Yet participants were still being careful not to identify themselves as being different from the other participants. To achieve group cohesion they were seeking to avoid differentiation. Not doing so would jeopardise the shared identity they had sought to achieve. For example, the following quotation infers that Adam, when hearing others voice their reluctance to engage with prison staff, is emphasising that he is the same as the rest of group even though his job requires him to speak with staff.

> *Adam:* *See ah'm, ah'm in a pass joab* [job] *so am opened up, a know, ah'm in mare contact wi them* [prison staff], *[…] don't get me wrang, a don't, ah'm no gonna* [going to] *go oot ma road tae, but a know whit wans, a know whit wans* [what one's] *a can approach and whit wans* [not to], *know what a mean…*

Adam, through the inclusion of *'don't get me wrang'*, was asking others not to misunderstand both the contact he had with prison staff and what he was saying, and then emphasised that despite this work related contact he would not make a point of actively interacting with prison staff unless he had to.

Sub-theme 1.1.2: 'We' are 'They'

Rudyard Kipling's poem "*We and They*" (1926) parodies insularity and prejudices towards other cultures. This sub-theme adapts Kipling's personification of 'we' and 'they' using it to describe how focus group participants initially viewed themselves as 'we' and their progression to becoming 'they'. The group initially believed that veteran prisoners were a different 'type' of prisoner compared with non-veteran prisoners. They

were different because of how their military indoctrination, subsequent military training and deployment prepared them for new challenges. As Craig stated *"Proper preparation prevents piss poor performance…* [*you*] *Improvise, adapt and overcome"*. They could adapt to, and engage with, the prison system and its staff to smooth their transition into custody and ensure their wellbeing while incarcerated. Non-veterans, they inferred, could not adapt and would give up caring for themselves and others or would adopt a position of conflict with staff.

Craig: *A lot o guys probably lost their respect when they came into prison, even cleanliness an that it's suhin* [something] *ye don't loss, ye just, yer here, yer just in a different place know what a mean.*

[…]

Brian: *Aye an a hink we're kinda mair* [kind of more] *like, obviously wi the staff an that we're kinda wee bit mare aye please and thank you whatever, cheers where a lot of people are ah fucking, ken, no interested an we're ken a wee bit mare […] … a mean a lot o people, a dunno stuck in the old ages hink they're anti screw kinda…*

That said, the group seemed uncertain as to whether they were only differentiating between veteran prisoners and other prisoners. It appeared initially that the group were referring to all non-veteran prisoners but this was not so. When discussing their views on their enforced association with other prisoners greater clarity was obtained. Early in the discussion participants agreed that "*people"* they came into contact with in prison were different from those they had contact with in their army and civilian lives. From Adam's perspective these *'people'* were of a different social class to him; *'people'* he would not normally socially engage with but, as a consequence of his imprisonment, he believed he was forced into doing so.

Adam: *…yer coming in fae oot there fi whatever background ye've come fi regardless ay being in the Army. Ye come in here an yer getting put in wi alkies and junkies a people* [that you would not] *socialise with ootside…*

The group consensus was that they were different from but not superior to or better than other people in prison. Moreover, it appeared that the only prisoner types that they felt dissimilar to, and had difficulty engaging with, were those prisoners who had alcohol difficulties and drug misuse problems. Yet this was a prisoner 'type' that George associated himself with and to which Craig, albeit unrecognised by him, as a consequence of his excessive alcohol use also belonged to, and that Brian had past experience of. Such problems were also evident in other veteran prisoners in Scottish prisons (see Chapter 7).

Group participants had initially strived to develop a cohesive veteran (focus) group identity and then sought to define a wider in-group and out-group status. The inference was that non-veteran prisoners would fall into the out-group and veteran prisoners into the in-group. When they attempted to provide reasons for each groups' affiliation their justifications begin to exclude some veteran prisoners from the in-group and include them in the out-group. As such, other than the focus group participants forming their own short-term veteran in-group for the purpose of the group discussion, it appeared difficult to identify the existence of a wider in-group consisting exclusively of veterans. They did, conversely, appear to identify a wider prisoner in-group and by default a prisoner out-group. Prisoner groups that, without initially realising, they were members of that comprised of different prisoner 'types': 'types' of prisoners that focus group participants had to adapt to and interact with.

Adam: *… ye've goat tae adapt tae it and it's in yer best interest, regardless whit any* [one] *does, drug problems… everybody tries tae get oan, ye need tae try an get oan wi yer peers whit's roond aboot ye.*

Adam's use of the term 'peer' is taken to mean that he regarded all other prisoners as being equal to him; though it did not preclude the group from identifying a small number of prisoners as being different from the majority of those imprisoned. This perceived difference confirmed the existence of a wider prisoner out-group and was used to justify their rejection and exclusion from the prisoner in-group.

Craig:	*There's guys in here who just don't give a shit aboot anyhin.*
Brian:	*Aye kinda young boys an that, couldnae gie two flyin fucks aboot their family or anybody else an they're no really interested know what a mean […] the outcasts that are maybe up tae nae good...*

To summarise, sub-ordinate theme 1.1 describes my interpretation of the group's actions and words: actions and words that appeared to have the same meaning to each member of the group. They used this shared meaning, even if their personal experiences of service and civilian life differed, to develop cohesiveness within the group and to confirm the group's identity. Even when the bond was open to challenge by dissention between group members they tempered their statements to minimise differentiation. By the end of the focus group it appeared that the group's participants believed that they were the same: the same type of veteran and the same type of prisoner. They also viewed themselves as being the same as, and equal to, most other prisoners moving from regarding themselves as being members of a veteran prisoner in-group to being members of a wider prisoner in-group. The crucial inference is that focus group participants appeared to identify themselves as veterans for the purpose of the focus group but when talking about their prison experience their primary group identity was that of being a prisoner.

6.3.2 Theme 1.2: The staff 'side of the fence'

The second sub-ordinate theme within the Group Identity super-ordinate theme examines how prison staff, including those that were ex-military, were perceived by focus group participants. It also examines how focus group participants think prisoners view and engage with prison staff. Additionally, the theme looks at how the group think prison staff view them as both veterans and as prisoners. The examination and interpretation of these are captured within two sub-themes. The first discusses the transition from being in the same uniform (military service personnel) to being in different uniforms (prisoners and staff). The second focuses on what focus group participants believed prison staff felt about them.

Sub-theme 1.2.1: Changing uniforms changes sides

Many prison staff spend time serving in the UK Armed Forces before commencing a new career within a Prison Service (House of Commons Justice Committee, 2009). This sub-theme examines the perceptions of focus group participants on their relationships with those staff who were also veterans. The group acknowledged that when they (prisoners and staff) were in the military they were the same (same identity, values, and purpose). One could infer that had focus group participants never become prisoners their joint history of military service would have ensured commonality; they would all just be regarded as veterans. Now they are in separate opposing groups; prisoners versus prison staff.

> *Adam:* *…we're* [veteran prisoners] *just oan the other side of the fence fi them* [veteran staff] *noo.*

The group believed that the new statuses of prisoner and prison staff severed their earlier connection. The military bond was no longer sufficient to bridge the perceived gap

that existed because of their new statuses. They were now different and the experiences they had in common no longer mattered because of how, as prisoners, they perceived veteran staff. Their prisoner status brought with it new expectations on how they were to engage with staff. Veteran prisoners were not meant to form relationships with veteran staff.

Adam:	*whir* [we are] *prisoners in there, they're staff […]. So they're always gonna you just, there's gonna be that divide. They're never gonna, never gonna, yer never gonna get close tae any o thum like that.*
[…]	
George:	*When a talk to officers in the landing, eh there must be a fucking right good reason that ah'm talking to them for a start because a just do not want tae, […] a don't even want them tae talk to us.*

Additionally, to the focus group participants both sides (prisoner and staff) were expected to adopt actions and behaviours which reinforced their differences. Being a veteran prisoner bought no favours from veteran staff, nor was it sought. Veteran prisoners expected veteran staff to be like other prison staff: to do the job they were hired to do and to not seek to interact with veteran prisoners.

Adam:	*Yer gonna get treated different that's their job (said together)*
George:	*Different uniform (said together) that's whit they're there for.*

Each side were now wearing different uniforms and their uniforms acted as visible symbols of their differences. The uniforms defined them as being either a prisoner or a member of staff and influenced the language that focus group participants used when describing prison staff. In the quote below, Craig uses the term 'shirt' to identify a specific group of prison staff (custody or residential staff). His use of 'shirt' is not dissimilar to the terms 'brown shirt" or 'black shirt' used in the Second World War to identify the paramilitary wing of the Nazi Party (brown shirt) or Mussolini's fascist

paramilitary wing (black shirt). Both were authoritarian and controlling groups. The inference from Craig's use of the term 'shirt' is that he was implying that the practices and approaches of prison staff when engaging with prisoners were similar to those used by the fascist or Nazi paramilitary groups.

Craig: *Ye can see that just withoot even speaking tae the guys like obviously the guys wi the shirts on ye can tell who's gonna gie ye* [going to give you] *and who's no.*

The group believed that their relationships with veteran prison staff were no different to their relationships with staff who had not served in the military. However, despite the absence of evidence, they also believed that veteran staff held negative opinions about them. They believed that veteran prison staff thought that they were better than veteran prisoners.

Adam: *Well they just (speaking together)… Aye, a hink they just look doon at us, they look doon at us noo.*

[…]

Craig: *A see it, a probably would imagine that a lot of them think we're just a waste o space noo because ay they've maybe been in the forces if they know ye in the forces an then ye end up here so they'll look doon on ye…*

Nonetheless, the above quote from Craig went further than that just stating that he felt they were looked down upon. While Craig used the collective term 'we' his statement could be construed as indicating a 'transference' of emotion, where he is redirecting his own negatively held view of self, as coming from an external source. He suggested that other veterans thought less of them, whereas he thought less of himself for leaving the Army and ending up in prison, externally positioning his own sense of failure onto those veterans he perceive as being more successful than him.

Sub-theme 1.2.2: Tarred with the same brush

This sub-theme offers insight into what focus group participants thought prison staff's attitudes and values were when working with prisoners. These were based upon their interaction with staff but also influenced by their own prejudices, the latter of which directly influenced focus group participants' opinions of staff. Participants believed that prison staff had a unitary view of what a prisoner was. They believed that staff thought that all prisoners were the same and as such they should be treated the same irrespective of individual needs or the expression of positive prison behaviours.

Adam:	*…they treat everybody… they treat everybody the same in here.*
George:	*Aye.*
Adam:	*They like to tar everybody wi the same brush.*

They believed that all prison staff were 'taught' by the prison system to think that negative behaviours and attitudes expressed by a small minority of prisoners were the norm for all prisoners. For example, when a prisoner with a history of substance misuse concealed his medication they believed that all staff thought that all prisoners engaged in this activity.

Adam:	*Whatever somebody's experienced somebody else dain they think everybody's up tae that. […] They think everybody's just chasing meds tae get fill ay it.*
[…]	
Adam:	*They look at everybody the same.*
Brian:	*He'd been drilled this is contraband, this is currency whatever else, generally no interested.*
Adam:	*In anything like that (said together). If he thinks (said together). He could take a few o them an he'll be oot his nut, we'll try an give him somehin else that doesnae, doesnae dae a thing. Just tar everybody wi the same brush. Somebody might need that medication.*
Brian:	*Mmhmm.*
Adam:	*But they'll no gie ye it because somebody else has abused it in the past.*

Participants took offence at being viewed the same by staff, not because they believed they were different from the majority of prisoners but because they believed they were

different from a small group of prisoners they identified as being *"outcasts".* The use of the idiom *"tar everybody wi the same brush",* as seen in the quote above, has negative connotations. For example, it has appeared in historical literature, such as Sir Walter Scott's 17th century novel *Rob Roy*, to suggest a person that others believe looks, acts and has the same characteristics as another unsavoury individual. There is also, however, a tenuous link to the ancient punishment of tarring and feathering, where boiling pitch tar was poured over a person caught engaging in criminal activity (Hendrickson, 2008). The word 'tar' seems to indicate that participants believed that prison staff were constantly reinforcing that focus group participants were criminals, that they were no different to all other prisoners, and they were in prison to be punished.

Despite participants' offence at being 'tarred with the same brush' they also adopted this approach to staff. After engaging in a critical or abusive interaction with a member of staff they would generalise their views of that one person to all staff.

Craig:	*It's just a gen, some of the officers' general attitudes can just… just stink.*
Brian:	*Mmhmm.*
Craig:	*Because they've goat that uniform on an they think they can talk tae yi like a bit o shit but like don't you say to yerself tae think that a wis serving fur that bastard know what a mean that's, that's yer attitude that ye end up getting wi some of them. Ye end up, end up hating them an a can see guys that just…*
Adam:	*Some o them (said together)…*
Craig:	*A lot of them (said together)… are awright, ye just know who to avoid (said together).*

Focus group participants were 'tarring [all staff] with the same brush' because of the actions of one staff member despite recognising that other staff had never engaged with them negatively. To group participants, all staff were regarded as being the same, even those with whom group participants had a degree of positive regard for.

In summary, subordinate-theme 1.2 examined the relationship between focus group participants and prison staff and how participants viewed their interactions with staff. Where they were once the same by virtue of their military service they were now different. Participants also believed that prison staff thought that all prisoners were the same and that the negative actions of one prisoner were viewed by staff as the standard behaviours for all prisoners. What is interesting is that there is a degree of commonality in how group participants viewed themselves and how they believe prison staff viewed them. The group acknowledged their veteran status but defined themselves as being prisoners and as being no different to most other prisoners. They also believed that staff treated them the same as other prisoners. Yet they were also angered at the thought of being regarded by prison staff as being the same as all other prisoners.

6.4 Super-ordinate theme 2: The needs of veterans

The second super-ordinate theme to be identified focuses on the needs of veterans. The theme assists in addressing a number of the study aims, in particular, veteran prisoners' pathway to imprisonment, their experience of prison, and what is required to address their social and criminogenic needs. This is divided into three sub-ordinate themes describing the perceived needs of veterans before prison, during their time in prison and in preparation for discharge from prison. The definition of 'needs' within this theme is broad. It captures focus group perceptions on access to not just health and social welfare support and a veteran prisoner's ability to request this, but also their perceptions on the challenges of their lived experiences in both 'civilian' and prison contexts. It also examines the perceived need for family relationships and the difficulties associated with maintaining these. There is also a brief examination of their views regarding access to employment post-prison. Lastly, it discusses whether veteran needs differ from the needs

of prisoners. As with the sub-ordinate themes discussed earlier in this chapter, each has its own sub-themes derived following interpretation of the transcript data (Figure 6-2).

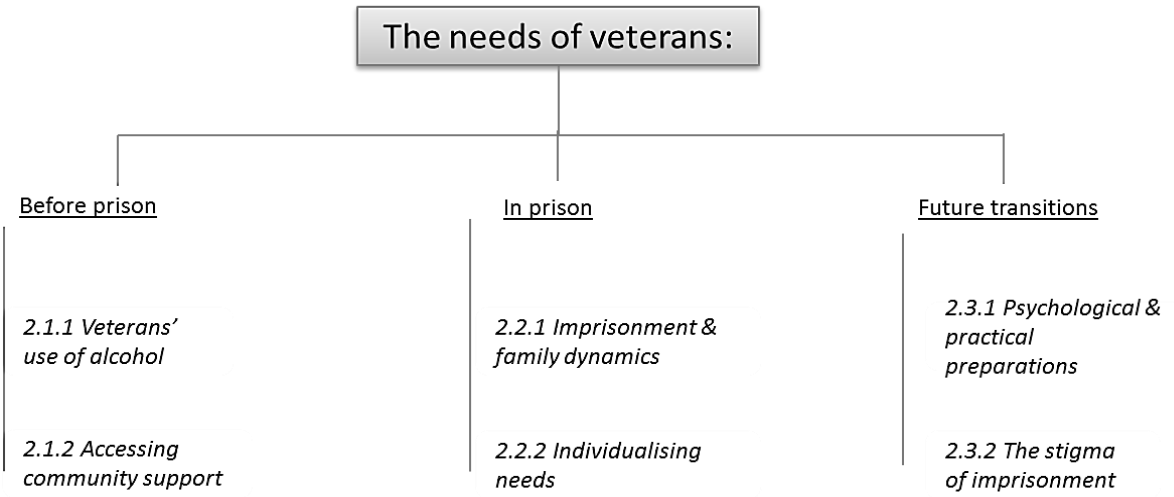


Figure 6-2: Super-ordinate theme 2: The needs of veterans

6.4.1 Theme 2.1: The needs of veterans: before prison

This sub-theme examines the perceived needs of veterans prior to their imprisonment. The period is not specific to the point immediately before their current incarceration but to their experiences of living in the community following military discharge and their attempts to obtain support for their needs while living as a civilian. Theme 2.1 is divided into two sub-themes. The first focuses on veterans' use of alcohol and the second on the perceived challenges of obtaining support while in the community.

Sub-theme 2.1.1: Veterans' use of alcohol

The group consensus was that leaving the Army and entering civilian life was challenging. The majority found it difficult to settle into their new existence. Two described it as *"horrible".* The perception was that they believed that they did not fit into civilian life and that this new life did not meet their preconceived expectations.

Adam: *Ye get oot, a hink when ye get oot the Army ye think it's gonna be the way it is when yer on leave wi all yer pals, 15 o yees* [us]

all coming back to the wan wee area and yees are all gonna go oot on the piss for a month. An ye come back an aw yer pals are working, they're just having normal boring lives, naebody wants to really dae anything.

Adam thought that when he left the Army his new life would still involve regular socialising but instead he found that his friends did not live like this. They spent their time working and living quietly: an existence that Adam found unstimulating and unfulfilling. Interestingly, the main activity Adam identified with when thinking about his discharge involved the excessive use of alcohol. Three of the group initially believed that alcohol misuse was a problem for veterans living in the community. Craig admitted that it was a problem for him personally and that it stemmed from his time in the military.

Interviewer:	*Is alcohol an issue for veterans?*
Adam:	*Ah'd say so aye…*
Brian:	*Mmm, aw tae dae wi boredom a kina hink.*
Craig:	*Me personally everything ah've done is been through drink.*
Adam:	*…it's just the way o life innit, everything rotates roon* [around] *a couple o beers at the end o yer shift in the Army.*
[…]	
Interviewer:	*Before you come into prison then but you've…, and obviously you've left military and you've got other aspects of life before you end up in prison, but were there specific support needs you would need to get addressed in the community that never got addressed that were military specific?*
Craig:	*Ah'd just say alcohol. Mine has always been alcohol, doon tae alcohol and a don't think it's ever been addressed. A don't think anything was ever addressed, it's just been recently* [in prison it has started to be addressed]*, just over the past few years.*

The fourth focus group participant, George, was teetotal, had never used alcohol and was less sure as to whether alcohol misuse was a problem for veterans. He appeared concerned that the group discussion was inferring that all veterans experienced this problem. He did, however, agree that during his time in the military the use of alcohol was heavily promoted as a means of forming relationships, to help unwind and to de-stress.

Interviewer:	*Can I then ask […] is alcohol actively encouraged in terms of de-stressing?*
Adam:	*Aye.*
Group:	*Aye.*

George's concern that the group were generalising the misuse of alcohol by some to all veterans appeared to eventually influence the thinking of other group participants. While alcohol use was still proposed as being problematic, or as a method of 'coping', the statements about its use became less absolute. For example, in the following quote Adam suggests that alcohol use is likely to always be a factor in military life and that some will leave military service and continue drinking or drink more. He then, however, indicates that he is uncertain of what he thinks.

Adam:	*It's just…, it's just a way, it's just part…, what's wrang* [wrong] *is people might look at it, that's just the way it is, just the way it's always been, it's the way it always will be, some people dae their time an they get oot an they still…*
Craig:	*Drink.*
Adam:	*Still drink as much as they did when they were in the forces, if they've experienced some stuff they'll maybe drink more when they get oot, thinking on it a don't know.*

After further reflection Adam then suggested that the use of alcohol by veterans was probably no different to non-veterans' use of alcohol: a view that was then adopted by other members of the group. The group then concluded that not all veterans had problems with alcohol: where alcohol was misused the reason for this was unique to the person and not necessarily as a consequence of military service.

Adam:	*It's like anything, some people drink , like he doesnae drink, some people still in there, in that environment, other boys will drink but they'll no drink, ye get some people that drink mare than others.*
Brian:	*Mmm.*
Adam:	*Same as oot here.*
Brian:	*Some people just go aw there just to socialise wi the guys, they'll drink but ur no drinking.*
Interviewer:	*So it's individualised?*

Brian: *Mmmhmm.*
George: *Aye.*

The group acknowledged that some veterans had problems with alcohol. This endorsed and supported Craig's disclosure that he experienced a number of life problems as a consequence of alcohol misuse while also confirming the group's view that alcohol misuse was not pervasive in veterans. Instead they inferred that alcohol misuse, and reasons for this, in veterans were probably no different to people with no prior military service.

Sub-theme 2.1.2: Accessing community support

The group were asked to identify what they believed were the main support needs of veterans living in the community. Both Adam and Craig offered suggestions but these appeared to be general responses rather than examples they had personal experience of.

Interviewer: *… do you think there's support needs that veterans have in the community that they're not getting addressed. What would you think?*
[…]
Adam: *A hink a lot o things (said together).*
Craig: *Mental health problems, housing, kina guys that have served four, five, six years in the Army and they're sleeping in the streets kina, a lot of things know what a mean, not getting support.*

Despite this, Craig's suggestion that veterans living in the community did not always receive support offered insight into their views on this issue. The group suggested that often veterans presented with too much bravado to admit they needed assistance or were too proud to request support when they recognised that they had a need. Instead veterans believed they had the resources to resolve their own problems or when they recognised they did not have these resources chose to ignore the problem. The acknowledgement of

a problem's existence was a sign of weakness that they were concerned about portraying to others.

Adam: *A lot of the guys (said together) See when you're in the Army naebody wants to admit they've got something wrang wi them or whatever, it's just everybody puts on a wee bit of bravado […] and wants tae be the man, a don't hink, …it's a pride thing, a lot o guys ah'll no admit […] they've goat problems wi any of it. They'll, they'll no admit they need help.*

[…]

Brian: *You feel as if, ye think as if though we can deal wi… it. […] … wi other people ye kina put a front oan it, bravado, an kina ah'm cool […] everything just goat blanked and loacked* [locked] *away in a box.*

If difficulties in requesting assistance are common amongst veterans who need support then it would seem to be important that a request for help is acknowledged and, where applicable, the need for support assessed and offered. Yet, this was not the experience focus group participants described. Instead they offered narratives that inferred a sense of 'being invisible', feeling de-valued or not worth caring about by those whose help they sought.

Adam: *Before naebody, naebody bothered wi ye.*

Where services had been provided there were inconsistencies in approach. Such inconsistencies appeared to result in a sense of injustice, unfairness, mistrust, and a perception that even when their situation was at its worse no-one wanted to help them. The inference was that veterans would not make a further request for assistance after they were treated in such a manner.

George: *… now me and a guy fi Glasgow eh went tae this meeting an it was tae sit there and convince the justice secretary […] that the* [company name removed] *was dain a great job, an why should we give them a quarter of a million pound funding. […] An then for about 18 months after that a was going wi this, eh, this worker, the reason a wis with her was because ma experience in*

> *the jails […] just before a came in on this sentence a wis, just before a done that robbery, a phoned them, a said look ah'm sitting in here, a haven't been fed for three weeks, a havnae had ma methadone coming on for 5 five weeks.[…] An eh, they went* [George] *sorry there's nothing we can dae for you. An that was the company a had sat an done aw that work wi an… nah, a cannae trust anybody to be honest…*

In summary, this sub-ordinate theme sought to identify from group participants what the main needs were for veterans living in the community. After a change of opinion the group suggested that alcohol misuse was not a veteran specific problem. The group suggested that some community living veterans needed assistance but support was not always available. However, veterans also had difficulties requesting help as doing so challenged the image of how they wanted to present themselves to others. Yet, when they requested assistance they believed they were largely ignored or treated unfairly reducing the likelihood of further requests for support being made. In George's case it also increased his propensity for further offending.

> *George:* *…ah've asked for it for years and years so it's no came forward so, ah'll be honest wi ye a put maself in this, in jail this time so a did.*

The needs of veterans in prison are now discussed in theme 2.2.

6.4.2 Theme 2.2: The needs of veterans: in prison

This sub-ordinate theme explores focus group participants' descriptions of their perceived needs and how and whether these should be addressed while in prison. It is divided into two sub-themes that discuss the challenges of being separated from family life while in prison and the need for individualised assessment to identify and prioritise need.

Sub-theme 2.2.1: Imprisonment and family dynamics

All four focus group participants held the opinion that being in prison was easy and largely unchallenging. Being in prison was an inconvenience that caused a disruption to their normal lives. Part of this disruption to normal living was, however, the impact imprisonment was having on their family relationships.

Adam: *Being away fi yer family an yer kids that's the hardest thing.*
Brian: *Aye, aye thas aboot the only hing that's kinda difficult know what a mean… Because obviously (said together)…*
Adam: *Having yer kids sitting (said together)… meet yer kids under these circumstances, huvvin them come tae visit ye in the jail.*

There was a sense of distance between them and their family and, as described by Brian, a feeling of being *"completely cut aff"* from what is happening within the family unit. The perception was that being in prison had stopped time for them while outside their families continued to live and move forward. Participants felt helpless as a consequence, unable to respond to their need to support and be with their family when the family experienced difficulties. It also made it more difficult for them to cope with their experience of imprisonment.

Brian: *Time ticks on oot there an in here it's…*
Craig: *They need tae keep ye going (said together).*
Brian: *mundane (said together).*
Craig: *Same auld stuff every day.*
[…]
Adam: *…If everything is goin alright oot there then it goes, a hink it's easier in here… If everything's going smooth ootside then everything goes smoother fur me… If that's aw start goin tits up oot there wi ma family then it's obviously a wee bit harder oan ye to take […] you're in here, your helpless, ye cannae dae anthin. Oot there ye've got a bank account an if things arnae goin right wi them do you know what a mean there's ways roond things. When you're in here […] When you're in here ye feel helpless, there's nothing yi can dae.*

Participants felt that they were burdensome to their families, which appeared to cause feelings of guilt. They believed they were responsible for the situation they and their

families were living in and separation from their families meant they could not engage in the actions and behaviours that would be expected of a partner and a father. Their role as the provider for the family had ended and, the inference being, they had become 'less of a man than they should be', relying on the help of others to provide the support they believed they should be providing.

Adam: *It's havin to deal wi stuff coz in here you could a been the person that's earning for the family, yer partner an whatever an paying aw the bills an then you're comin in here, do you know what a mean, yer having to listen to them an aw the problems they've goat they're tight, they're gonna be struggling noo.*

[…]

Craig: *Get yerself into this situation, it's yer family who ye depend oan where you could be in here tae maybe Christmas time or whatever, the weans still need their Christmas, stuff like that so it could be like me, a would probably say tae ma auld man, need tae gie us money or whatever whereas a shouldnae be in that position tae say tae him.*

Brian: *Aye.*

Craig: *So yer putting a burden oan yer family in a way by coming in here.*

This sense of burden extended beyond not being able to provide for their family to needing their family to provide for them financially and emotionally whilst in prison.

Adam: *Plus they've goat to keep you while you're in here, they're struggling, trying tae get money tae pay… put money on your phone and things like that so …It just kinda snowballs.*

[…]

Craig: *Ye depend oan yer family tae a dunno what, support ye in here whereas ye shouldnae be here, yer old, big and old enough tae be daein it yerself.*

There is recognition within the group that relying on their families to support them while in prison is wrong. Their imprisonment and their need for emotional and financial support made the lives of those close to them more difficult. This resulted in a paradox where participants' subsequent need for contact and support from their family made imprisonment easier but disadvantaged the family, for example financially. This then

impacted on the participant's perception of their role as a provider for their family causing further feelings of guilt and a loss of self-worth. Attempts were then made to address these feelings by obtaining further support from the family. It is important to acknowledge, however, that participants from the focus group believed this need for family contact and the maintenance of positive family relationships was not a veteran specific issue. Instead they believed it impacted across the prisoner population.

Adam: *A don't hink it's got anything tae dae wi the Army a hink everybody, it's the same for everybody in here…[…] Boys… even boys (said together) that have nothing tae dae wi the Army, a can see that in the hall, same as, you know what a mean, if everythin is goin alright on the ootside then they're alright an then ye can tell when somebody's feeling a bit doon ye can see it […] their heid is up their arse, kind kinda thing […] phone call or a bad visit or suhins happening… so naw a don't think it has got something to do with the Army it's just […] that's just wan o the challenges in here.*

Brian: *…it's the same for everybody a reckon know what a mean.*

The groups view was that any prisoner who cared for his family could experience family related difficulties in prison. Changes in family dynamics were a driver for this. How they were supported by their family and the challenges they experience trying to provide support influenced how some prisoners coped with their imprisonment. Military service provided experience of being separated from family members for long periods of time but during these periods participants were able to financially support their families. They also had military welfare systems in-situ that provided emotional and practical support to their families in their absence. When serving, the men also had their own support mechanism through the camaraderie of their military unit, but in prison, like all other prisoners, they had none of these.

Sub-theme 2.2.2: Individualising needs

Focus group participants appeared to believe that there were no unique prison-based needs for veteran prisoners. Further, they believed that the needs of veterans in prison were not comparable because of their different military and subsequent life experiences. They also believed that veterans' needs in prison did not warrant access to veteran specific support services. The latter belief reinforces the notion that focus group participants did not see themselves as being different from other prisoners. Craig provided deeper insight into this. While his quote below suggests that veteran prisoner needs are the same as non-veteran prison needs, it also infers that once a veteran is imprisoned for committing a crime he loses any rights that his veteran status bestows. To him, a veteran in prison is no different to any other person in prison and as such should not be treated any differently.

Interviewer:	*…what you think would be the main support needs for ex-service guys whilst in prison?*
Craig:	*A don't think it should be any different fi any other person. Like. Really. We've aw, we're here for a reason, we've aw, we've committed a crime so we shouldnae get any.*

When the group were asked more specifically whether the needs of veterans in prison were similar to the needs of non-veteran prisoners, again there was group consensus that needs were the same. In citing PTSD as an example of a clinical presentation that can be experienced by all prisoner types, and not just veterans, they confirmed their belief that veteran prisoner and non-veteran prisoner needs were alike.

Interviewer:	*…do you think that your needs as military veterans are the same type of needs that non-military veterans have in prison?*
George:	*Aye ye can still suffer wi eh, what de ye call it?*
Craig:	*PTSD.*
George:	*Aye, post-traumatic stress if yer a civvy or if yer military, ye know, so naw there's nae difference really, is there.*
Craig:	*Naw.*
George:	*Nah a wouldnae think there's much difference.*
[…]	

Brian: *Then ye've got somebody who's went through a lot in their life know what a mean they, they, they've goat the exact same hing, know what a mean it's just doon tae each person.*

Adam: *A hink it's just the same, Army or normal people in here.*

Moreover, Brian provided an account of his pre-military life in which he described experiencing a range of traumatic events, including his father being shot in the street. He believed that these were much worse than anything he was exposed to whilst in military service but which were of a similar harshness, he believed, to unpleasant experiences that other people in prison had been exposed to in their lives. The inference for the group was that it would be wrong to offer special treatment to veterans when the clinical needs of non-veteran prisoners were similar, as Adam pointed out:

Adam: *...somebody needs help or they don't need help…Somebody might come in, a soldier could come in wi alcohol problems, somebody else could come in aff the streets wi alcohol problems.*

Their conclusion to address this was to suggest that all prisoners should be assessed as individuals and any identified needs could then be prioritised. To them 'needs' were unique to each prisoner and in this regard there were no needs that were specific to veterans in prison. People in most need should receive access to support first, irrespective of whether they were veterans or not.

Adam: *As a say a hink it's just doon tae the individual a hink everybody would need to get assessed different […] It's just, ye just need tae get assessed individually […] ye get assessed how much help ye need…*

[…]

Interviewer: *So its individual assessment, experiences probably not really that different? […] Is that the general consensus?*

Adam: *Aye.*

Brian: *Mmm.*

Craig: *Ah'd say so, just the same as them, aye.*

Craig's concluding statement in the quote above provides insight into how the group viewed the needs of veterans when in prison. In it he reaffirms that any needs that arises as a consequence of their life experiences, including military service and their imprisonment, are the same as the needs of other prisoners. A further inference, however, can also be made when interpreting the meaning behind the statement. It can be interpreted that he was also reaffirming that the group not only have the same needs as non-veteran prisoners but were also the same people: they were all part of the wider prisoner in-group.

6.4.3 Theme 2.3: The needs of veterans: future transition

The final subordinate theme in this section focuses on participants' views regarding what they believed would need to be addressed to support veterans successfully leaving prison, returning to the community and not reoffending. Much of what was described would benefit all prisoner types and not just veteran prisoners. That being said there was recognition that some veteran-specific services existed, specifically services that supported re-settlement of veteran offenders back into the community. There was also a tacit acknowledgement that these services would be used: not because their needs differed from the needs of non-veteran prisoners but because the service was accessible and because they feared being liberated, reoffending and then being re-imprisoned. The sub-ordinate theme has two sub-themes. The first focuses on the need for psychological and practical preparations being made prior to discharge and follow-up once liberated. The second sub-theme focuses on stigma and the consequences imprisonment has when attempting to re-integrate back into community living.

Sub-theme 2.3.1: Psychological and practical preparation

All four participants voiced concern at the thought of being liberated from prison. Adam, who was only a few weeks from liberation, noted he was looking forward to being released but was worried about re-establishing himself back into civil society and into the family-unit. He was principally concerned about how he was going to take up the responsibility of supporting his family again. Other participants appeared to voice significant feelings of anticipatory fear.

Interviewer:	*…wonder how, in your own heads you marry this notion of the resources, the skills you have eh as an individual to adapting to leaving prison and going back into the community, for example getting a job, settling back down… whether that's a feasible option for you or... what you think about it?*
George:	*Fucking dreading getting out.*
Brian:	*Mmm […]… a dunno a kina fell oot wi ma burd* [partner] *after the 9 year a goat, ah'm goin what ah'm a supposed tae be dain* [doing] *here, kina a wee bit loast* [lost], *ah'll probably need tae go and stay wi ma maw again an take if fi there but wee bit dauntin at the same time.*
[…]	
Adam:	*Ah'm looking forward tae it but as a say… It's just ye worry about, how ah'm a gonna start, how aye, how ah'm a gonna get by, know what a mean…[…] ah'm worried aboot, ah've got a wee, ah've got a new, ah've got a two yer old boy noo so a all a can think about right now, a need tae get a job.*

The fear and worry they expressed appeared to be driven by not knowing how they would cope when liberated, how they would be supported when out, and a concern that they would end up back in prison. The fear was that they would fail and be failed by others, expecting this to happen because of their past experiences of leaving prison.

George:	*…ah've been libbed that many times that it's just repetitive, naw a mean ah'll probably be oot a week or two.*
Brian:	*Ah'm no dreading getting oot ah'm dreading getting oot an coming back that's what ah'm dreading aboot.*
Adam:	*It's a revolving door for a lot o the boys, innit. […] It's a revolving door fur them coz they're no getting the help that they need tae get themselves a job an being put on the right road when they get oot so they're getting let oot that big gate, they're getting right back intae the lives.*
[…]	

George: *…in the jail, they say this is ready for ye that'll be set up for ye, this an that, a says right […] this is the day a was getting out, […] a walked to the nurse, ah'm here to get a week's medication, this is the very first thing that was set up for me, ah've no even got your name on the list.[…] this is the day a move, […] an the first things failed, ye know, and as that day went on a walked into the job centre, don't even know who you are, walked into the housing, George who? Naebody had a fucking clue what the other person was dain.*

Cognisance must be given, when reading the above quotations, to their indoctrinated military mind-set that drives their need to be prepared. As discussed previously on page 141 Craig's military quotation *"Proper preparation prevents piss poor performance"* provides insight into this. If things are not correctly planned for then the likely feasible outcome is failure of the task being addressed. For focus group participants, failure [of the task] of planning for their liberation from prison was likely to result in re-incarceration. Their perceptions of the prison service's planning for their discharge was that they personally felt under-prepared and that support services were inadequately arranged.

There was some recognition that support provisions had improved recently. For example, George talked about making a new start when transitioning from prison back into the community with the support of veteran specific services. Yet it was also apparent, when the group was asked specifically what would make the transition from prison to community easier, that he remained uncertain about whether this would be beneficial. George stated that he did not know what services or support would make the transition easier, while Brian suggested gaining employment would facilitate resettlement. Adam and Craig recommended that preparation start in prison through the appointment of a person to help guide prisoners as to what would be available to them once liberated. This person would then chaperon them as they moved from prison into the community. The

key factor for them was that the service would be available in the community when their life situations became challenging.

Craig:	*Guidance, that's it. Just, see instead o getting hit wi that lib grant.*
Adam:	*See when a, see when we were talking aboot aw these people that can help ye noo, see, you need to wait to, ye can start a process prior to you going oot so you've got something tae go oot tae rather than a go oot that door an a can phone an make an appointment wi help the heroes, ah'll see them next week…*
Brian:	*Mmm.*
Adam:	*Ye've already been oot fur a week, ye still don't know, yer heid's up yer arse, ye still don't know whether yer coming or going, if you, if you were basically had a wee build up tae that, meeting these people an finding out what things you can access when you're oot there employment wise, courses anything like that, that would be a big help.[…] You know you're walking oot tae something, yer walking oot tae that help rather than getting tae that gate an like that right.[…] get it all kick started like before you leave here.*

Overall, what was evident was that group participants appeared to lack confidence in the prison service being able to prepare them for their liberation. They also lacked confidence in their own ability to cope with being liberated from prison into community living. Seemingly being unprepared for this reinforced their expectation of failure. Provision of a 'guide' to support their resettlement into their community lives would, they believed, prevent them from re-engaging in behaviours that would lead to further incarceration. This would help them obtain stability in their interpersonal relationships and help their engagement of pro-social activities such as employment. As Craig notes when asked what would help him leave prison and not return: *"…employment is the main thing coz you need money tae survive."*

Sub-theme 2.3.2: The stigma of imprisonment

The group agreed that military enlistment generally bestowed a number of benefits on those who had served. Ex-service personnel tend to be viewed positively by employers

and obtain a range of skills and resources that are transferable across working practices (Ashcroft, 2012). Focus group participants acknowledged this but suggested that any benefits a veteran might have accrued would be lost following a period of incarceration. Any positive impression they made because of their military service would be coloured by the stigma of imprisonment.

Adam:	*See a lot of the benefits you'd a goat fur being in the Army, woulda goat ye, help ye walk intae a job.*
Craig:	*Aye.*
Adam:	*Coz ye've got that bit military background but noo that ye've been in here aw that…*
Brian:	*Aye (said together).*
Adam:	*yer just like everybody else noo, yer a criminal (said together)…*
Craig:	*Might as well be (said together).*
Adam:	*Criminal record, ye'll never, whether ye were in the Army or no […] They're gonna take somebody, they're gonna take somebody oan that's no been in the jail over somebody that hus been in the jail.*

Craig's suggestion in the above quote that *"*[you] *might as well be"* appears to justify that in the absence of employment, criminality is the likely outcome. As prisoners, they would be unlikely to obtain stable employment when liberated so they would have to offend to survive. In Craig's experience when looking for a job, his veteran status was no longer recognised by employers who instead only regarded him as *"a criminal".* A consequence of this is that liberated ex-prisoners may display the antisocial behaviours expected of them when they are labelled by others within society as 'criminal'. Similarly, when in prison the process of encouraging pro-social behaviours placed participants in a quandary: to express honesty or dishonesty. They were encouraged to be open and honest when applying for jobs but believed that doing so would reduce the likelihood of them being employed. Not disclosing their past offending to a potential employer might result in them being employed but their dishonesty would then likely result in their employment

being terminated if their offending history became known. Group participants believed that they were 'damned if they did disclose and damned if they did not'.

Adam: *…when a done ma* [last] *sentence, this when a left* [name of prison removed]*, a women came and spoke tae us aboot disclosures. The way it was explained tae me, is it disnae matter if ye've goat a criminal record, its aboot being honest. […] If you, you don't admit your offence an then they check that then, they say it just came back that you've been done wi that, but if you tell them an put that oan there an it comes back, that doesnae mean, mean, somebody is gonna get a job like that. Ah'd be like right Joe Bloggs blah never been in bother in his life, he's got all this experience you've got mare experience but you've just done 5 year in the jail, they're never gonni pick you.*

[…]

Craig: *…as soon as they see that disclosure that's it.[…] …yer employers no asking fur disclosure sayin how good you wur in yer past, he's asking how bad ye wur.*

Participants believed that employers regarded the presence of past criminal convictions in absolute terms: if a conviction involving imprisonment existed, then the person was always going to be a criminal and a criminal was someone who could not be trusted with the offer of employment. A possible solution proposed by the group was for offenders not to be open and transparent: to not disclose their past offending history and hope that a check would not be made. It was recognised, however, that this was unrealistic. To them, the only realistic solution was to obtain employment in a job that did not require a formal disclosure check: a job where they could hide their past from the scrutiny of others.

Adam: *Yer never gonna go fur a joab that you need a disclosure noo […] The only way ye can hide yer past is going self-employed.*

Perceiving that their criminal histories limited work opportunities they suggested that being self-employed was their only viable option. Self-employment however, brings its own challenges such as requiring money to start a business, business acumen, and the

ability to manage through periods of austerity and other financial challenges. Such an approach, and the challenges it would bring, does not appear to be conducive to promoting the stability that a person recently released from prison would be seeking as they look to settle into their new community life. It may be successful for some former prisoners but seems an unrealistic option for most.

Overall, participants realised that their future employment options were limited because of the stigma of imprisonment. They were attempting to be hopeful but were worried and fearful at the thought of being liberated. They recognised that employment and family life provided stability, structure and purpose when out of prison and not having these could lead to them returning to prison. The inference from their described experiences is that prisoners need support during their transition from prison to the community. They also need to believe that, because of their offending histories, they will not be discriminated against when they attempt to obtain meaningful employment.

6.5 Chapter summary and conclusion

The experiences and opinions of a single focus group consisting of four veteran prisoners were examined. Two super-ordinate themes, each with sub-ordinate and associated sub-themes, explored these experiences. The first super-ordinate theme addressed perceptions of group identity and how this influenced relationships with non-veteran prisoners and with prison staff. The second super-ordinate theme examined what the group believed were the primary needs of veterans when living in the community, when in prison and in preparation for discharge from prison concluding that while veterans found it difficult to disclose a need for support, their needs were not that different from other prisoners.

The next chapter details findings following IPA of transcripts of a small number of 1:1 interviews with imprisoned military veterans who have declared mental health, drug or alcohol problems.

Chapter 7 - Findings for Part 3 of the study: IPA of 1:1 interviews

7.1 Introduction

This chapter presents the findings for the 1:1 interviews. Participants within this component of the study comprised of veterans who were residing in Scottish prisons. All had a declared mental health, drug or alcohol problem. The analysis aimed to answer what veterans with mental health, drug or alcohol problems perceived to be the cause of their imprisonment, their subsequent experience of imprisonment and what they believed was required to address their health, criminogenic and social needs.

The analysis is presented as a single super-ordinate theme titled 'The experiences of prison'. This super-ordinate theme parents five child/sub-ordinate themes. This is visually represented in Figure 7-1 and Appendix 11 provides an example of sub-theme to sub-ordinate theme development. The conventions followed when presenting participants' quotations are the same as those described in section 6.1 in Chapter 6.

7.2 Participant portraits

Eleven veteran prisoners from three Scottish prisons initially agreed to participate in the 1:1 interviews. Five veteran prisoners, after consenting to participate, did not attend for interview and opted to withdraw from the study. One further interview did not proceed as there had been an error by a prison VICSO during recruitment resulting in a participant being invited to interview but was then found to not meet the study inclusion criteria. Another volunteer was found to be intoxicated so I did not proceed with the interview.

This participant did not wish to reschedule to another interview date and was withdrawn from the study.

Four participants from two prisons, equally split, completed the 1:1 interviews. At the time of interview their ages ranged between 35 and 41 years of age. Of the four participants, two had been remanded into custody awaiting trial. The remaining two were serving short-term sentences (a sentence of less than four years). Prior to imprisonment, two had been living with their partners and two were living alone. Three of the four were in prison for committing a crime involving violence. For one, this was his first time in custody. All four had served in the Army during the 1990s with periods of service ranging between one to six years. Three out of the four had served in conflict theatres, of which one had multiple postings. The remaining participant had not served in a conflict zone. All participants had a planned discharge from their military service with two receiving honourable discharges, another resigning after completing his initial training, and the fourth being medically discharged due to his mental health problem. All had active and past histories of mental health difficulties. Two of the participants' mental health problems started whilst they were still in the Army: both following deployment to a conflict zone. Two, John and Bob, believed that their experience of military service was related to their eventual imprisonment but was not a direct cause. The remaining two participants believed that their military service was not related to their imprisonment. Appendix 10 provides a summary of participants' demographics and other characteristics.

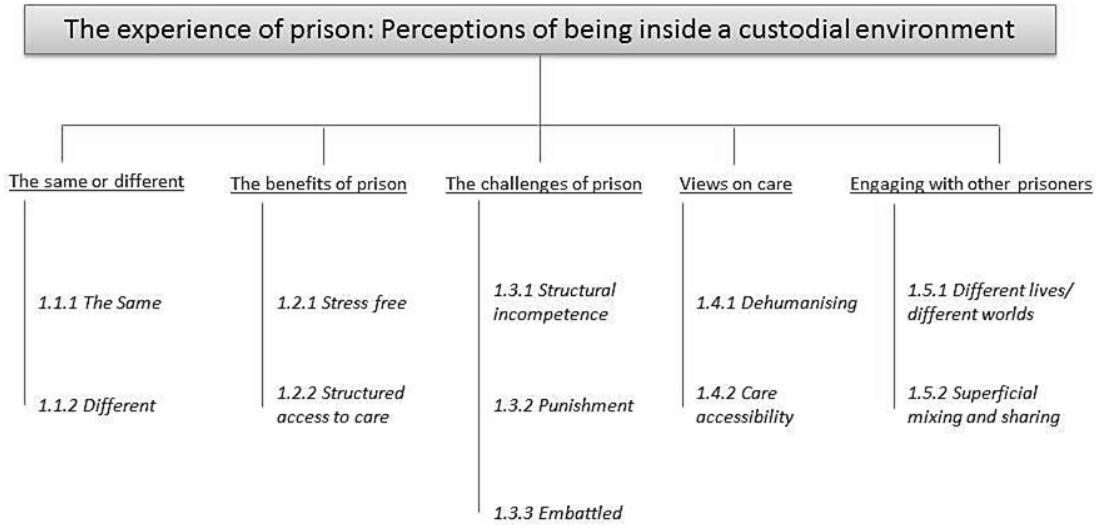


Figure 7-1: Visual representation of super-ordinate and sub-ordinate themes

7.3 Super-ordinate theme 1: The experience of prisons

This super-ordinate theme addresses participants' perceptions of their experience of being in prison. It examines interview participants' perceptions on how prison compared with being in the Armed Forces. It also examines their perceptions of benefits they obtained from being imprisoned, challenges they experienced while in custody, and their perceptions of the care provided by the prison system. The super-ordinate theme comprises of five sub-ordinate themes; the same but different, benefits of prison, challenges of prison, views on care, and engaging with other prisoners. Each of these has its own set of sub-themes which were derived from the close reading and analysis of the transcripts.

7.3.1 Theme 1.1 Perceptions on being inside a custodial environment: the same or different

Sub-Theme 1.1.1: The same

John and Bob both thought their experiences of imprisonment had strong similarities to their experience of serving in the Army. Bob, at a very pragmatic level, experienced both institutions as exactly the same. This was because he understood that when people leave them they leave behind an organisational system that caters for their basic social and welfare needs.

Interviewer: *Is the experience of leaving prison a similar experience of leaving the Army?*

Bob: *Aye. Aye it's like the exact same because in here you've got yer three meals a day, you've got yer bed, ye get yer visits, it's like a, yer in a routine in here.*

Agreeing with Bob on the provision of 'a routine' John also suggested the similarity rested on the presence of structure and order.

John: *There's a routine, there's discipline.*

Both suggested that the Army and prison are similarly structured hierarchical organisations governed by rules and that both involve discipline. Discipline by the institution through the adherence to rules and through the medium of punishment and discipline of 'self', for example, self-control to avoid deviating from the rules.

Bob: *It's just (breath) it's just, same kind of rules as the Army …But the prison staff, see that's what I mean, this is, jails just like, prisons just like being in the Army. Yer, the prison staff are just like yer sergeants, you know…You just follow by their rules if you follow by their rules then everything is alright.*

For Bob there were also relational similarities. Both prison and Army provided him with a sense of belonging, of being part of something greater than being an isolated individual. For Bob this was obtained through access to a defined group identity and the social contact this brought with those he had this bond with.

Bob:	*It's just like, it's just, it's just like being in the Army ay, hink [think] it's just being part of that group… It's sort of yer in the Army you belong to a wee [small] group and then when you come into prison it's like yi get pit [put]in the wee group…[and later comments] […] The jail is just like the Army, to be honest with you.*
Interviewer:	*Is it?*
Bob:	*Aye.*
Interviewer:	*In what way?*
Bob:	*Just jibbing wi aw yur* [jobbing with all your], *it's like being in wi aw yur boys.*

This experience, however, may have been unique to Bob. None of the other three participants made reference to this similarity. Yet, it clearly resonated with Bob who also, when discussing similarities and differences between the two institutions, used the terms 'prison camp' and 'army camp'.

Bob:	*A prison, a prison, a prison camp is just like an Army camp basically but the difference is in the Army you've got a gun and ye can, it's a lot, there's a lot, they're so similar but yet they're quite, you'll get, obviously you get your freedom that's the only difference, that's the only difference.*

Bob's use of the word 'camp' had more than one interpretation. He used the word 'camp' to describe the structures that defined where he resided; for example, his living quarters, the transiency nature of his stay, or the organisational processes that governed his stay in that environment. Conversely, it could be interpreted as a collective gathering of people with the same group or category identification. For Bob both interpretations were applicable. He saw structural similarities and he saw interpersonal similarities through contact with his peers.

Sub-Theme 1.1.2: Different

Despite these similarities Bob, however, was able to identify a clear difference between the two organisations. In addition to having access to a gun, he suggested that in the Army he had his freedom. This, to Bob, was the only difference between being in the

Army and being in prison, although Bob's definition of freedom would have been context specific. When joining the military he would have had to forego some of his freedoms to meet the requirements of military service. Kenneth provided an insight into the views he held when comparing the two organisations. Whereas Bob and John both saw strong similarities between their prison experience and their time in the military, Kenneth was less certain. For Kenneth, the Army was a much more demanding experience. He believed that when living in prison there is a clear difference in freedom of choice, commitment to engage with what happens in prison and the motivation of the people in prison. For Kenneth, prison living is easier when compared to living in the Army.

> *Kenneth:* *It's like prison some sometimes relates a wee bit to the Army except obviously it's easier, more relaxed, because you dinae* [don't] *have to dae* [do] *nothing whereas in the Army ye were, that's it, ye hud* [have] *to, ye were told to dae it yed dae it, whereas in here there's too much, too easy, too many people aw a'hm putting a complaint in, ah'm no moving, sitting doing nothing – laziness basically.*

Kenneth also suggested that prison is paternalistic in its approach to its prisoners. Being in the Army meant being treated as an adult whereas in prison the experience felt like being treated as a child when in school; expected to conform, not challenge, and not be as knowledgeable as those in authority.

> *Kenneth:* *… it's more childish in here. In here's more childish. In the Army, in the Army a hink yer taught, yer treated more like an adult then and in here it's like being back at secondary school.*

Ryan extended upon Kenneth's adult/ child analogy. To Ryan, one institution was an enabler and the other is a disabler: one gave responsibility and the other removed this. The Army fostered new learning and developed personal responsibility and accountability: the prison system impeded this, curbing the ability to look after oneself.

Ryan: *Well in the Army you're, you're taught basically, ye ye yer taught to look after yerself. An in here it's a restriction ih* [in] *how much you can only look after yerself.*

Ryan was the only interview participant who was of the opinion that prison and army were very different institutions and that his experiences of both were dissimilar. To him, these two institutions were opposites, describing how they differed as being like *"night and day"*, and had nothing in common.

Ryan: *Everything's completely different. Everything's completely, there's pfff the difference between the two o* [of] *them are night and day. Across the board.*
Interviewer: *Are there any similarities*
Ryan: *None at all.*
Interviewer: *None at all?*
Ryan: *None at all.*

This difference did, nonetheless, come as a shock to Ryan who believed that he entered prison with a false sense of preparedness. He thought he knew what prison would be like because of his experience in the guard house during his time in the Army but the reality of his prison experience was very different.

Ryan: *…before prison a wis thinking to maself, because a'hve* [I've] *done time in prison just for stupid things…Like going back way, fights, everybody gets in fights, everybody that's been in the forces has served time in the guard hoose* [house]*, so fur me to think aboot coming to prison an whit ah've been through it's gonna be, a walk in the park but it's no, it's nothing like that, it's every, it's a mental struggle every single day.*

Moreover, to Ryan, this struggle was unrelenting as he felt he was repeatedly encountering the same set of challenging prison experiences.

Ryan: *Just getting by every day. Every day. Every day is the exact same and it just means its groundhog day, every day is exact same as what it's gonna* [going to] *be the next day, it's just gonna be the same, same routine.*

In summary, this theme focused on whether participants' experience of prison had a similarity with their experience in military service. For some, there were clear similarities with both institutions regarded as being structured hierarchically and rule-bound. Yet, not all concurred, with Kenneth suggesting that people in prison engaged in behaviours that would never be accepted in a more demanding military environment. Moreover, Ryan strongly asserted that there were no similarities between the two experiences. He also disagreed with Kenneth, arguing that the unending monotony of prison was much more of a challenge than his experience of military service.

7.3.2 Theme 1.2 Perceptions on being inside a custodial environment: the benefits of prison

Theme 1.2 focuses on whether participants benefited from their prison experience. It describes how, or in what way, they experienced this benefit and describes how, for some, it provided an opportunity to experience a break from the challenges of the outside world. Sub-themes within this sub-ordinate theme are 'stress free' and 'structured access to care'.

Sub-Theme 1.2.1: Stress Free

Both Bob and Kenneth described the experience of being in prison as being *'easy'*. Bob missed his family and would have preferred not to be in prison but found prison unchallenging. For Kenneth, the inference was that prison offered an opportunity to access a quality of life he did not experience elsewhere. This was a life he enjoyed and benefited from as being in prison was providing him with an opportunity to relax in the absence of being exposed to stressors from his life pre-incarceration.

> *Interviewer:* *Can you describe to me what it's like being in prison?*
> *Kenneth:* *Pff. Easy.*

[Then later in the interview]

Interviewer: *So it's* [prison] *easy?*
Kenneth: *Aye. Basically. A quite, a like it, if I, because, …Well a dinnae have to bother aboot, ootside a have to worry aboot ma rent an ma gas a dinnae have to worry aboot fighting and ken whit [know what] a mean. There's nae fighting in here unless ye want tae fight, ay so aye a quite like it (laughs)*
… A mean a couldae been oot o here for another four weeks coz a goat bail fi the sheriff but a told him to keep it a didnae want to sit aboot oot there any mare as a said a wanted to come back in here, it's like a brek [break], *like relaxing getting everything off yer shoulders, ay.*

Kenneth described his time in prison as though he was on a holiday. When asked if he had any additional care needs he indicated that he had none, that he was well and content with his current situation.

Interviewer: *Is there anything else you think could help you?*
Kenneth: *Nah a think to be honest wi ye ah'm quite awright, ah'm quite happy, well having a wee break"*

Moreover, Kenneth suggested that his being in prison had its advantages as it provided him with a period of respite from his alcohol use and offered him time to reflect on what he wanted for his future.

Kenneth: *Well it'll give me a fresh start when a get out, eh it's keeping me off the drink, it's geein* [giving] *me time to get ma head together an that, gies me a time to see who ma real friends are oot there ken and basically sit an hink what a want tae dae when a get out an that.*

That being said Kenneth's reported experience of prison as a reflective holiday, albeit one he did not choose, was unique amongst those interviewed.

Theme 1.2.2: Structured access to care

Bob and John acknowledged that being in prison had been beneficial. For Bob, the benefits were practical and it was these benefits that made it easier to cope with the bind of imprisonment. Prison provided him with regular food and social contact.

Interviewer: *And what's it like being in prison?*

Bob: *(long long pause) You just get the heid doon* [head down] *and get on wi it init. It's just like (pause) it disnae bother me, a know that's bad to say but it disnae bother me, you're getting, like a say, yer in wi yer pals, yi get fed three times a day.*

For John, it was the very structure of the organisation and its routines that made it easier for him to cope with his imprisonment. He knew that embedded into the prison system and its routines were support structures and preventative measures that helped him address his health needs. People would come to see him and offer him assistance, while the rules of the environment he resided in stopped him from engaging in activities that were harmful to his wellbeing.

Interviewer: *And does the discipline and the organisation and the structure make it easier?*

John: *Aye. Aye.*

Interviewer: *In what way does it make it easier?*

John: *Because it's, you know yer getting that help. You know you've goat* [got] *structure there, you know there's people there to support you so it is…*

[then later in the interview]

Interviewer: *... what is it then that the prison gives you that you don't get when you're outside?*

John: *(long pause) Help. Help that ah'm really needing an then when a go back oot, ah'm no getting the help ah'm needing.*

Interviewer: *Ok so what kind of help are you getting in here?*

John: *Ah'm getting help through ma alcohol addiction so am are… Whereas outside it's, when a phone, when a court orders fae* [from] *the court aboot go to alcohol counselling an help wi ma addictions ah've never ever hud it. It's It's just a case ay go up and see a social worker, speak to a social worker for aboot 5-10 minutes an then yer oot the door. Ye don't get the help ye need, the support ye need. In here yae dae.*

John also credited prison with keeping him alive. He believed that without his periods of incarceration he would, as a consequence of his alcohol use, be dead. Like Kenneth, imprisonment gave him an opportunity to abstain from alcohol but for John it also addressed his health and hygiene needs and provided him with regular access to food.

John: *A think sometimes ah'm in prison to, it's keeping me alive because when a go off ma routine a start the drinking an a go away, weeks, months oan* [on] *the drink an ah'm no eating, ah'm no wash, sometimes ah'm no washing, no keeping maself clean, hygienically clean …when ah'm in prison ah'm oaff* [of] *the drink an it dis help me an then wance* [once] *a get back out a kind of know what ah'm doin.*

To John, and to a lesser degree Kenneth, prison was a caring institution, one that provided access to assistance and support from people who were interested in seeing and spending time with them. In John's case, this countered his experience outside prison where he believed he was not afforded the regular and adequate contact time with support staff that he believed he needed to keep him well. With Kenneth it was the access to clinical services, once he knew how to do this, and the prescribing of medication that he had not previously received whilst in the community, that demonstrates to him that prison was supportive of his needs. These actions were to John and Kenneth indicative of a caring prison albeit, from Kenneth's perspective, prisoners had to understand the rules and learn the procedures for requesting assistance before support could be easily accessed.

Interviewer: *What's it been like trying to get help for your problem then in prison? Your alcohol problem?*
John: *It's easier because when ye come in they'll ask ye what yer addictions ur* [are] *alcohol, drug abuse stuff like that an if you say that they'll come an see ye.*

[Different participant]

Kenneth: *Aye definitely making me feel better* [medication he receives in prison].
Interviewer: *Who started you on the, on the, on the medication that's helping you?*
Kenneth: *Ehh the doctor in here… that's a hink, a hink that's the first time ah've took them ah'm no sure (laughs) but they seem to be workin though. Getting a review next month.*
Interviewer: *So has it been straightforward to access people you want to see?*
Kenneth: *Aye as soon as you know what yer doin...*

Three out of the four interviewees described experiences that demonstrated that prison had been beneficial to them. Firstly, for Kenneth, prison provided him with medication he did not receive in the community and respite from the challenge of living in the outside world. Secondly, while more subtle, Bob benefited from having regular contact with his friends in prison and his basic needs met and these countered the loss of his freedom. Lastly, for John, prison saved his life: it gave him an opportunity to stop his alcohol use and addressed the physical and psychological decline that can accompany excessive drinking.

7.3.3 Theme 1.3 Perceptions on being inside a custodial environment: the challenges of prison

Participants' perceptions of the challenges they experience whilst imprisoned are discussed in sub-ordinate theme 1.3. These challenges can be clustered around three sub-themes: 'structural incompetence', 'punishment' and 'embattled'.

Sub-Theme 1.3.1: Structural incompetence

The term 'structural' within this theme has dual representation. It represents participants' need for structure to their time spent in prison: a structure that provides a sense of routine and a sense of purpose. It also represents structures that both form and define the organisation, e.g., enforced removal from society, organisational hierarchy for both staff and prisoners, a uniformed service, rehabilitation and health services. One benefit of prison, as mentioned in sub-ordinate theme 1.2, is the presence of a routine but problems with routines have also been identified and used as evidence of structural incompetence. For both Ryan and Kenneth, the structured, and in some cases compulsory, routines provided within prison failed to meet their needs resulting in feelings of frustration. For Ryan, prison routines such as compulsory employment did not provide sufficient structure to his day or occupy his time. These resulted in him experiencing

lengthy periods of inactivity, a sense of having wasted time, feelings of boredom and a perceived lack of control. Further, it challenged his very ability to survive his time in prison.

> *Ryan:* *… as a said that's how ye survive in here, ye survive in here by occupying yerself…*

Kenneth was also concerned that there was not enough happening in prison to occupy his time and despite having two prison-based jobs still found his experience of prison unstimulating. For Kenneth, the challenge of imprisonment was being under-challenged. Both Ryan and Kenneth expressed dissatisfaction with how the prison provided meaningful activity and purpose during their stay in custody.

> *Ryan:* *…pff even at that by the time you leave yer cell in the morning ye go to, ye go to yer work, ye come back at say 11 o'clock then yer back oot at 2 o'clock then ye come back at half past four so it's only like four an a half oors* [hours] *a day an in between that yer just walking aboot, wandering aboot, standing waiting…(expels air) it's nothing, there's nothing can get done aboot it so you've got nae feelings towards it, it can be frustrating... but ye just put it to the back o yer mind and accept what's goan oan.*
>
> *Kenneth:* *… Em which is basically the only thing that annoys me in here. Coz there's no enough to do even like ah'm working two joabs* [jobs] *in here but even at that ma joabs are sitting aboot and nuthin* [nothing] *challenging if ye ken whit a mean…Quite simple tho, ay* [yes], *so that's the only bad thing aboot being in here just like getting somehin* [something] *challenging, everything that you do in here it's quite easy.*

Kenneth, however, went further holding the prison responsible for disrupting any personal routine he attempted to establish, blaming the prison's ongoing tampering with their rules. For Kenneth, establishing and maintaining a routine was essential as he used this to keep himself active, to minimise the amount of contact he had with other prisoners and to prevent him from becoming aggressive.

Kenneth: *…routine's basically the best thing in here for me […] that's another thing that annoys me in here… ye cannae* [cannot] *get into a routine when they change their silly wee rules.*

These experiences in isolation may not have been enough to lead Kenneth and Ryan to believe that the prison was structurally incompetent. Kenneth even accepted that things can go wrong, but, the unreasonable rule changes were not the only negative experiences he reported. He suggested that the structures put in place to operate the prison, for example, where prisoners are located, what they eat, how they are moved around the establishment, and the quality of staff the prison service employs, were indicators of organisational incompetence.

Kenneth: *… once in a blue moon suhin* [something] *will go wrong but a mean a dinae see how it can go wrong aw the time. A mean ye've got a sheet an ye've got somebody employed tae count the numbers on the sheet for a meal but yer at least two or three times a week come back wrong […] am in an enhanced hall so the gates are meant to be left open which depending on which staff come from what landing some of them will leave the gates loacked* [locked] *so ye've goat to shout them an ask them for everything […] ye cannae go doon to use the gym because they've put the gym on the hall on the side where aw the people who've goat addictions are oan so they're aw stoatin* [wandering aimlessly] *doon ti get their (laughs) meth* [methadone]. *[…] Staff training every Friday an they've been here 20 years, what they learning now? […] (laughs) it's no staff trainin every Friday or they're, either that or they're aw dumb because a mean what do ye need to be trained oan after 20 years ay dain* [of doing] *the same joab (laughs)…*

Ryan also offered an example where the practices within the prison failed to demonstrate a cohesive approach and effective communication instead demonstrating incompetence in practice that resulted in him being punished.

Ryan: *…a was prescribed the same medication as whit a wis getting oan the ootside in here … cut maself doon to 150 […] and a spoke to the nurse aboot this and the nurse said to me that she was gonna refer me to see a doctor[…] on the 16th of January a wis handed this slip of paper […] paper said a had an interview to*

> *see ma doctor […] but ma appointment wi the doctor was on the 14th of January so a missed the appointment. […] so a still had like 14 days' worth of, eh, medication that a wisnae taking […] ma cell was searched…and they found oot, they found the medication that a shoulda* [should have] *been taking […] and they changed ma, a was a low category prisoner and they changed it to a medium category prisoner. Even though a had all this evidence that a was being totally legit aboot it they wurnae* [were not] *interested, […] a wis kicked oaf the landing, pit doon* [downgraded]*, loast* [lost] *ma joab an everyhin, […] a told the nurse that a wisnae taking the medication […] and punished anyway.*

For Kenneth and Ryan, the prison system displayed incompetence across the range of services it delivered. Both perceived the structural incompetence of the organisation at micro and macro levels. At a micro level, the structural incompetence impacted directly on them limiting what they could do in prison to maintain a sense of purpose and self-worth causing them to experience feelings of frustration. At a macro level they perceived their personal experiences of service failure as evidence that these failures were pervasive across the prison system. They felt that these personal anomalies were indicative of wider structural failings that affected all prisoners and, for Ryan, were indicative of being further punished.

Sub-Theme 1.3.2: Punishment

Ryan had served as an infantry soldier in a number of conflict theatres, yet it was his experience of prison that he described as being horrible.

> *Interviewer:* *Can I ask you a little about being in prison, can you tell me what it's like, em, being in prison just now*
> *Ryan:* *It's horrible.*

To Ryan, contrary to the other three prisoners interviewed, the experience of prison was one of ongoing punishment, where other prisoners were a danger to him and prison was analogous with being in Hell. Hell, however, was not as inferred in the modern Christian

lexicon; instead it was more akin to the Greek mythological place of Tartarus[6]. For this participant, prison was not able to achieve its primary purpose of supporting and rehabilitating prisoners whilst they served their time in custody. To him, the experience was one of constant struggle where he felt as if there were obstacles deliberately and constantly blocking his progression from residing in a closed prison to an open prison establishment. This placed him in a 'Catch 22' position. He believed he could not complain about his treatment without jeopardising his progression; yet, he experienced frustration and anger at the thought of how he was being treated, and was concerned that he would lose his temper, be punished by being '*placed on report*' [a prison charge for unruly behaviour] and as a consequence delay his progression to an open prison. For Ryan the actions of the prison were deliberate.

Ryan: *…because this is, this is, this is hell in here … (laugh/huh) yer in here, yer in here to serve yer punishment, yer no in here, yer in here to serve yer time because you've been punished. Yer no in here to be punished. …another thing, as well is the drug addicts in here. They've, a know numerous people that have goat hepatitis an there is nae protection fur anybody that's came in here clean, there's nae protection at all. Yer made to share cells wi thum* [them] *an if ye complain aboot that, complain aboot that ye've absolutely nowhere. Nowhere at all. […] …when yer in here yer entitled to it* [entitled to have your rights respected] *or so they say an yer getting nuhin, absolutely fucking nothing. […] it's it's it's trying to deal wi the way, the way ye get spoke tae in here. The way ye get spoke tae the way you get treated the the basically the way you get looked at in here is half the, a mean that itself is a struggle… so for no to be used to that and getting treated like that to come in an having, having to deal wi it every single day that's an obstacle in itself […] in here ye fly oaf the handle and ye just get put in report and a cannae afford to get put on report because am chasing, am chasing open prison to get oot o here…*

[6] Tartarus: a deep abyss at the bottom of Hades that is used as a dungeon where the torment and suffering of the wicked can take place.

It is, nonetheless, important to emphasise that it was only Ryan that described the experience of imprisonment as a place of ongoing punishment and his view was clearly divergent from the views of the other interviewees. As Bob pointed out *"You just follow by their rules, if you follow by their rules then everything is alright"*. For Bob his punishment was the loss of liberty but to him living in prison was not punishing.

Sub-Theme 1.3.3: Embattled

Ryan, and to a lesser degree Bob, offered insight into their experiences of feeling they have had to battle to survive. For Ryan, who constantly felt on guard, it was clear to him that the battle existed only in prison and much of it was in conflict with prison staff who, he inferred, wanted him to surrender and conform.

Interviewer: [Ryan] *Does it feel like your defence gets put up quite often?*
Ryan: *In here?*
Interviewer: *Uh-huh.*
Ryan: *Every day. Ma defence is never doon in here.*

[Then later]

Ryan: *It's just a fight in here, yer, yer, ah'm occupied, a'hm occupied most of ma time in here wi fighting. Concentration, concentrating getting oot so... em... a mean don't, don't get me wrong a have days in here and yer just, yer just banging yer heid against the wall but the way, the way that a'hm dealing wi it is, just fighting to get past that.*

[Then when discussing the approach prison staff take when dealing with prisoners he described that he felt he was losing the battle and that they wanted him to surrender.]

Ryan: *… an every, ye just have to bite yer tongue every single day an just keep trying and trying. […] Ehm, to lie doon, that's half, half o them, half o the the prison officers want, they want that for ye, they just want for ye to lie doon and give up and stoap* [stop] *asking questions…*

Bob, who thought it was best not to personalise things when prison officers were *"cheeky"* was happy to conform to institutional requirements:

> *… a think they think ah'm ok because ah'm pleasant an ah've never been angry or raised ma voice to anybody in here, they, whit they ask me tae do a go an do it.*

Bob's struggle to survive existed beyond his experience of imprisonment. For Bob, 'everyday living' was his battle and this spanned his past and present life and his expected future. He attributed his battling skills to his army experience, stating that the *"Army snap you, they turn you in to what you are in life…"* and whilst Bob believed this could be beneficial if your post-army life was successful, he suggested that it could have negative consequences if your life is less successful and you have *"to fight for survival"*. To Bob, his life had been unsuccessful and as such he was engaged in a relentless conflict.

Bob:	*… if you get a positive job or whatever, an it can be unpositive if yer having to fight for survival a suppose.*
Interviewer:	*Does it feel like you're fighting for survival?*
Bob:	*Every day.*
Interviewer:	*Every day?*
Bob:	*Aye.*

Where Bob believed he had no options available to him other than to attack and eliminate a threat, he believed he would do so, even in prison. When survival is the key priority Bob would 'do whatever he needs to do' and that would be what the Army trained him to do.

Bob:	*… if a get backed up into a corner the obvious things is ahm gonnae huv to retaliate.*
Interviewer:	*Do you think that's part of your military training or is that just part of who you are?*
Bob:	*The Army trained ye for aw that, tried no to get into that position, if you get put into that position to try and avoid that position, if you cannae avoid it then obviously, whichever way means you know…. […] If it comes to me then a'hll* [I'll] *need to take, take the measures to deal wi it won't a…*
Interviewer:	*Is that…*
Bob:	*Whatever, which way or form.*

Conversely, while Ryan also adopted an approach of 'doing what needs to be done' to survive, his approach was less retaliatory and offered less of a threat of overt aggression. Ryan, for all his frustration and concerns about how he believed he was being treated by the prison system and its staff, did not revert to a military type response but instead adopted a 'conforming compliant prisoner' approach. Conforming to the requirements of the prison system, and by demonstrating that he was a 'model' prisoner, suitability rehabilitated and fit for return to civic society, was his method of 'doing what needs to be done'.

> *Ryan:* *Every single day a just look at whit a can dae, whit a can volunteer fur, every single tick that a can, every boax [box] that a can tick if a can see it's gonna help. That maybe selfish but a don't care, it probably is […] Every boax that a can tick an it's goan on ma record that a volunteer fur this, volunteer for that, volunteer for everyhin, gonna goes towards courses work for me released early then that's whit am gonna dae.*

In summary, Kenneth, Bob and Ryan all identified challenges from their stay in prison. Bob and Ryan described being engaged in an ongoing battle: Ryan within the prison environment, which he feared he might be losing, whereas Bob's life was a daily struggle for survival. Kenneth's challenges, however, were specific to how the prison system delivered its services and the anomalies that can occur when large-scale bureaucratic organisations operate a rule-bound people-based service. Moreover, prison is generally regarded as a noxious environment; yet, Kenneth found imprisonment easy and would rather be incarcerated. This provides insight into how challenging his pre-prison life experiences had been to him, inferring that he too might have struggled to survive if he was not in prison.

7.3.4 Theme 1.4 Perceptions on being inside a custodial environment: views on care

Within this theme the term 'care' is being used in its broadest sense to describe all aspects of care, for example, provision of healthcare, welfare, personal care and the prison's duty of care [its responsibility for the safety and wellbeing of the people it is charged with holding in custody]. The sub-ordinate theme contains two sub-themes, 'dehumanising' and 'care accessibility'. These are not uniquely distinct and there is slight cross-over: dehumanising makes it easier to ignore care needs.

Theme 1.4.1: Dehumanising

One of the processes deployed in Scottish prisons is to remove aspects of a prisoners' personal identity. Prisoners are provided with a prison number which the prison use as a means of identification and which prisoners have to use when engaging with a range of prison procedures, e.g. obtaining medication, ordering canteen [personal supplies of food stuffs and beverages], and requesting access to courses and training.

> *Bob:* *You just go to a wee room and she asks you what your jail number is. Ye gee* [give] *her yer jail number and she hands yi yer medication and that's you fur a week.*

Additionally, prisoners are provided with a basic uniform and have restrictions placed on them as to when they can wear normal clothing. However, Ryan and Kenneth gave descriptions of their perceptions of care that indicate dehumanising of prisoners occurred in other forms: some subtle and others more overt. There was, nonetheless, also an indication that prisoners dehumanised prison staff and other prisoners. Ryan described overt dehumanising by staff of prisoners and, although failing to recognise this, his own overt dehumanising of prison staff.

> *Ryan:* *some of the screws are alright but other screws are just animals that treat ye like yer fucking, worse than shite, em, nane* [none]

o them have goat a civil, civil word to say to yeh. […] An the majority o them just treat yi wi contempt anyway, yer a criminal and that's it.

Ryan's view was that to prison staff only who you are now matters, not what you were before, and just now he was a criminal. Kenneth's example is more subtle and at first reads as though he is complaining about prison staff's lack of interest in the welfare of prisoners. To him, prison staff deliberately ignored bullying and intimidation of prisoners, although it was unclear if the bullying and intimidation was prisoner on prisoner or staff on prisoner. He believed, however, that at times prison staff's actions, or lack of, made them complicit.

Kenneth: *…ah've, a just think that... if a could see like if a could see what's going on in prison an what was going on in the Army* [Kenneth observed Army staff regularly assault junior staff during his basic training] *ken bullying wise an that, am pretty sure the officers can as well so instead o sticking to their silly wee rules and daein joabs they should be trying to help people a wee bit mare a reckon. Ken coz they ken whits goan oan as well, they're no daft. But they turn a blind eye when it suits themselves.*

Kenneth proceeded to describe how prison staff told prisoners that they should be respectful to one and other, but then used the word 'beast', a pejorative slang term used by prisoners for a person convicted of an offence in which sexual violence, usually directed towards children, occurs. While Kenneth was unwittingly dehumanising other prisoners with the use of this term, he was inferring that prison staff endorsed the dehumanising distinction between prisoner types and overlooked the bullying of such prisoners because they deserved it. To Kenneth some prison staff were not interested in protecting the people they were responsible for and some prisoners were not human enough to warrant protection.

Kenneth: *… ye get yer interview an they tell you aw ye should treat everybody the same, an then ye've goat like beasts an*

> *everything like that, people put on protection, but they* [prison staff] *turn a blind eye when it suits them. They expect us tae dae it [treat other equally] but they dinnae dae…*

For Ryan, though, it was not just the actions of prison staff that indicated to him that the prison sought to dehumanise the person. Ryan, who spent time as a 'peace-keeper' in the Balkans during his military service and was tasked with protecting the rights of the people living there, was asking who would now protect his rights during his time in prison. He believed the prison environment and the practices deployed in prison challenged his human worth and dignity. To him these practices dehumanised him by reducing the rights he had as a human being. However, unrecognised by him, through his prejudice he too was seeking to reduce the human rights of others.

> *Ryan:* *Everybody's still got human rights and every single day they're getting violated even if it comes doon tae, as a, as it, every single day your human rights are being violated because of the standard of hygiene in here. It's absolutely disgusting. Your human rights are being breached because yer put in, yer put at risk wi sharing, sharing a cell wi people that have got blood borne diseases.*

Both Kenneth and Ryan appeared to believe that prison purposefully attempted to dehumanise prisoners while at the same time voicing comments that dehumanised staff or other prisoners. It should, however, be recognised that only two out of the four participants made reference to experiences suggestive of dehumanising practices occurring.

Sub-Theme 1.4.2: Care accessibility

Ryan was generally dismissive of the provision of care in the prison, citing inadequacies and inconsistencies in approach by the prison in supporting him care for his hygiene needs and healthcare staff in caring for his health needs. As a consequence, he believed he was unnecessarily exposed to risks not of his own making. To Ryan, the

approach adopted by the prison conveyed to him that prison (its systems and people) did not care and that there was, therefore, an absence of care.

> *Ryan:* *An (cough) as a say, the care in here, the hygiene, eh, the place is shocking, it's ridiculous, the showers are absolutely disgusting, ehm, […] Yer no getting, if you asked, like questions aboot, like the hygiene in here, is terrible, there's nuhin gettin done aboot the hygiene in here. There's hundreds and hundreds ih people using different door handles every day an, there's nuhin…*
>
> […]
>
> *Ryan:* *There's, there's, there's nae care, […] ah've been cairyin* [carrying] *this infection wi me fur, pff, 3 weeks or suhin noo* [something now]. *A've pit in numerous, numerous complaints and numerous nurse referrals to see a doctor and a finally seen a nurse which was two days ago and a wis told there was nuhin wrong wi me.*

Ryan went further in his condemnation over the lack care within the prison stating:

> *Naebody cares in here. Nobody cares in here. Every prison officer, and a mean that across the board, every prison officer is in here to dae a 9 till 5 joab. There is nae care whatsoever. You ask a question and nine times oot o ten it's generally, generally blanked.*

Ryan inferred that prison staff approached their work as if their job was outside of prison and not responsible for the welfare of prisoners. The evidence to Ryan was that more often than not, when he approached prison staff with a question, he was ignored and was made to feel invisible. Further, to Ryan, this practice was pervasive and ingrained and had resulted in those people working in prison no longer caring about prisoners and those residing in prison no longer caring about themselves or others in prison.

Bob concurred with Ryan's opinion that there appeared to be an absence of care. However he was less cynical and dismissive than Ryan when describing his perceptions of care provision in prison. When asked by the interviewer what it had been like trying to get help in prison, Bob was apologetic when responding that there was no help.

Moreover, whereas it was clear that Ryan knew that there should be care provision, but believed the prison service was being maleficent in its failure to deliver this, Bob appeared to genuinely believe that, other than receiving medication, no care provision existed in prison. The failure of the prison care services to approach Bob to assess his needs and their general lack of visibility indicated to him that there was not only no help for his health problems in prison but no help for any of his problems. This inferred that Bob had problems that he would have liked assistance with but that no support has been offered to him. Instead, because he believed he had been forgotten, he thought he was not worthy of support and that he needed to resolve his problems on his own.

Interviewer:	*Bob, what's it been like trying to get help for your problem in prison, your health problem in prison?*
Bob:	*There's not, there is no help?*
Interviewer:	*There is no help?*
Bob:	*Nut. Naw* [No].
Interviewer:	*No help at all?*
Bob:	*Nope. Sorry. Well a'hve no seen any help. Nobody's come to me or asked me aboot anything. Aw a get is ma medication and that's it. Ahm forgot aboot* [I'm forgot about].

John and Kenneth, however, described contradictory experience to Ryan and Bob. To John and Kenneth, accessing help in prison had been without difficulty. For Kenneth it had been easy because he had a known history of care from previous prison sentences and the prison doctor recognised this and made referrals for support.

Interviewer:	*How easy then has it been to access help for your problem whilst in the prison?*
Kenneth:	*Well a put in, basically it was the doctor that done it because it was on ma records but a asked to speak to a mental health person an a spoke to him…*

John found it easy to access services because the services (in this case healthcare) initially came to him. For John, though, the important factor was for prisoners to acknowledge

when asked on admission that they had difficulties and would like assistance with them. Once they did so John believed services would then engage with them.

Interviewer:	*How easy then is the access to services and support when you're in prison?*
John:	*See if ye admit that ye've got problems like that aye it's easy tae access aye.*
Interviewer:	*So you know where the services are and it's easy to get a hold of them.*
John:	*Aye, well as a said, when ye come in you, you get assessed by the doctor so ye dae an the nurses they'll ask ye if ye've goat any addictions, whether it be drink or drugs, an ye say ye've got issues, eh addictions fur drink or drugs, that's when the support starts comin in tae ye.*

However, John and Kenneth specifically described accessing support for drug or alcohol misuse and it may be that services that addressed these specific prison needs were more accessible than services that supported other mental health difficulties. It is also worth noting that John was of the opinion that prisoners were not asked if they have served in the military when they were admitted to prison and believed that health care staff were unaware of his veteran status.

Interviewer:	*Do the clinical staff know that you're an ex veteran?*
John:	*It's something they don't, they don't ask ye when ye come in if yer ex-military.*

One can therefore assert that John believed the ease at which he accessed care on admission to prison was not influenced by his veteran status. John went on to describe that care provision continued throughout the prison stay and, as long as the prisoner agreed, would include preparation for discharge and transfer back to a community support service. For John, his experience of accessing health care in prison had been positive with evidence of regular support from admission through to discharge for his alcohol and mental health issues.

John: *...when a come through, when you go to the doctor they ask you if you have any addictions whether it be drink, drugs stuff like that that sumhin ah've iyways* [something I've always] *said ah've goat alcohol issues an the help that ah've hud in here wae mental health team come to speak to me at once a week eh then they ask if ye want help when ye go outside everything then ye say aye an they get ye linked up wi some organisation ootside an a go tae that.*

What is less clear is why John was successful in obtaining access to health care and Ryan was not. John advocated acknowledging one's need and asking for support when invited to do so and that by doing this support occurred. Yet, Ryan, earlier, described asking for support from health care when he thought he had an infection and being told he had nothing wrong. John's need may have been more readily identifiable and amenable to support, whereas Ryan's infection was likely to have been a self-limiting ailment that would rectify itself with time. It may also be that the prison service prioritises addressing the mental health needs of its prisoners. This being said, the way both participants described their experience was suggestive of different approaches being adopted by each when asking for help. John described being transparent and honest about his needs when asked and that his needs were significant enough to warrant intervention. Both substance misuse and poor mental health can impede rehabilitation in custody, preparation for discharge back to the community and increase the risk of reoffending. Ryan, however, described placing numerous requests and complaints as part of the request for assistance with a minor ailment and then when seen by a nurse instead of a doctor was dismissive of the response he received from healthcare.

To summarise, there were two separate points of view when describing perception of care in prison: care appeared non-existent and instead prison staff actively pursued a practice of prisoner dehumanisation; or, care and support was easy to access if the prisoner knew how to access it. Nonetheless, while John described the ease at which he

obtained support for his alcohol issues, it was illuminating to note that if alcohol was available in prison he would drink it.

John:	*Well ye cannae drink in here. Cannae git alcohol in here.*
Interviewer:	*Do you think that's the only thing that stops you drinking in here?*
John:	*Aye.*
Interviewer:	*That you just can't get alcohol?*
John:	*Aye.*
Interviewer:	*So, if there was alcohol available in here do you think you would drink?*
John:	*Aye.*

For John it was not his engagement with the people who delivered the alcohol support interventions that had helped him stop his drinking. It was being detained in the prison environment with the restrictions this brought on accessing alcohol.

7.3.5 Theme 1.5 Perceptions on being inside a custodial environment: engaging with other prisoners

This sub-ordinate theme provides an interpretive account of participants' experiences of mixing, sharing and engaging with other non-veteran and veteran prisoners. It has two sub-themes; different lives/ different worlds, and superficial mixing and sharing.

1.5.1: Different lives/ different worlds

Kenneth and Ryan both expressed values that indicated that they regard themselves as different, and in Ryan's case, superior to other prisoners. There was a hint that Kenneth held a belief that he had superior status over non-veteran prisoners but, equally, he felt inferior to other veteran prisoners. He did not believe he was a 'proper veteran' because of his short military service and his non-deployment to a conflict theatre and this appeared to cause him embarrassment. Despite this, and despite him preferring not to discuss his military service experience with prison staff, he believed that staff who were aware he

had been in the Army would think he was a better person than the majority of other prisoners they cared for.

> *Kenneth:* *Well a think em a think they* [prison staff] *think a wee bit better ay me ken coz you've actually done something an yer no just somebody that's grew up stealing fi people and taking drugs or whatever ken what a mean. They think a wee bit better ay ye coz ye huv tried to do suhin ay.*

Moreover, he preferred to limit his contact with other prisoners by actively seeking solitude, where possible, because they had different priorities to him. It was through his use of the term 'them' which he used to describe all other prisoners on his hall that provided some insight into his values and beliefs.

> *Kenneth:* *Aye a wis just walkin aboot an a goat up, a mean up in the hall the only reason a got oot and lock ma door because if a dinae go oot everyone will come to the shutter aw the time ye goat this, ye goat that, ye goat this, ye goat that well if yer oot and aboot ye can just walk away fi them.*

Ryan's bias was, however, more explicit and stigmatising. Ryan, while expressing exasperation, used the analogy that the majority of other prisoners came from a 'different world' from him, one that he had difficulty engaging with and had only started to get used to. When asked if he mixed with prisoners he answered in the negative citing that most prisoners were substance misusers.

> *Interviewer:* *Do you mix with prisoners generally?*
> *Ryan:* *(Expels air) The majority o them are junkies* [substance misusers] *so naw. Naw, we lead a, a, a completely different lifestyle, compared to whit a wis used ti, em they've, they're in a different, it's like a different world fi what a wis used to.*

When asked again if he spent time with other prisoners he did respond with a less absolute answer stating that he would mix with 'clean' prisoners. Yet, a clean prisoner to Ryan

was not just a prisoner who was drug free, but also a prisoner who was free from blood borne viruses and only in prison for committing 'petty crimes'.

Interviewer:	*So do you spend any* [time] *at all then with non- veteran prisoners?*
Ryan:	*The clean ones aye. Aye. A mean ah've been in the civilian life noo, a mean ah've, a'hve adapted a don't a, a don't hing aboot wi, a don't associate wi, junkies.*
Interviewer:	*Ok, so when you define a clean one, a clean one would be?*
Ryan:	*Like a prisoner who's been in for petty crime, petty crime an they're clean, there's nothing wrong wi their blood, they're no, they're no drug abusers.*
Interviewer:	*Ok, so you would mix with those individuals?*
Ryan:	*Aye.*

While the above concern was driven by a fear of contamination the incongruity was that Ryan was serving a sentence for the supply of Class A drugs. Furthermore, he would not know if a prisoner had committed a 'petty crime' or had been tested for a blood borne virus unless he directly engaged with the prisoner. Ryan did not, however, limit his non-engagement to the 'unclean', he also held the opinion that he was different from people with mental health problems despite having his own mental health difficulties.

Ryan:	*… a mean there's pe… people in here that you look at an they* [other prisoners] *cannae haud* [hold] *a two minute conversation wi them because ye know that there's somehin wrong wi them mentally.*

Ryan's opinions, and prejudices, were much more overt than Kenneth's, yet both were in discordance with Bob's description of how other prisoners (and staff) saw veterans in prison. Kenneth and Ryan held negative views of other prisoner groups and believed they had a superior status to them. This then limited their interaction with other prisoners. Bob, however, believed that other prisoners did not apply any great value to his military experience, believing that they thought, despite him serving in the Armed Forces, that he

was no different to them. He also believed that prison staff treated him no different to other prisoners.

Interviewer:	*What do you think they would think if they knew you were ex-military?*
Bob:	*(Pause) Just like any other person, to be honest.*
Interviewer:	*What does that mean?*
Bob:	*They just treat you the same as the next guy …You know. Just treat you as your average, just your everyday kind of guy.*
[…]	
Interviewer:	*And do they* [prison staff] *treat you any different from being ex-military or…*
Bob:	*No.*
Interviewer:	*They treat you the same?*
Bob:	*They treat us all equally the same.*

Bob's opinion does warrant a caveat. While Ryan and Kenneth expressed a sense of superiority over other prisoners and Bob believed other prisoners thought he was an 'average guy', he did share some similarities with Ryan and Kenneth. Like Ryan and Kenneth, Bob attempted to minimise how often he mixed with other prisoners. Moreover, because other prisoners did not know he was ex-military, Bob was making an assumption as to what he believed other prisoners would think of him if they knew about his past military service.

1.5.2: Superficial mixing and sharing

Three out of the four 1:1 interview participants presented as uncomfortable socialisers who held back information about themselves and only shared what they believed they had to in order to get by in prison. Kenneth admitted that he could, with ease, speak and interact with other people in prison but preferred not to. This was partly because he wished to keep part of himself private and also possibly because he did not see the value in investing time in forming new relationships with people he had no desire to get to know or had little in common with.

Kenneth:	*Ehh a do it quite easily, but a dinae like daein* [doing] *it.*
Interviewer:	*You don't like doing it?*
Kenneth:	*Naww a kin do it but a dinae like daein it if a had ma choice ah'd rather keep maself to maself. Ken, if a didnae huv to speak to naebody a wouldnae.*
Interviewer:	*What is it you don't like about it?*
Kenneth:	*Well a just dinae see the point ay. There's nae point in me pretending to somebody a want to be their pal when a dinae, ah'm quite happy to be on ma own company, ahd rather a say hiya just to be nice an no be ignorant … to be honest wi ye a mean a wouldnae gie any of them a second thought if a wisnae in here.*

Bob also had superficial contact with other prisoners and was reticent in explaining why he stated he did not really mix. Bob lost his mother at a very young age and lived in a children's home. He entered the Army on leaving the children's home and subsequently ended up in prison. Bob had swapped one group-based, cared-for institution for another across his life. He described the friends he made in these institutions as being his family and because of this he 'fitted' into prison.

Bob:	*A'hve always been used to no having ma mum in my life and stuff like that coz a grew up in a home…So ma family ur ma friends… so when a joined the Army, coz a was brought up in a home a fitted right in with the Army and when a left the Army and a came into prison a fitted right in with the prison, you know. Coz a treat everybody like, treat em like, treat them like family sorta hing, ay.*
Interviewer:	*They're like your family?*
Bob:	*Aye.*
Interviewer:	*And do they treat you like family?*
Bob:	*(Cough) Aye a get on wi everybody.*

Bob had a need for attachment. He needed to feel he belonged: that he 'fitted'. The prison provided him with a network of people that he had a degree of commonality with. This group fulfilled his sense of what a family is and provided him with a place where he belonged. However, the enigma that Bob proposed was that he felt he was part of a family, particularly when he was with *'his boys'*, and got on well with all other prisoners, yet, stated that unless he had to he did not mix with other prisoners.

Interviewer:	*So can I ask you then, what's it like mixing with other prisoners? I mean you talk about being with your boys, what is it like mixing with them?*
Bob:	*I don't really mix with other prisoners. The only time I mix with other prisoners is when I go out to exercise. I maybe speak to the odd wan and that but… it's usually keep the heid doon and get oan wi it.*
Interviewer:	*So when you say being with your boys what does that mean then?*
Bob:	*Well on exercise you'll always have like a group you'll sit and talk wi, and talk to so that's what I mean by that.*

What appears evident from Bob's concluding statement is that he had reverted to an army mind-set. Prisoners regularly received exercise (controlled access to the outdoors) which they used to socialise with prisoners from other residential halls, but Bob's concluding statement could also be a reference to when he was in the Army going out on exercise with his squad and the camaraderie that this provided. The 'bonds of brotherhood' he obtained through military service had been lost following his medical discharge from the Army. One could argue that the social network he had formed in prison was an emulation of the social network he had when in the Army and lost when discharged.

Bob refused to discuss his military experience with other prisoners. He made a conscious decision not to raise it and to change the subject when others raised it. Bob described memories of experiences in the Army that he did not want to remember: memories that he forced into the past and did not want to share, even with those he regarded as family. This provided an example of 'keeping his head down'. One inference that could be made was that he was engaging in cognitive avoidance/ escape behaviour to mitigate against post-traumatic stress symptoms (intrusive imagery, memories and flashback). Not talking with other prisoners about his experiences may have helped to manage symptom distress by avoiding opportunities to talk with other prisoners about his army experience.

Bob:	[when asked what other prisoners think about his military experience] *Don't know coz a never speak aboot it.*
Interviewer:	*Is that a conscious decision?*
Bob:	*Just something a don't talk aboot. It's a distant, it's a distant memory innit* [isn't it].
Interviewer:	*So if someone raises it with you, one of the boys raise it with you, what do you do?*
Bob:	*Just say to them a don't want to talk aboot it.*
Interviewer:	*Ok. Does that work?*
Bob:	*Aye. (Long pause)(yawn) Either that or change the subject.*

Both Ryan and Kenneth also preferred not to discuss their time in the Army and would not raise the subject with others but for different reasons. Ryan believed that there was a common bond between ex-service personnel, irrespective of branch of service. For him, another veteran would be able to tell that he served by observing and listening to him and he, in turn, could identify them. Ryan inferred that the nature of the conversation between the two would be brief and superficial, for example, regiment, year and location of place(s) deployed, and that this would be enough to pass on the necessary information to facilitate shared understanding. To Ryan, only another veteran could understand his military experiences. Non-veterans lacked the insight or knowledge to do so and, therefore, he saw no point in discussing his experiences with them as it would be a waste of both his and their time.

Ryan:	*Well, it's, it's no suhin a would bring up in conversation, a'hm no gonna sit doon an oot the blue tell someone a was in the forces, just disnae work that way.*
Interviewer:	*Ok.*
Ryan:	*If it came up in conversation then, a wid, an it's happened in the past, ah'd say, say where a came fae an what ah've done an that but apart fi that, naw. A dinae, a dinae advertise for veterans to be pals.*

Ryan's perspective on this must be viewed alongside his opinions on other prisoners and with the knowledge that this was his first experience of custody. His limited engagement with other prisoners because of his contamination fears and sense of superiority reduced

the opportunity to speak about his experiences. Ryan, like Kenneth, was not looking to make any friends in prison, even if the other person was a veteran. Kenneth, though, did not speak about his military experience partly because he was suspicious of other people knowing too much about him and partly because he was embarrassed by it. He believed other prisoners could tell he was in the Army through the actions and behaviours he openly expressed, for example, keeping his prison cell and possessions in order. Yet, he chose not to tell non-veteran prisoners about his time in the Army because he *"dinnae like people kenning too much about* [him]*"* and wanted to control what others knew about him. His reason for not telling other veterans was that he feared being negatively judged by them. A real veteran to Kenneth was a person who has seen war, been shot at and killed the enemy. He had done none of these things so, to him, he was not a veteran and believed that real veterans would think this and judge him to be weak for not continuing past his initial Army training.

> *Kenneth:* *Aye a dinnae really speak much about it coz a in a way a wish a'hd stayed and in a way no sure if a done the right thing and in another way am glad a left. So an ma minds still a bit ken, did ye do the right thing or… a mean what's the point in saying to somebody oh a went to the Army done ma basic training then just left ay, ken wit a mean.*

John was the only participant out of the four who appeared comfortable speaking about his military experience with other prisoners and where prison appeared to provide relationships with others through their common interests and experiences. John mixed with other prisoners, including non-veteran prisoners, and saw the relationships he had in prison as being very similar to the relationships he had when in the Army. Like Bob, he described going out for exercise as being a practice that was very similar to what he did whilst serving and used this time to bond socially with other prisoners, just as he did in both the Army and Territorial Army.

Interviewer: *And how do they feel* [other non-veteran prisoners] *about that* [John being in the Army]*?*

John: *Eh they feel awright. They ask me what it was like being in the Army because ah've actually spoken to some ay thum* [them] *who says that it's something they'd like to have done. An they ask me what it was like when a joined up and things that ah'd done and where ah'd been tae an that wi the Army as well, plus wi the TA as well.*

[…]

Interviewer: *Do the guys you tend to mix with in prison is it, is it the same kind of relationship you had when you were in the Armed Forces, for example, mixing with your, your peers in the Army?*

John: *Aye aye, just the same. Just the same. Because sometimes if we're aybe sit and talk aboot stuff we'd done in the Army.*

What was different between John and Bob was that John was comfortable talking about both his regular and territorial military experiences, whereas Bob suppressed these memories, trying to avoid thinking about them. Bob's memories of military experience appeared to be too distressing to want to recall. John's memories appeared rewarding. They brought him into contact with others and facilitated the forming of relationships.

7.4 Chapter summary and conclusion

This chapter has explored the experiences of imprisonment as described by the four 1:1 interview participants who had mental health and or substance misuse problems, and identified a number of key sub-ordinate themes and associated sub-themes. It examined participants' views on the similarities and differences between prison and military institutions and their practices and then explored in detail the perceived benefits and challenges that being in prison brought to each participant. These themes ranged from feeling stress-free and having structured access to services to concerns regarding prison incompetence and participants' feelings of ongoing punishment and embattlement. The latter two themes resulted in some of the participant's believing that they were engaged in a daily fight for survival. Another sub-ordinate theme identified participants' views on

the care they received while in prison, with concern regarding their experience of being dehumanised being raised and contradictory experiences described on the accessibility and quality of care provision. The final sub-ordinate theme explored participants' relationships with other prisoners, identifying both a degree of superficiality to some of the relationships formed and perceptions of being different, and for two participants superior, to non-veteran prisoners.

The next chapter will discuss these findings and how they relate to the focus group findings presented in Chapter 6 to enhance understanding of the lived experiences of veterans in prison. The chapter will then use the findings from the qualitative analysis of parts 2 and 3 of the study to enhance understanding of the findings reported in Chapter 5. This final integration will then help enrich the overall understanding of the phenomenon being explored within the study.

Chapter 8 - Discussion

8.1 Introduction

This study offers an original contribution to knowledge by providing insight into the mental health and social wellbeing of veterans in Scottish prisons. In doing so it examines veteran prisoners and both non-prisoner veterans and non-veteran prisoners to identify similarities and differences between them. Reflecting on the discursive aspects of the research experience and through phenomenological interpretation it also enables greater understanding into how veterans in Scottish prisons make sense of their journey to imprisonment, how they adapt to custody, and the identities they adopt. An interpretative approach also aids understanding of the interpersonal relationships veteran prisoners form or maintain whilst in custody and the authenticity of these interactions, and their social connectedness. Lastly, it illustrates some of the concerns they have about their own and other prisoners' mental health and wellbeing.

This chapter synthesises the findings reported in Chapters 5 to 7 to address the aims of this study. It uses the findings from the qualitative analyses presented in Chapters 6 and 7 to enhance understanding of the quantitative findings presented in Chapter 5 and to provide insight into the lived experiences of veteran prisoners, including some with mental health problems. The chapter structures the discussion of study findings, and how these address the study aims, in three sections; pathways to prison; common or idiographic vulnerabilities; and the prison experience. Each section is discussed in the context of wider literature findings. The chapter concludes with a reflection on the limitations of the study.

8.2 Pathways to prison

This section examines the range of challenges experienced by some veterans that can lead them on to a pathway of offending and eventual imprisonment. Using the findings from both the quantitative and qualitative components of the study it discusses how the nature of their decision to leave the Armed Forces, their length of service, their access to employment and the challenges of community living can all lead to offending and prison custody. Factors that increase the likelihood of veteran imprisonment are then discussed.

In this study, the use of alcohol or drugs, the marital status of a veteran, and whether a veteran was raised by someone other than their birth mother, all independently influenced whether a veteran would be imprisoned. All, bar the mother parenting issue, have been noted as having relationships with veteran offending, arrests or imprisonment in the wider literature (Erickson *et al.,* 2008; Pandiani *et al.,* 2003; Benda, Rodell and Rodell, 2003) (see Chapter 2). However, it is important to acknowledge that it is rarely one factor that can lead a veteran on this pathway: the routes to offending are more commonly multifaceted. Some of the challenges experienced will be unique to veterans but others will be present in non-veteran population groups.

8.2.1 From military to civilian living

Both staff and prisoner veteran groups started military service at the same age but their ages when leaving service differed. The veteran prisoner group, on average, left military service at 24 years of age. Leaving military service at this age or younger is not uncommon and can account for more than 50% of military service leavers in a single year (DASA, 2010). However, leaving military service and trying to re-settle into a new civilian life at such an age can be challenging (Kapur *et al.,* 2009). Moreover, nearly half of the veteran prisoner group reported leaving service with less than a 4-year' service and

because of this some would have been regarded as Early Service Leavers (ESLs) (Ministry of Defence, 2010). ESLs tend to report experiencing higher levels of childhood adversity than non ESLs (Buckman *et al.*, 2013) and often leave their service before completing the minimum contract period, losing any entitlement to resettlement support (Ministry of Defence, 2010). They also experience the greatest difficulties when transitioning from military service to civilian living with many ESLs experiencing high rates of suicide, debt, homelessness, substance misuse, and crime (The Howard League for Penal Reform, 2010), and are more likely to self-report symptoms of common mental disorders and PTSD (Buckman *et al.*, 2013). Given that some of the prisoners in this study would have been ESLs the challenges they experienced leaving the military and trying to re-settle into civilian living could have, for some, started their journey to imprisonment.

How and when a person is discharged from military service can have an impact on the future health or employability of a veteran. For example, it is known that military personnel who have mental health problems whilst serving tend to have poor rates of retention and are discharged early from their service (Jones *et al.*, 2009). They also experience ongoing mental health difficulties and are more likely to experience job transience or have a greater chance of being unemployed post-discharge (Dandeker *et al.*, 2003; Iversen, Nikolaou, *et al.*, 2005). Military service *per se*, however, does not impact on the ability to obtain future employment (Albæk *et al.*, 2013), yet many veterans express a fear of unemployment (The Royal British Legion, 2006). Not having employment is also strongly associated with offending behaviour in some veteran populations (Benda, Rodell and Rodell, 2003). Most military personnel join the Armed Forces upon leaving school and have no experience of applying or obtaining civilian employment and often need guidance on this prior to leaving service (Ashcroft, 2014).

Those who leave early are not likely to have access to this guidance, or training to address other educational/ skill deficiencies they may have, making it likely that they will experience unemployment post-discharge (House of Commons Committee of Public Accounts, 2008). This difficulty can be compounded if marriage or stable partnerships dissolve post-discharge as such relationships have a protective effect when looking to access and maintain employment (Iversen, Nikolaou, *et al.*, 2005).

Post-military discharge: some of the study participants had difficulty finding work, while others found their jobs unstimulating or experienced difficulties in adjusting to being part of a civilian workforce. These experiences have been found in other veteran populations (Johnsen, Jones and Rugg, 2008). Employment difficulties, however, were not limited to the period immediately post-military discharge. Stable employment continued to be a challenge for the veteran prisoner group prior to their current imprisonment. It has been suggested that there is a bi-directional relationship between employment and crime (Mesters, Geest and Bijleveld, 2014) and that obtaining employment reduces the likelihood of committing a crime (Mallubhotla, 2013). Support for this was evident when listening to the concerns of focus group participants. They talked about their need for employment post-release from their current prison sentence. Without employment they feared a return to custody. One can question, however, whether this is unique to veterans. There was no difference in employment status between the two prisoner groups prior to their most recent incarceration. Being unemployed may be linked to reasons for offending and it may have been a common experience that veterans encountered on their pathway to imprisonment but in this study it was not a veteran specific reason.

Maladaptive coping, through the use of violence, to the range of challenges experienced when engaged in community living may lead to imprisonment. Aggressive behaviour has been associated with violent offending (MacManus *et al.*, 2013) and in this study, notwithstanding that it just failed to achieve significance, a greater proportion of veteran prisoners appeared to have feelings of anger and hostility compared with non-veteran prisoners. They also had greater feelings of aggression than the veteran staff group. Some of the interview participants openly admitted that they would resort to violence if the situation they found themselves in warranted it. Some suggested this was for their own protection as they *battled to survive* but one suggested it would be a first choice option to resolve a problem that they were experiencing and it is likely that for some of the veteran prisoners interviewed using aggression as a solution to their problems ultimately contributed to their imprisonment. Likewise, the offences committed by veteran prisoners also appeared more serious with the level of violent offences appearing greater, albeit marginally missing significance, than those committed by non-veteran prisoners, resulting in around half of veteran prisoners serving a sentence of more than four years. This is similar to findings in other studies (Noonan and Mumola, 2007; DASA, 2010; The Howard League for Penal Reform, 2011; Lindo *et al.*, 2012; HM Inspectorate of Prisons, 2014) suggesting that the use of aggression and acts of violence, either as a deliberate response to resolving a challenge being confronted by a veteran or through poor impulse control, contributes to veteran imprisonment.

8.2.2 The risk of imprisonment

Having discussed the challenges veterans' experience re-settling into civilian living that can lead to offending, this section examines the factors that increase the likelihood of veteran imprisonment focusing on the use of alcohol and drugs, marital and family relationships and parental influences. Each of these was found to independently influence

the risk of veteran imprisonment within this study and, with the exception of parental influences, similar findings have been reported in the wider literature. However, and again with exception to parental influences, it is questionable whether the risk is unique to veterans.

Focus group and 1:1 interview participants commented on the influence that alcohol had on their offending and incarceration suggesting it either directly related to their criminal behaviour, by being drunk at the time of the offence, or occurred as a consequence to being unable to access support for their alcohol use. Additionally, through statistical modelling, the use of alcohol was also found to independently increase the risk of veteran imprisonment. However, the SPS has previously reported on the use of alcohol by veteran prisoners finding that similar proportions of veteran prisoners and non-veteran prisoners had been drunk at the time of their offence (McCoard, Carnie and Broderick, 2014) and in this study no differences in veteran prisoner and non-veteran prisoner groups' use of alcohol were found.

The pathway to criminal behaviour when people consume alcohol is complex, involving factors such as the characteristics of the person drinking or where the alcohol is consumed (Martin, 2001). The use of alcohol may be encouraged whilst in the military (Jones and Fear, 2011) and some military veterans may go on to develop problems with alcohol misuse (Browne *et al.*, 2008; Jacobson, Ryan and Hooper, 2008; Wilk *et al.*, 2010) but not all develop this problem and not all who do offend. In this study, for example, 28% of veteran staff had hazardous/ dependent levels of alcohol use but had no offending histories. Furthermore, the misuse of alcohol is not only a problem that effects military and ex-military personnel. Alcohol misuse is widely evident within the general population: in Scotland around 30% of males consume alcohol at hazardous levels and a

further 7% can be defined as harmful drinkers (York Health Economics Consortium, 2010). While this study demonstrated a specific relationship between alcohol use and veteran imprisonment it cannot be said that the use of alcohol is unique to veterans given that there was no difference in alcohol use when comparing both prisoner groups.

Some veterans engage in problem drug use because of, and to alleviate the symptoms of, trauma (Hartl *et al.*, 2005; Back *et al.*, 2014) and many veterans in this study reported symptoms of PTSD. However, much of what has been discussed concerning alcohol misuse is equally relevant when considering veteran drug use. Drug misuse was independently associated with veteran imprisonment and, despite some focus group participants distancing themselves from being seen to be similar to drug misusing prisoners, other focus group participants admitted to past drug misuse. Research supports the argument that veterans using drugs can end up in prison (Drug Policy Alliance, 2009); however drug use and crime is inextricably linked to other factors, such as socio-economic disadvantage and social exclusion (Seddon, 2006), and not veteran status.

Many Scottish prisoners come from socially disadvantaged and excluded communities (Houchin, 2005) and have substance misuse or dependence problems (Graham, 2007; Gillies, Knifton and Dougall, 2012). What is more, recently the SPS (McCoard, Carnie and Broderick, 2014) found that more non-veteran prisoners than veteran prisoners reported that drug use was a problem for them while living in the community and that the use of drugs had an influence on their current offence. Interestingly, once veterans were incarcerated the SPS found that veteran prisoners' drug use increased to match the use of non-veteran prisoners (McCoard, Carnie and Broderick, 2014) raising the possibility that for some veteran prisoners the availability of drugs in prison, and the difficulty accessing support for their perceived needs, results in them 'self-

medicating' to cope with prison and their other individualised needs. Findings suggest that despite drug use being an independent influence on veteran imprisonment the similarity in drug use between prisoner groups has little relevance to veteran status and instead is more closely influenced by factors present in both prisoner groups, such as unemployment, poverty, social exclusion, poor mental health and relationship breakdown (Seddon, 2006; Levitas *et al.*, 2007).

Difficulties maintaining relationships with a spouse or partner and their families were acknowledged by a number of veterans in both the focus group and 1:1 interviews. Some spoke of the challenges that leaving the military and returning to civilian living placed on their partners and families: challenges that ended their marriages or relationships. This study found that veterans who were not married or cohabiting were four times more likely to be incarcerated. Research elsewhere has found that incarcerated veterans are less likely to be married (Greenberg and Rosenheck, 2009) and proportionally, within this study, more married or cohabiting veterans were found in the SPS veteran staff group than in the veteran prisoner group. Yet there was no difference between the marital status of veteran prisoners and non-veteran prisoners. Considering that marriage is a protective factor that reduces offending (Sampson, Laub and Wimer, 2006; King, Massoglia and MacMillan, 2007), and that prisoners are more likely to be single when entering custody (Williams, Papadopoulou and Booth, 2012), it seems reasonable to conclude that being single increases the likelihood of imprisonment irrespective of veteran status.

Being raised by a parental figure other than a birth mother and/ or birth father occurred more often in the veteran prisoner group than the other two groups studied, and being raised by a non-birth mother increased the odds of veteran imprisonment by more than fourteen times. As one of the interviewees suggested, the absence of a mother-figure was

his motivation for seeking family type relationships elsewhere, most notably in the military and in prison. The impact different parenting structures have on child development and on their future have been noted by others. Biblarz and Raftery (1999) note the negative future socioeconomic consequence that can occur as a result of an absent parent, with single father or step-families having a worse impact on a child's future. Older children, when cared for by single fathers or fathers and step mothers, because of poor direct and indirect control over the child by the father-figure, were also found to be more antisocial than those cared for by single mothers or stable two parent families (Demuth and Brown, 2004). In kinship care, behavioural and emotional problems have been experienced by children cared for by relatives (Billing, Ehrle and Kortenkamp, 2002), including grandparents (Smithgall *et al.*, 2006). Boys, when raised by their grandmothers, in particular, can develop problems such as conduct disorders, hyperactivity, inattention, difficulty engaging with peers, and poor pro-social behaviour (Smith and Palmieri, 2007) possibly due to an absence of a grandfather to provide a gender role-model and both control and affection (Solomon and Marx, 1995). These studies support the argument that parenting structures impact on children and their future lives. No studies can be identified that are specific to the impact that different types of parenting structures have on veterans in their childhood. This study is the first to find that veterans raised by a person other than their birth mother can impact on their future risk of imprisonment. Nonetheless, such a finding needs to be replicated in future studies.

A further factor worth considering when examining what contributes to veteran imprisonment was inferred by both focus group and 1:1 interview participants, although was not examined quantitatively. For some participants, living in prison was easier than living in the community. This was particularly the case if they had been in prison before and, indeed, having previous prison experience may be the reason why all focus group

and most 1:1 interview participants reported prison as being easy while other interviewees found it challenging. For example, one participant reported having never been in prison before and was the only one to note that he never wanted (or expected) to return to prison again. Being in prison before removes the 'unknown' and can make it a less challenging option than other forms of non-custodial punishments for offenders (Williams, May and Wood, 2008). As reported in Chapters 6 and 7 being admitted into prison removed some of the personal responsibilities required to live successfully within the community and offered respite from daily life stressors. One interviewee suggested some veterans may seek imprisonment and another confirmed he would rather be in prison than be living in the community. Some veterans believed that coming into prison was the best option for them. Food and shelter were provided as were social networks and access to support: support that for some was difficult to obtain in the community but was perceived to be more readily available in prison.

8.3 Common or idiographic vulnerabilities

Whether a veteran prisoner has a unique set of vulnerabilities or whether he shares these with other veteran prisoners, or with non-imprisoned veterans and other prisoner types, merits discussion. Vulnerabilities, such as alcohol misuse and poor self-efficacy, which can develop as a consequence of early childhood adversity and with poor mental health, are examined. There is also a specific focus on PTSD and the possible causes, concluding with a suggestion as to why, in this study, PTSD may be a significant problem for veteran prisoners compared with other participants.

8.3.1 Early life experiences

Adverse childhood experiences have been found to impact on the health of military personnel (Iversen *et al.*, 2007; Agorastos *et al.*, 2014) contributing to severe mood and

anxiety disorders (Sareen *et al.*, 2013), other mental health difficulties (Montgomery *et al.*, 2013), post deployment PTSD (LeardMann, Smith and Ryan, 2010) in military personnel, and, as discussed in section 8.2.1, to early service leaving (Buckman *et al.*, 2013). Adverse childhood experiences are also found within prison populations (Williams, Papadopoulou and Booth, 2012) and have been directly linked with adult criminal behaviour, including violent offending (Reavis *et al.*, 2013). In this study, veteran prisoners experienced greater exposure to sexual assault when under the age of 17 years compared with veteran staff but not when compared with non-veteran prisoners. However, no differences were identified between any of the groups for the exposure to physical abuse, although the proportions experiencing this in each group appeared considerable. Experiencing childhood physical abuse, therefore, may be common across the three groups whereas exposure to childhood sexual abuse appeared more common in the prisoner populations but was not unique to veterans.

Exposure to parental antipathy and neglect did appear to be greater in the veteran prisoner group. Father antipathy was significantly different when comparing veteran prisoners with veteran staff and with non-veteran prisoners, and other forms of parental antipathy and neglect experienced by veteran prisoners had differences that almost met significance. These parenting styles may offer insight as to why other differences, such as high levels of psychological distress, were present within the veteran group. Parental antipathy and neglect has been found to influence future personality traits of a child, in particular by making them more introverted and less open to others, and more emotionally unstable and antagonistic (Robinson, Lopez and Ramos, 2014). It can also contribute to the development of stress sensitisation (Harkness, Bruce and Lumley, 2006) where children, when exposed to potentially traumatic experiences, develop a heightened vulnerability to emotional and behavioural dysregulation but are unable to rely on their

primary care givers to help them manage their response to stress (Grasso, Ford and Briggs-Gowan, 2013). Once sensitised, lower levels of life stressors become sufficient to cause distress and the occurrence of mental ill-health when older. For example, stress sensitisation can result in both minor and major stressors increasing the frequency and severity of depressive illness in adolescents (Morris, Ciesla and Garber, 2010) with depressive symptoms worsening if an anxiety disorder is also present (Espejo *et al.*, 2007).

8.3.2 Mental health and wellbeing

Most of the mental health and wellbeing measures found differences between veteran prisoners and veteran staff although these differences were not (or were less) evident when comparing prisoner groups. A similar pattern was found when comparing alcohol and drug use measures: veteran groups differed but prisoner groups did not. However, before discussing the mental health of veteran and non-veteran prisoners a comment must be made on the wellbeing of the SPS veteran staff group. Forty per cent of the veteran staff group were found to meet GHQ-12 '*caseness'* for the presence of psychological distress (Goldberg *et al.*, 1997), a level that is strongly associated with public and private sector occupational sickness absence (Whittaker *et al.*, 2012). Sixteen per cent reported symptoms consistent with having a PTSD diagnosis, a figure that is five time greater that the level of PTSD found in the general population (McManus *et al.*, 2009). More than a quarter of the veteran staff group also reported consuming alcohol to hazardous levels. Finding that a quarter of the SPS staff veteran group consumed hazardous levels of alcohol is less of an anomaly: McManus *et al.*, (2009) found that around 30% of males in England consumed alcohol at hazardous levels and this rose to 45% for those aged between 25 and 34 years. Despite this, consumption of alcohol to hazardous levels by this occupational group should not be ignored and neither should concerns over their

psychological wellbeing. Working as a prison officer is recognised as being a 'high-stress' occupation that involves exposure to traumatic operational stressors such as violence, harassment, personal attacks, and death, the consequences of which affect the physical, and psychological wellbeing of a person and changes their social and behavioural functioning (Brough and Biggs, 2010).

Returning to the discussion on vulnerabilities experienced by veteran prisoners, this study found that many mental health issues and the use of alcohol or drugs in this group were also common in non-veteran prisoners. Finding mental health and substance use problems, including co-occurring disorders, in prisoners has been widely recognised (Brooker *et al.*, 2002; Fazel and Danesh, 2002; Fazel, Bains and Doll, 2006; Brooker and Birmingham, 2009; Sirdifield *et al.*, 2009; Fazel and Baillargeon, 2011) and similarities in Scottish prisons between veteran prisoners and other prisoners in these presenting problems have also been reported (McCoard, Carnie and Broderick, 2014). Further, within this study many of both prisoner groups had GHQ-12 scores indicating caseness for psychological distress (86% for veteran prisoners and 68% for non-veteran prisoners). As a concept, psychological distress has been defined as having a perceived inability to cope, where emotions are changeable and feelings of discomfort are present but are often miscommunicated, and where the body and the person can experience harm (Ridner, 2004). It has also been more simply described as "*a state of emotional suffering characterised by symptoms of depression and anxiety and sometimes accompanied by somatic symptoms"* (Drapeau, Marchand and Beaulieu-Prévost 2012:123). Within this study, psychological distress was measured using the GHQ-12 questionnaire and from this some differences between the prisoner groups were found. Veteran prisoners reported higher scores for psychological distress, although this may have occurred as a consequence of exposure to trauma: PTSD was experienced by veteran prisoners in

greater proportions than those in other groups studied and poor coping as a consequence of trauma is associated with psychological distress (Littleton *et al.*, 2007).

8.3.3 PTSD in veteran prisoners

Common for both prisoner groups; high levels of PTSD across all methods of PTSD checklist measures were found, although the veteran prisoner group proportionally had nearly twice as many participants meet the diagnosis, or achieve a score greater than 50, than the non-veteran prisoner group. PTSD has previously been identified in prison populations around the world. In the late 1990s, around 5% of the English prison population were found to have PTSD (Singleton *et al.*, 1998). In more recent times, following systematic review, PTSD prevalence was found to range between 4% and 22% in sentenced prisoners (Goff *et al.*, 2007) but more recently rates as high as 72% have been reported for Italian prisoners (Ardino, Milani and Blasio, 2013). For veterans in prison it has been suggested that 39% of incarcerated veterans have PTSD (Saxon *et al.*, 2001). Within this study 36% of non-veteran prisoners met a PTSD diagnosis; a figure that is slightly greater than those found by Goff and colleagues in their systematic review. For veteran prisoners, however, 60% met a PTSD diagnosis which appears much greater than those found by Saxon and colleagues.

The relationship between PTSD and criminality has been examined. Discussed in detail in Chapter 2, Shaw *et al.* (1987) found no direct relationship between PTSD in veterans and crimes leading to imprisonment and Elbogen *et al.* (2014) found that PTSD co-occurring with alcohol misuse was associated with violent aggressive behaviour but PTSD on its own was not associated. Others have also identified interacting associations such as PTSD, violent offending and exposure to combat (Fastovtsov, 2011; MacManus *et al.*, 2013). Combat exposure has been strongly linked with PTSD (Hoge *et al.*, 2004)

and identified as a significant risk factor for the development of PTSD (Phillips *et al.*, 2010), particularly where multiple combat deployments occur (LeardMann *et al.*, 2009). This could lead to a supposition that within this study the presence of PTSD found within the veteran prisoner group is combat-related but this has to be discounted: there was no reported difference between the veteran prisoner group and the veteran staff group in their combat exposure. Furthermore, more than half of both groups reported having 'light' or 'light to moderate' combat exposure and around two-thirds of both groups reported serving in none or a single combat deployment, again reducing the likelihood of combat exposure being the principal cause of PTSD.

When examining factors that independently influenced the presence of PTSD, veteran status was an independent predictor but being exposed to physical assault or experiencing enforced sexual activity, both when under the age of 17 years, also greatly increased the likelihood of PTSD occurring. Victims of childhood abuse (physical and sexual) have an increased risk of developing PTSD (Widom, 1999) and exposure to multiple childhood traumas increases the risk (Agorastos *et al.*, 2014). Military personnel and veterans exposed to adverse childhood experiences and abuse are also at risk of developing post-deployment trauma (Iversen *et al.*, 2007; LeardMann, Smith and Ryan, 2010), even when controlling for combat exposure (Van Voorhees *et al.*, 2012). Sareen *et al.* (2013), however, found no association between adverse childhood experiences and PTSD in military personnel and in this current study neither parental antipathy nor neglect independently influenced the presence of PTSD in the prisoner groups. Moreover, nearly 40% of the SPS veteran staff group experienced physical assault as a child and had significantly lower PTSD scores and symptoms compared with the veteran prisoner group, countering the proposition that veteran prisoner PTSD is solely attributable to childhood trauma.

As discussed in section 8.2.2 a greater proportion of the veteran prisoner group were raised by their non-biological mother and/ or non-biological father-figures than both the veteran staff group and the non-veteran prisoner group. Being raised by non-biological parents, even if it is by other members of the family, has emotional and behavioural impacts on children (Dubowitz *et al.*, 1994; Billing, Ehrle and Kortenkamp, 2002; Smith and Palmieri, 2007) and can impact on their mental health, including development of PTSD, in adult life (Fechter-Leggett and O'Brien, 2010). How children are parented also has an influence on the development of self-efficacy (Bullock, 2013; Tam *et al.*, 2013) which can be further compounded if a child has been exposed to abuse (Diehl and Prout, 2002). Self-efficacy has a direct influence on the development and maintenance of PTSD (Benight and Bandura, 2004) and a relationship between self-efficacy and PTSD has been found in former military personnel. MacEachron and Gustavsson (2012) noted that having an increased general self-efficacy reduced perceived PTSD symptoms in veterans who had served in both Iraq and Afghanistan conflicts. Ginzburg and colleagues also proposed that veterans with PTSD had lower perceived self-efficacy compared with veterans without PTSD (Ginzburg *et al.*, 2003). This was similar to the findings reported in this thesis where veteran prisoners had lower self-efficacy compared with veteran staff. However, self-efficacy was not found to influence the presence of PTSD and no difference in self-efficacy was noted when comparing veteran prisoners and non-veteran prisoners. It therefore cannot be said whether parenting styles or poor self- efficacy are reasons for veteran prisoner PTSD in this study.

A hypothesis can however be proposed to explain the higher levels of PTSD within the veteran prisoner group: one, I suggest, that considers differences and similarities between the veteran prisoner group and the other two groups. Veteran prisoners may experience an accumulation of life stressors without having the resilience and other

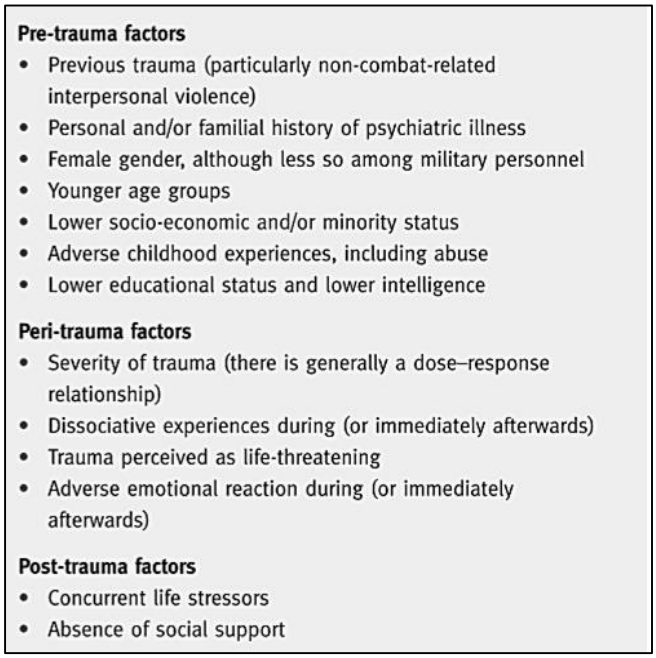
protective factors that mitigate against PTSD occurring. For example, they may: 1) have been exposed to risks that can occur from being raised by non-biological parents; 2) may experience unhelpful parenting approaches and childhood abuse which hinders the development of self-esteem, self-efficacy and the perceived ability to cope; 3) they then join military service at a young age (with some already experiencing post-trauma symptoms and poor stress control as a consequence of childhood adversity); 4) they then experience the challenges posed by military service including, for some, combat deployment and with some already experiencing PTSD (Hoge *et al.*, 2004; Maguen *et al.*, 2008); 5) they then experience early service discharge and the stress of transitioning back to civilian living; and they finally, experience imprisonment and the possibility of PTSD being triggered by prison-based trauma (Freyne and O'Connor, 1992).

People developing complex trauma histories through repeated exposures to traumatic events has long been recognised as a cause of PTSD, often with more severe symptoms than PTSD as a consequence of a single event (Green *et al.*, 2000; Suliman *et al.*, 2009). One suggestion from neurobiology is that kindling phenomena impacts on the limbic system when people are repeatedly exposed to trauma (van der Kolk and Saporta, 1991). The repeated exposure causes neurobiological and behavioural changes that are mediated by alterations to the temporal lobe of the brain. Individuals, who are then exposed to further trauma, even if it is construed as a minor incident, may experience intense distress as a consequence of the current incident combined with the unresolved impact of previous critical incidents (Flannery, 1999). This is not to say that kindling and its relationship with sensitisation can be regarded as solely a biological phenomenon. Segal and colleagues, for example, build upon Post's (1992) neurobiological suggestion that aspects of kindling, such as stimulant-induced behavioural sensitisation, resemble the course of recurrent depressive illness, by applying an information processing paradigm to the

process (Segal *et al.*, 1996). Segal and colleagues conclude that just like the neurobiological model, where electrophysiological kindling and behavioural sensitisation change neurological pathways that operate in recurrent depression, cognitive models, while operating in parallel to the biological processes, also evoke analogous processes where repeated depressogenic information processing trigger other psychological processes, such as how we behave or act. This worsens the depressive state and also increases the likelihood of the depressed cognitive process being triggered when exposed to other less distressing experiences as the links between the depression and the depressed cognitive constructs become strengthened as they are repeated. It is recognised that such information processing biases also exist in PTSD and that they occur concurrent with neurobiological activation of brain areas, such as the limbic system, during trauma-related thinking (Weber, 2008).

Additionally, veteran prisoners may also be predisposed through greater vulnerability to PTSD occurring. To varying degrees, studies (Brewin, Andrews and Valentine, 2000; Ozer *et al.*, 2003) have shown a range of factors that are predictive of PTSD occurring. These include age at trauma, educational attainment, exposure to previous trauma, childhood adversity and exposure to childhood abuse, personal or family mental ill-health, prior-to-trauma psychological wellbeing, trauma severity including perceived threat to life, and actual or perceived lack of social support during and post trauma. While Brewin *et al.* suggest that factors that occur during or after the trauma may have a stronger influence, it may be that veteran prisoners in this study not only met more pre, peri and post trauma vulnerability factors than participants of the other two groups but also the nature of the specific vulnerabilities and how they interacted had a greater influence. Figure 8-1: reproduced from Klein and Alexander's 2009 article distils Brewin *et.al.* and Ozer *et al.*'s findings on factors that are predictive of PTSD and their relative weightings.

This thesis provides the opportunity to question whether it is the presence of such complex trauma histories, through exposure to multiple traumatic events throughout an individual's life-course, within the veteran prisoner group that accounts for their PTSD presentation and differentiates them from the other two groups. While the veteran staff group and the non-veteran prisoner group may have participants that experienced exposure to multiple traumatic events, such as those that can occur in childhood and in the military (as seen in the veteran staff group), and in childhood as a result of adult social deprivation and in imprisonment (as can be found in non-veteran prisoners), it is perhaps only the veteran prisoner group that has been exposed to them all. It may be that this group experience more PTSD because they have been exposed to more traumatic incidents, have developed the neurobiological and cognitive changes described above and were more vulnerable.



Pre-trauma factors

- Previous trauma (particularly non-combat-related interpersonal violence)
- Personal and/or familial history of psychiatric illness
- Female gender, although less so among military personnel
- Younger age groups
- Lower socio-economic and/or minority status
- Adverse childhood experiences, including abuse
- Lower educational status and lower intelligence

Peri-trauma factors

- Severity of trauma (there is generally a dose–response relationship)
- Dissociative experiences during (or immediately afterwards)
- Trauma perceived as life-threatening
- Adverse emotional reaction during (or immediately afterwards)

Post-trauma factors

- Concurrent life stressors
- Absence of social support

Figure 8-1: Predictors of Post-Traumatic Stress Disorder (Klein & Alexander 2009:285)

In summary, this section has drawn on wider literature to look at whether veterans in prison have common or idiographic vulnerabilities and examined the influence of early

life experiences and mental health and wellbeing. It also offered a detailed discussion regarding the possible reasons for the higher presence of PTSD in veteran prisoners. While there were many differences between the two veteran groups there were more similarities between the two prisoner groups; although higher parental antipathy and neglect was found in veteran prisoners and this group also appeared to experience greater levels of psychological distress. Veteran prisoners also experienced greater levels of PTSD than either of the other two groups. Why this is so is uncertain although a possible explanation has been proposed.

8.4 The prison experiences

Section 8.4, using mostly the findings reported in Chapters 6 and 7, discusses veterans' perceptions of their experience of imprisonment. It looks specifically at their perceived identity and the identity of others, why and how relationships in prison are formed, and how they maintain a sense of social connectedness with their families. The section concludes with a discussion of the challenges of addressing the health and welfare needs of prisoners and identified gaps in service provision that prevent them from receiving appropriate care.

8.4.1 Identity, belonging and social connectedness

Some of the veteran prisoners in this study had multiple social identities. Social identities are formed by the views individuals hold of themselves that are derived from their perceived membership of a social group. Group participants, through social comparison, define people who are similar as being in the in-group and those who differ as being in the out-group (Stets and Burke, 2000). Social identity is associated with belonging as it is this that infers insider and outsider status (Crisp, 2010). As expected, the focus group participants identified themselves as being different from non-veteran

prison staff but less expected was that they also regarded themselves as being different from staff who were military veterans. Becoming a prisoner or prison officer meant to veteran prisoners that they no longer shared a social identity or belonged to the same social group.

Some interview and all focus group participants, while acknowledging their veteran status, recognised their prisoner identity. Focus group participants progressed from identifying themselves as being veterans, and being different from other prisoners because of their military experience, to identifying themselves as being similar to most, but not all, other prisoner types. The latter was evidenced by them taking umbrage at being '*tarred with the same brush*' by prison staff. The approach of prison staff challenged veteran prisoners' sense of prison identity by associating them with the prisoner out-group: a group of prisoners that cause disruption to the daily prison routine or who frequently chase illicit drugs and whom other prisoners do not want to be associated with.

Not all interview participants held a shared prisoner identity. Two participants did not see themselves as being the same as other prisoners but equally they did not use their veteran status as a means of differentiation from other prisoners. Both also acknowledged that they mixed with other prisoners. In Part 1 of the study very few veteran prisoners reported never mixing with non-veteran prisoners, possibly because the environment dictates that it is in the best interest of prisoners to get on with others, even if this is a superficial engagement. Examples of such superficial prisoner relationships have been found elsewhere (De Viggiani, 2006). This is not to say that prisoners do not form strong friendship bonds while in custody but where they do these social relationships are conditioned by the need to adapt to imprisonment. As Crewe (2009) points out, they look

to mix with people who have shared ambitions, such as the desire to avoid 'hassle', as the primary purpose of these prison friendships is "*to provide risk free social company*" (Crewe, 2009:336). In this study, prison may have been construed by most focus group and interview participants as being easy but for others challenges existed. Additionally, for most participants in Parts 2 and 3 of the study, it was still an experience that had to be endured and for a few interviewees a struggle to survive. Social identity, and its interaction with belonging, can help motivate a person to overcome challenges that they face helping them to achieve their goals (Cohen and Garcia, 2008). For study participants, social identity helped form relationships with other prisoners that made it easier to navigate their journey through imprisonment.

Social identity is also associated with being socially connected to others through a sense of belonging. Being socially connected is different from belonging however. Insights from psychology note that the need to belong has been considered as *"a fundamental human motivation"* (Baumeister and Leary 1995:521), and making and maintaining connections are precursors for the development of belongingness as well as a means of reinforcing it (Crisp, 2010). Although as Crisp (2010) notes a person can have a 'sense of belonging' and not be socially connected and can be 'connected' but not feel they 'belong'. It is possible for veteran prisoners to belong to a prisoner in-group but not be socially connected to this; they belong to the [prison] community but have no clear sense of connection with its members [other prisoners]. In this regard they have engaged in elective belonging (Crisp, 2010).

Whether this engagement in elective belonging is unique to veterans in custody is questionable. Crewe (2009) discusses different prisoner typologies and how they develop and engage in forming social relationships. Crewe notes that some prisoners are

enthusiasts for the forming of relationships, some are *retreatists* who only form associations, others adopt a *stoic* approach and are more solitary, while Crewe's final typology are *players* who are highly loyal and mutually obliged to a few close peers that agitate against the prison system. Veteran prisoners are like other prisoners in this regard and participants in this study could be assigned individually to one of Crewe's typologies when examining their relationships in prison. Yet, given that most of the veterans in the focus group and interviews did not freely disclose their veteran status to others, it is likely that these relationships will not be based on their veteran status. With the exception of the shared veteran identity formed during the focus group there was no evidence in the data of a cohesive veteran identity, or sense of feeling connected to other veterans. Despite some Scottish prisons holding veteran prisoner forums in the attempt to create opportunities for connections, this finding suggests that there is no natural social connectedness amongst veterans in prison. Instead, data revealed that each veteran adapted to imprisonment to meet their own individualised needs and is probably no different to other prisoners in this regard.

If the prison system is successful in mediating social connectedness between veterans, a connectedness that re-engages their military-based values, beliefs and aspirations, this may in fact be contrary to the values needed to survive in a prison community. In prison, the environment can be tense and relationships are often exploitative, characterised by one-upmanship, racism, homophobia, sexism, and the portrayal of a macho image (De Viggiani, 2006); whereas, for example, the British Army, currently respected by society, expects soldiers (albeit perhaps expressing an idealised version of personnel attributes) to demonstrate courage, discipline, integrity, loyalty, respect for others, and putting the needs of others before his own (Ministry of Defence, 2008). Cognitive dissonance can occur where these opposing beliefs are held at the same time: beliefs that self-identify as

being a prisoner may contrast with beliefs that self-identify as being a former member of the Armed Forces. The prison system would need to monitor for potential, and consequences of these, internalised conflicts. Being socially connected to two communities (a veteran community and a prison community) which have opposing values and beliefs can result in a person experiencing psychological and behavioural difficulties, such as low self-esteem, depression, and substance misuse (Mashek *et al.*, 2006). This questions whether the SPS should continue to look to offer veteran prisoners' opportunities, through the VICSO and other veteran specific services, which encourage them to reflect on their military experience. Doing so could re-establish both individual and collective veteran identities that clash with their prisoner identity.

Another important aspect of social connectedness is the relationship between a prisoner and their family (Doogan and Begun, 2013). Focus group participants commented on the challenge of maintaining relationships with their families whilst in custody and the burden this placed upon their partners and children; yet, assuming there was a prior substantial connection (Richter and Thompson, 2012) this would be the same for most prisoners when they enter custody. Focus group participants seemed to believe that they were no different to other prisoners in this regard. They were like other prisoners in seeking to avoid contact with prisoners who did not care about their families. To participants, those prisoners who did not care for their families' wellbeing did not share the aspirations and values of most prisoners. These aspirations include the pro-social drive to 'keep their head down and do their time' and 'do what needs to be done' to achieve progression within the prison system and obtain release from custody back home to the family.

A final comment on social connectedness is worth noting, albeit one that focuses on maintaining family and community relationships whilst being incarcerated. Being socially connected with families and other out-of-prison social networks reduces the chances of recidivism (Hairston, 1988), however doing so is not without challenges. Families experience a cost, both social and economic, when attempting to maintain a relationship with a person in prison. Trade-offs exist between the life families need to live outside of the prison while maintaining the connection with the incarcerated family member (Christian, Mellow and Thomas, 2006). Some veteran prisoners in this study recognised this, and the potential for distress that it can cause, but perhaps because of their prior military experience are better prepared for it. Veteran prisoners served on deployments abroad experiencing family separation and the emotional and practical difficulties it brings to maintaining a family life (Buckman *et al.*, 2011). Having this previous experience may make it easier for veteran prisoners to adapt to the separation caused by imprisonment although it is not likely to make it easier on their families as they confront the socio-economic and emotional challenges of maintaining social connectedness.

8.4.2 Addressing needs and providing care

The Howard League, in their Inquiry into Former Armed Service Personnel in Prison (The Howard League for Penal Reform, 2011), found that veterans in custody were a diverse population, ranging from young men who served in recent conflicts to those who had served in the Second World War, and as such their needs were diverse. This study also captured a diverse age range of veterans in prison, with different military experiences, some of whom had mental health, drug or alcohol problems. The normal convention is for veterans to be supported by the UK's commitment to the Military Covenant [now called the Armed Forces Covenant (Ministry of Defence, 2013)]. This

Covenant obliges the UK Government and wider society to support the needs of UK veterans. For example, in Scotland, NHS Chief Executives have to ensure priority treatment to Armed Forces veterans for any health condition that is likely to be related to their military service (The Scottish Government, 2008). Post-integration of prison healthcare services with the NHS (The Scottish Government, 2012) this requirement is also applicable to healthcare providers in Scottish prisons. Assuming their needs dictate it, veterans in prison are entitled to priority treatment compared with other prisoners, thus challenging one of the principal drivers for integrating prison and NHS healthcare: the need to tackle health inequalities in marginalised groups by ensuring equity of service provision (Prison Health Advisory Board, 2007).

One of the difficulties posited when examining this instruction by the Scottish Government, and the subsequent prioritising of veteran health needs, is that some health problems are more difficult than others to define as a service-related condition. The discussion in section 8.3.3 on PTSD provides an example of this: are the symptoms of PTSD experienced by veteran prisoners service-related or attributable to a wider range of factors? Furthermore, focus group participants were of the view that the needs of veterans in prison were not different to the needs of other prisoners and would be best addressed through individualised assessment and prioritisation based upon need rather than a prisoner's pre-prison experience.

From some of the focus group and interviewees' perspective the prison system's ability to address the needs of prisoners appeared unresponsive. Participants mentioned difficulties when trying to access care while in prison and raised concern about the quality of care received. Such concerns are not new, for example, HM Chief Inspector of Prisons For Scotland (2008) commented critically on the challenges prisoners experience when

trying to access care and support to address their mental health needs. More recently, NHS Greater Glasgow and Clyde identified that mental health was considered by both prisoners and staff, in the prisons it was responsible for delivering healthcare to, as being the single most important health issue within a prison population (Gillies, Knifton and Dougall, 2012). Despite this, and like other UK based prison mental health services (Edgar and Rickford, 2009), they concluded that their prison-based mental health services are under-resourced and unable to address the mental health needs of its prisoners. Findings were similar for their alcohol and drug misuse support services. It seems that the concerns voiced by focus group and interview participants on the difficulties they experienced accessing mental health care, including support for alcohol and drug misuse, are valid and at the time of the study unresolved. Given the evidence, the assumption is that non-veteran prisoners would also raise the same concerns if asked.

To summarise, section 8.4 discusses how veteran prisoners describe their experience of imprisonment examining how their social identity influences their sense of belongingness and their connectedness with other veteran and non-veteran prisoners. The principal identity adopted by veteran participants was that of a prisoner and while friendships can form in prison, there is often a practical purpose behind these relationships or a lack of authenticity in them. Challenges that families experience while maintaining connections with prisoners are noted, as are concerns over prisons failing to address prisoner needs.

8.5 Study Limitations

A number of limitations have the potential to impact on the findings and aims of this study. These are reflected upon, in the order they appear within the study rather than their

level of importance to the finding, examining the nature of the limitation and the reasons for the original decisions being made.

This study adopted a mixed-method approach using IPA to assess qualitative data. Some have suggested that using IPA introduces subjectivity to study findings which can challenge their credibility and makes replication unlikely (see Brocki and Wearden, 2006). Two methodological concerns raised by this approach are worth highlighting. Firstly, there are challenges that can occur when 'bracketing'. Bracketing to limit bias is a pre-requisite prior to interpretation but this also requires interpretation by the researcher on what is their own preconceived knowledge. For example, having worked previously for the SPS I was aware of some of the terms used by prisoners to describe their time in custody and recognised that many of these words had military connotations, such as 'going out for exercise', having to 'give your name and number', and to 'follow orders'. However, when hearing these terms used during focus group and 1:1 interviews I initially assumed, because I was focusing on participants' ex-military status, these were related to their military experience. Mistakenly, instead of recognising that participants were using words common to all prisoners, I had applied bias meaning to the experience because of my preconceived thinking. Identifying this meant I then had to reflect upon whether I was looking for, or expecting to hear, these terms, and then had to return to the original transcription and re-examine both the words used and the experience being described before engaging in further interpretation and subsequent re-interpretation. Secondly, only a small number of sub-themes of the total number of themes extracted, focusing on a particular point of view, are presented. Moreover, how these sub-themes are formulated and then develop into sub-ordinate themes relies on researcher interpretation, with much more (for example, emergent theme to sub-themes development or the interactive and dynamic practices of the researcher) being 'unseen than seen' by those who read the

findings. However, the credibility and quality of findings can be conveyed when researchers provide examples of their interpretive process. For this study, Appendices 8 and 11 provide examples of this with each appendix demonstrating sub-theme development, highlighting themes initially identified from the reading of transcripts and how these evolved into the sub-themes reported in the study findings.

When the questionnaire booklet was being developed, a draft version was reviewed by a veteran living in the community. The draft version of the booklet was formatted in A4 size whereas the final versions were printed in A5 format. While these were piloted by a volunteer from each of the three groups and no complications were identified once large scale recruitment commenced, some of the returned questionnaires were incomplete or contained errors which prevented a number of areas of analysis from occurring. This included comparisons of postcode data to identify whether issues of social deprivation were present, the comparison of physical health and functioning, and a more in-depth examination of parental psychological abuse. Feedback from some respondents via the VICSO identified some difficulties participants had completing the booklet including a concern about being identified through the disclosure of postcode data, feedback that some of the questionnaires looked 'too busy' on a small page, and that some questionnaires required too much reading. A more thorough piloting of the booklets may have identified these issues. The decision to print the booklets in A5 format was to reduce the overall size of the document with the intention of making it easier for participants to complete and submit via the post.

Using SPS staff as the veteran comparator group limits the potential for extending the findings to other non-imprisoned veterans. Veterans who work for the SPS may form a distinct sub-group of the veteran population and may be different from those veterans

who do not work in a criminal justice service. Additionally, this group were marginally older, and had been discharged from military service for longer when commencing the study, than the veteran prisoner group. They also had more participants who had served in the Navy or Air Force when compared with the veteran prisoner group. However, given that the levels of exposure to conflict, and the deployment to theatres of military operation, were similar it is likely this had little influence on the differences in mental health and wellbeing reported in Chapter 5. The decision to include SPS staff was pragmatic as they provided easier access to a veteran sample that had no history of criminal conviction instead of recruiting from veterans living in the community and having to confirm the absence of an offending history.

It was not possible to estimate a response rate to the survey questionnaire, as no record was kept of the number of questionnaires distributed. This does raise the possibility of response bias. The initial recruitment processes and subsequent revisions were agreed in conjunction with the SPS so as to lessen the demand placed upon the organisation and the VICSOs, and to maintain good order within prisons.

The fourth and fifth limitations are linked. Post analysis, one concern that became apparent was whether the mental health difficulties identified from the survey data were present prior to their 1st and most recent incarceration. Being able to identify whether survey respondents had mental health difficulties prior to incarceration would remove the uncertainty as to whether their incarceration was a contributing factor for their psychological distress and PTSD. Further, the PTSD diagnosis could have been corroborated through clinical assessment. Without this, there remains a possibility that the rates of PTSD identified through self-report are erroneous. Clinical assessment was not included as the survey was targeting what was thought to be a psychologically well

population and the high levels of PTSD identified were not expected prior to study commencement.

The final limitation relates to the examination of focus group and interview participants experiences of imprisonment. While the findings from IPA are specific to the study participants examined and are not for generalisation, it is believed that the study would have benefited from the inclusion of a second focus group and a separate group of 1:1 interviews, each containing non-veteran prisoners. This would have provided an opportunity to explore if their experiences of imprisonment were similar to veteran prisoners. The absence of such however does not impact on the overall study findings.

8.6 Chapter summary and conclusion

Discussions within this penultimate chapter focused on three themes. The first theme looked at pathways to imprisonment, discussing the challenges veterans experience transitioning from military service back to civilian living, specifically looking at military specific discharge factors, how these influence gaining employment and the relationship employment has with criminality. The theme then discussed a range of risks that increased the likelihood of imprisonment but concluded that most were risks for all prisoner types and not just veteran prisoners. The second theme focussed on identifying whether veteran prisoners had a unique set of vulnerabilities or whether they shared these with other veterans and/ or prisoners, finding both similarities and differences. It also discussed the levels of PTSD identified in veteran prisoners and offered a possible reason for this. The final theme discussed veteran prisoners' experience of prison examining the development of their social identity, how interpersonal relationships in prison are developed and the challenges of maintaining social connectedness with their families. The chapter concluded with a reflection on some of the limitations of the study.

The final chapter (Chapter 9) provides an overall conclusion for the study and identifies implications for policy, practice and further research, closing with a list of recommendations for consideration.

Chapter 9 - Study conclusions, implications and recommendations

9.1 Study conclusions

Overall, this original piece of research set out to examine the experiences of military veterans in prison prior to, and during, their incarceration in Scottish prisons and in doing so to conduct an analysis of their mental and social wellbeing. The overarching aims of the study were to identify whether veterans in prison had different mental health, substance misuse and social welfare needs compared to non-veteran prisoners and what, if anything, was required to address these. The study also sought to explore what veterans in prison believe caused their imprisonment and their experience of prison, to identify whether veterans in prison had unique vulnerability/ risk factors, and whether they had a common or idiographic pathway that led to incarceration. These aims were met by carrying out a mixed-method study, within Scottish prisons, combining quantitative analysis of survey data with qualitative interpretative phenomenological analysis of focus group and interview data, with the latter enriching and enhancing the understanding of the former.

Many of the mental health, alcohol and drug use problems experienced in prison by veteran prisoners were also experienced by non-veteran prisoners. Post-traumatic stress disorder did appear to be a specific problem for veteran prisoners but this did not appear to be solely attributable to their military experience. They also appeared to experience greater levels of psychological distress but this may be attributable to their exposure to trauma. Veteran prisoners' experience of interpersonal relationships and

social wellbeing also appeared similar to other prisoners. Veteran prisoners may have been more adaptable to the need to form relationships within prison, albeit relationships that either shared a limited set of goals or were superficial in nature, and may have been more able to maintain a sense of social connectedness with their families because of their military experience. This being said, veterans in prison seemed to identify with their prisoner identity rather than their veteran identity, with participants reporting that they did not believe that they, as individuals, were different from most other prisoners or that their needs differed.

Most focus group and interview participants did not believe their experience of military service was a cause of their imprisonment and factors that lead to incarceration are likely to be multifaceted. Nonetheless, when compared with a non-imprisoned veteran group, differences were identified and some of these impact on the socio-economic wellbeing of a person and have a relationship with offending. However, many non-veteran prisoners are also exposed to the same socio-economic challenges. Other factors, such as marital status and alcohol or drug use, also have a strong evidence base supporting their relationship with offending but, again, these were not specific to the veteran prisoner population studied. Unique to this study, however, was the influence of not being raised by a biological mother on the increased risk of veteran imprisonment. This, however, requires further research given the potential for sample size bias.

Lastly, while veteran prisoners did not believe their health and welfare needs greatly differed from non-veteran prisoners, some of the veteran prisoners did report being concerned about the difficulties they experienced accessing support to address their needs whilst in the community and in prison. Some of these difficulties, as reported by participants, were self-driven because of concerns about how a veteran would be regarded

if he requested assistance, however, other concerns about the absence or inadequacies of support services in prison appear valid. Gaps in the provision of mental health care in prisons, including those in Scotland, have long been recognised and would have existed at the time of data collection. Other perceived gaps in service provision may, however, be more attributable to prisoners feeling unprepared for their release from prison back to the community with some reporting that they felt unsupported and stigmatised during this process. This sense of unpreparedness may stem from their perceptions of their experience of transitioning from the military back into civilian living but it is more likely the recognition that participants 'failed' to stay out of prison following previous liberations. It may also be attributable, given the absence of prison-based and community-support services, to the 'struggles' some participants reported experiencing when dealing with the routine responsibilities of daily community living. For those who have been in prison before, they may consider prison living as being the easier option: one where they can avoid these responsibilities.

9.2 Implications and recommendations

9.2.1 Implications for policy and practice, and suggestions for further research

In 2007, Graham suggested that the SPS had deficiencies in its mental health services but some of these gaps in Scottish prisons' mental health care provision continue to persist (Gillies, Knifton and Dougall, 2012). In this current study, a large proportion of prisoners appeared to have unrecognised and unsupported mental health needs, including needing support to address the consequences of exposure to psychological trauma. The SPS and its regional healthcare providers should therefore continue to develop mental health services that address gaps in service provision. Both providers should also consider introducing routine psychological trauma screening and assessment processes, including assessing trauma histories, to identify psychological distress on admission to prison.

Prioritisation should initially be focused on the current veteran prisoner population given the high proportion of participants from this group who self-reported a PTSD Checklist score of 50 or more. This prioritisation of assessment, and any subsequent intervention, is based upon identified need rather than their veteran status. The mental ill-health, and in particular PTSD, identified in the prisoner population also warrants further scientific investigation. Research, involving face-to-face clinical assessment, to identify the prevalence of PTSD in male prisoners in Scottish prisons should be considered.

How interventions for veteran prisoners with PTSD are delivered should also be reconsidered. For example, in prisons located in Greater Glasgow, a referral is currently made to external specialist veteran services to support veteran prisoners with PTSD (Gillies, Knifton and Dougall, 2012). Given that veteran prisoners' PTSD may not be military specific, and considering the social identity principally adopted is that of a prisoner rather than a veteran, delivery of the intervention by a veteran-specific service would not necessarily be required. Removing the need for a service to be provided by a veteran-specific service would allow for support to be provided by generic psychological trauma trained staff. To assist in reaching this decision, research comparing trauma-specific clinical interventions, such as Accelerated Resolution Therapy (Kip *et al.*, 2012) or Eye Movement Desensitisation and Reprocessing (Shapiro, 1995), both of which have been used with veterans who have PTSD (Silver, Rogers and Russell, 2008; Kip *et al.*, 2013), delivered by veteran specific and generic clinical services should be considered to determine whether differences in outcomes occur.

Further, the SPS and its NHS Health Board partners should give consideration to adopting a trauma-informed approach to their operational practices in prison. This should initially commence with prison mental healthcare services as the need to practice trauma-

informed care is becoming fundamental to effective mental health nursing and should be bound within all nurse-client therapeutic relationships (Muskett, 2014). A trauma-informed approach, however, does not need to be restricted to healthcare environments and has been implemented in other care settings (BC Provincial Mental Health and Substance Use Planning Council, 2013). Consideration has also previously been made to its implementation within prison facilities (Miller and Najavits, 2012). This would involve embedding the approach's key principles: trauma awareness among staff and prisoners; emphasising safety and trustworthiness; provide an opportunity for choice, collaboration, and connection; and be strengths based and skills building (Dinnen, Kane and Cook, 2014). Additionally, where needed, and facilitated by prison-based mental health nursing services, implementation of trauma-specific services to address organisation and prisoner need. [See Cook and Newman's (2014) trauma competences which can be used as a basis for staff training and the development of a trauma-informed workforce].

Similar to the 2013 Scottish Prison Service Veteran Prisoner Survey (McCoard, Carnie and Broderick, 2014), this study found that many veteran prisoners had previous prison sentences. Moreover, study participants appeared to adapt and, where required, integrate into and conform to the prison system. They regarded themselves as prisoners rather than veteran prisoners and should therefore not be viewed as a specific sub-group of the prison population.

The absence of veteran-specific prisoner identity also brings into question the role of the VICSO. One of the functions of the local prison VICSO is to socially connect veterans in their prison, offering an opportunity to share their military experiences: yet resurfacing their military identity and its associated values may conflict with the prisoner identity and

the values they need to survive in prison. For some it may also be a reminder of the traumatic experiences they were exposed to. Another function of the role is to signpost veteran prisoners to veteran-specific services both in prison and in the community. This raises concern over potential inequality of service provision, particularly when veteran prisoners may not see themselves as having different support needs from other prisoners. In this regard, given that there appears to be no evidence for this to be continued, veteran prisoners while in custody should not receive access to services and support that are unavailable to non-veteran prisoners to ensure there is no conflict with the other drivers for equality of access. Nonetheless, this issue would be worthy of continued debate in government. Further, given that the VICSO role has been in-situ for a number of years but the engagement of the role depends on the competing demands and interest of the member of staff, research across all Scottish prisons that examines the outcomes the role delivers and the experiences and views of prisoners it supports is warranted.

Lastly, in section 8.3.2 concern is raised over the health and wellbeing of some of the prison service staff who participated in this study. The levels of psychological distress found within this participant group are often associated with high occupational absenteeism, and the amount of alcohol being consumed could in the medium and long-term cause harm. Given that a prison officer role is regarded as a stressful occupation, the SPS should consider examining further the health and wellbeing of its workforce. Research comparing staff who have had military service with those who have not, examining previous traumatic exposure, resilience and stress management, should also be considered.

9.2.2 Recommendations

Policy

- Veteran prisoners should not be regarded as a specific sub-group of the prison population.

- The SPS and NHS should continue to address gaps in mental health and substance misuse service provision for all prisoners.

- Access to mental health services should be prioritised according to assessed need rather than a prisoner's previous pre-prison employment/ occupational status.

- All prisoners should have equity of access to prison-based support services. Only where the SPS and NHS have to respond to their statutory obligation to address veteran specific needs (need occurred as a consequence of military service) should this approach be deviated from.

- The SPS should consider conducting a review of the health and wellbeing of its prison officer workforce.

Practice

- Prison-based healthcare services should consider screening all current veteran prisoners for the presence of PTSD and arrange for formal clinical assessment where screening flags are identified.

- SPS and the NHS should consider introducing routine psychological trauma screening on admission and implementing a trauma-focused assessment of prisoners when screening flags are identified. This should include assessing childhood experiences and parenting approaches as well as exposure to previous traumas.

- SPS and the NHS should consider how treatment is provided to veteran prisoners with PTSD. Consideration should be made to utilise generic trauma services where no military service related trauma is present

- The adoption of a trauma-informed approach when working within a prison environment should be considered by both the SPS and the NHS and, where

required, facilitated by prison-based mental health nurses, trauma specific services should be implemented to address prisoner need.

Research

- Research should be carried out to identify the prevalence of PTSD within a Scottish male prison population.

- Research should be considered to evaluate the outcomes of generic trauma services compared with military/ veteran-specific trauma services when addressing military-related PTSD.

- Research should be conducted to examine the outcomes delivered by prison VICSOs, including obtaining feedback from veteran prisoners who have been supported by the role.

- Research should be carried out to confirm an association between not being raised by a 'birth-mother' and veteran imprisonment.

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Appendix 1: Abridged systematic review protocol's inclusion/exclusion criteria and search strategy

Military veterans with mental health problems: a protocol for a systematic review to identify whether they have an additional risk of contact with criminal justice systems compared with other veterans groups.

Authors: James Taylor, Tessa Parkes, Sally Haw, Ruth Jepson., (2012) *Systematic Reviews* , 1(1), p. 53.

Criteria for selecting article/ studies for this review

The systematic review will consist of automated and manual search strategies. The initial selection criteria will be broad to ensure as many studies as possible are identified for initial screening. General, topic specific, inclusion and exclusion criteria, as defined below, will then be applied to titles and abstracts for the purpose of screening. This will be conducted independently by two members of the project team. Full articles and reports will be obtained for those documents that meet the general inclusion criteria or where there is insufficient information available to exclude the document at screening. Full articles and reports will then be reviewed against the general inclusion / exclusion criterion and then against the stage / design specific inclusion criteria, independently by both team members. Where differences of opinion occur regarding inclusion eligibility resolution will be sought through discussion.

General Inclusion Criteria

- All articles and reports must include military veterans who are no longer in active service or who are reservist or territorial personnel who have experienced deployment but have now returned to civilian life;
- The UK definition of veteran will be adopted irrespective of paper geographical location or sample nationality i.e. must have served one day in an armed force;
- Military veterans with 'honourable', 'dishonourable' and 'medical discharges' will be included;
- Veterans must have mental health problems. Mental health problems will include those with substance use problems;
- Mental health problems will be defined as those that would meet, on appraisal, categorisation in the following ICD-10 classifications:

    - F20-29 Schizophrenia, schizotypal and delusional disorders
    - F30-39 Mood (affective) disorders
    - F40-48 Neurotic, stress related and somatoform disorders
- Where an article predates the publication of ICD-10 then the authors will match the clinical presentation described with one of the modern classifications. For example, war neurosis, combat fatigue, shell shock, hysteria, psychoneurosis and anxiety reaction would be matched with the ICD-10 F40-48 classification; and manic depression and reactive depression would be matched with the ICD-10 F30-39 classification.
- Substance use problems will include alcohol problems and dependence, and other psychological and behavioural problems associated with alcohol use;
- Substance use will include regular illicit drug use, drug dependence and misuse of prescription medication, as well as other psychological and behavioural problems associated with substance use;
- Criminal justice systems will include court services, probation services, correctional, young offender and prison services, and other remand or post sentence custodial or secure environments, e.g. secure mental health facilities.

General exclusion criteria

- Reports and articles that focus only on police arrests and police cautions;
- Reports and articles that only address military veterans, reservist and territorial personnel with diagnosed anti-social personality disorders;
- Reports pre-dating the onset of World War 2, i.e. prior to 1939;
- Articles or reports that are wholly descriptive, where there is no evidence of either qualitative or quantitative structured enquiry;
- Material not in English;
- Articles or reports that primarily focus on the physical health consequences of alcohol or substance use.

Quantitative stage specific inclusion criteria

- Studies reporting on the prevalence and/or incidence of veterans with mental health and/ or substance use problems;
- Studies reporting on the prevalence and/or incidence of reservists or territorial Army personnel with mental health problems and/ or substance use problems;

- Studies reporting on the prevalence and/ or incidence of veterans or reservists/ territorial Army personnel engaged with criminal justice systems, as defined in the general inclusion criteria;
- Empirical case-control and cohort studies comparing military veterans, including reservists, with and without mental health problems and who have and have not had contact with criminal justice systems.

Quantitative stage specific exclusion criteria

- Studies detailing mental health or substance use data obtained prior to joining military service where no empirical case-control or cohort post service comparison is available;
- Case-control or cohort studies obtaining mental health or substance misuse data from reservists/territorial Army personnel during screening for deployment where no previous deployment has occurred;
- Studies that only focus on the testing of psychometric properties of measuring tools for detecting mental health problems;
- Studies where mental health problems have not been clinically confirmed.

Qualitative stage specific inclusion criteria

- Focus group or interview studies reporting on the views, opinions and experiences of military veterans with mental health problems, irrespective of model of qualitative analysis used;
- Focus group or interview studies reporting on the views, opinions and experiences of reservist or territorial Army personnel with mental health problems, irrespective of model of qualitative analysis used.

Qualitative stage specific exclusion criteria

- Single case studies;
- Studies examining the opinion and views of territorial or reservist personnel pre-deployment where no previous deployment or post deployment analysis has occurred;
- Studies reporting only on the views, opinions and experiences of criminal justice worker contact with military veterans;
- Studies examining qualitative methodological issues only.

Search strategy for identification of articles

Sets of database search terms/ keywords will cover the four concepts: criminal justice,

military veterans, mental health, and substance use. International reports and articles will be included in the review, however all papers must be written in English or have a published English language translation. All databases will be searched up to the end of November 2011 from either the date of commencement of database archive or 1939. Databases to be used for automated searching are: Web of Science, Medline, Cinahl, Health Source Nursing Academic Edition, Psych Info, Psych Articles, National Criminal Justice Reference Service Abstracts, PILOTS Database Abstracts, Social Services Abstracts, Sociological abstracts and The Cochrane Database of Systematic Reviews. Table A1-1 describes the search structure and lists the keywords used during the literature search. Table A1-2 lists the MeSH headings that will be searched. In addition to searching the formal databases defined above, combined keyword searches will be conducted in Google Scholar and Google Web and manual searches will be conducted on the following websites:

- DASA
- The Royal British Legion
- The Howard League for Penal Reform
- Scottish Prison Service
- Scottish Government
- UK Ministry of Justice and National Offender Management Service
- United States Department of Veteran Affairs Justice
- United States Department of Justice
- Australia Government Department of Veteran Affairs
- Social Sciences Research Network
- Prison Health Research Network
- School of Forensic Mental Health.

All articles and reports that meet inclusion criteria will have a manual search of their references to identify any additional articles. Peer reviewed articles identified through electronic automated searches that meet inclusion criteria will have their citations manually checked (title and abstract) for articles relevant to the review. Authors will be contacted where full text articles or reports are not available electronically or via the British Library.

Table A1-1: Example of database search terms and enquiry structure

Database search terms/ keywords and search structure				
1) substance misuse	2) drug use	3) illicit medic*	4) narcotic*	5) medication abuse
6) #1 OR #2 OR #3 OR #4 OR#5	7) alcohol	8) alcoholic beverages	9) inebriant	10) intoxicant
11) #7 OR #8 OR #9 OR #10	12) mental health	13) mental illness	14) psychiatr*	15) depress*
16) PTSD	17) Traum*	18) #12 OR #13 OR #14 OR #15 OR #16 OR #17	19) #6 OR #11 OR #18	20) veteran*
21) ex-military	22) $military	23) armed force*	24) soldier	25) army
26) navy	27) marine	28) air force	29) military	30) #20 OR #21 OR #22 OR #23 OR #24 OR #25 OR #26 OR #27 OR #28 OR #29
31) prison*	32) incarcerat*	33) custody	34) jail	35) gaol
36) offender	37) criminal	38) inmate*	39) probation*	40) law enforce*
41) legal	42) court	43) justice	44) police	45) sentence
46) correction*	47) #31 OR #32 OR #33 OR #34 OR #35 OR #36 OR #37 OR #38 OR #39 OR #40 OR #41 OR #42 OR #43 OR #44 OR #45 OR #46	48) #30 AND #47	49) #19 AND #48	

Table A1-2: MeSH headings to be used during search

MeSH headings		
Veterans	Veterans Health	Military Personnel
Military Psychiatry	Military Medicine	Prisoners (and subheadings)
Prison	Drug users	Substance related disorders
Street Drugs	Alcohol related disorders	Alcohol Drinking
Alcohol induced disorders	Alcoholic intoxication	Law Enforcement
Mental Health	Mental Disorders	Mentally Ill Person
Depression	Mental Fatigue	Post Traumatic disorder
Diagnosis, Dual Psychiatry	Combat Disorders	

Quality assessment, grading of evidence and data extraction

Each stage will record standardised data, including details of design and methodology, participant characteristics and demographics, country, year of study, where published, and adverse events, comments or findings, if reported. Quality appraisal of the quantitative studies reviewed will depend on study type. Case-control or cohort studies will be evaluated using the corresponding Critical Appraisal Skills Programme (CASP) critical appraisal checklists. Prevalence or incidence studies will be appraised using the criteria and methodological scoring system developed by Loney and colleagues. The process and value in assessment of quality in qualitative research has long been debated and there are many tools for doing so. This review will assess the quality of the primary research articles obtained using the CASP critical appraisal tool for qualitative studies. This tool will also be used to record the demographic data

for the qualitative studies. A spread-sheet or simple database, one for each of the evaluation methodologies, will be created to document the quality assessments of the full text reviewed as well as the standardised information mentioned above.

Prior to data extraction all included articles will be receive a coding classifying the nature of the clinical presentation. Coding will define the principal clinical presentation as being either one of the mental health ICD-10 classification, alcohol use, substance use, alcohol and substance use, or a mixed presentation. Additionally, if required, for articles examining alcohol and substance use the authors will further define a sub-classification process based on type of use. *A priori* classification will prevent any unintentional misclassifying of data after the analysis process has been concluded and interim results are identified.

Information obtained from data extraction will be tabulated. Where available, statistical results will be identified from the quantitative research papers included, whilst the themes, key concepts, narratives, and theories will be obtained from the qualitative reports. Where there is incomplete information an attempt will be made to contact the authors of papers to obtain the information.

The quality assessment and data extraction process will be conducted by a single researcher (Taylor), but will be cross-checked by a second reviewer (Parkes). Quality assessment and data extraction by a single researcher does introduce a potential for bias; however, the quality control cross-check process will reduce this. Disagreements, discrepancies or uncertainties over inclusion, quality assessment, or data extraction will be resolved by discussion or through the involvement of a third researcher from the team.

References removed

Comparing mental health, drug and alcohol use of veteran offenders with other veteran types

Reference	Population studied	n	Findings
Shaw et al. (1987) *Comprehensive Psychiatry*	Vietnam war veterans from Iowa city area aged between 27-47 years who had served between 1964 and 1975. Compared incarcerated group with group living in city catchment area. Mean age, age entering military, and education attainment similar for each group	Incarcerated group = 31 Non-incarcerated group = 30	Veteran offenders greater rates of: anti- social personality disorder (*n*2 non-incarcerated vs. *n*11 incarcerated, p<.05) drug use/ dependence (*n*9 non-incarcerated vs. *n*18 incarcerated, p<.05), adjustment disorder (*n*7 non-incarcerated vs. *n*19 incarcerated, p<.01) Non veteran offenders' greater rates for affective disorders (*n*20 non-incarcerated vs. *n*6 incarcerated. P<.01) No difference in rates of PTSD No difference in rates of alcohol misuse
Kulka et al. (1990) *Trauma and the Vietnam War Generation*	Veterans who had served during the Vietnam War era. Compared theatre veterans with era veterans. Full study examined males and female veterans and matched population demographics for ethnicity. Study included examination of those veterans with PTSD and substance misuse *[Note: Only male data was used in this review]*	3016 - individual interviews conducted 344 - theatre era clinical interviews conducted 1192 - Examination of criminal justice involvement from age of 18	Theatre era veterans with current PTSD diagnosis differed in involvement with criminal justice services compared with theatre era veterans with no PTSD diagnosis (X2 =94.9, p<.001) Theatre era veterans with PTSD had greater contact with justice service than those without PTSD (p<.001) Theatre era veterans with PTSD had more multiple arrests (32% vs. 9%) Theatre era veterans with PTSD had more felony arrests (12% vs. 3%) Theatre era veterans with substance misuse differed in involvement with criminal justice services compared with theatre era veterans without substance misuse problems (X2=89.94, p<.001).

			Theatre era veterans with drug or alcohol misuse had greater contact with justice services than those with no substance misuse (p<.001) and significantly more multiple (24% vs. 5%) and felony arrests (8% vs. 1%)
Black et al. (2005) *Military Medicine*	Gulf war era veterans based in State of Iowa were interviewed and had health assessments between 1995 and 1996. Questioned on whether previous incarceration. All subjects had active service between August 1990 and July 1991. 845 reported previous incarceration	3695	Incarceration rates for cohorts deployed to the Gulf War and those cohorts not deployed (25.9% vs. 21.7%; OR 1.04, 95%CI 0.9-1.3), Incarcerated post August 1990 deployed compared with non-deployed (8.1% vs. 8.4%; OR 0.71, 95%CI 0.5-1) Veteran reporting being 'ever incarcerated' had greater rates compared with never incarcerated for: Depressive disorders (p≤.05) Alcohol abuse (p≤.05) Symptoms of PTSD (p≤.05) Any anxiety disorder (p≤.05) Veterans reporting serving in the Gulf War and being 'ever incarcerated' had greater odds compared with never incarcerated for having: (x2) Any depression (x2) Any anxiety (x2.5) Alcohol abuse (x3) PTSD Veterans incarcerated after Gulf War had greater prevalence of: Symptoms of PTSD (4.4% vs. 3.6%; OR 3.6, 95%CI 1.4-8.9). Use of illegal drugs pre August 1990 associated with being 'ever incarcerated' (p≤.05) Contact with mental health professional associated with being 'ever incarcerated' and incarceration after the Gulf War (p≤.05)

McGuire et al. (2003) *Psychiatric Services*	Los Angeles based study comparing jailed veterans with homeless veterans – whether they had differences in mental health, drug/ alcohol use or incarceration rates.	1676 jailed veterans 6560 homeless veterans	Incarcerated veterans had greater rates for: clinically assessed psychiatric illness (35% vs. 23%, $X^2 = 95.64$, $p<.001$) mood disorders(21% vs. 13%, $X^2 = 64.46$, $p<.001$), personality disorder (3% vs. 2%, $X^2 = 7.86$, $p<.001$), schizophrenia (11% vs. 6%, $X^2 = 63.50$, $p<.001$) other psychotic disorder (6% vs. 4%, $X^2 = 11.03$, $p<.001$). alcohol abuse/dependence (48% vs. 42%, $X^2 = 20.25$, $p<.001$) drug abuse/ dependence (62% vs. 39%, $X^2 = 274.86$, , $p<.001$) dual diagnosis (23% vs. 13%, $X^2 = 102.73$, , $p<.001$) Homeless veterans had greater rates for PTSD as a consequence of combat exposure (6% vs. 5%, $X^2 = 6.50$, $p<.001$)
Erickson et al. (2008) *Psychiatric Services*	Administrative data for veterans who received VA medical, surgical, psychiatric or substance use inpatient treatment between 1993 and 1997 were merged with department of corrections data for people imprisoned within one year of discharge.	36385 228 history of incarceration	Incarcerated group more likely to have: Adjustment Disorder (7.5% vs. 4%, X2 =6.7, p<.001) Anxiety Disorder (16.3% vs. 7.4%, X2 = 25.7, p<.001 Major Depression (25.4% vs. 8%, X2 = 92.7, p<.001) Personality Disorder (6.6% vs. 2.1%, X2 = 22.7, p<.001) PTSD (18.9% vs. 7.1%, X2 = 46.6, p<.001) Schizophrenia (12.3% vs. 5.1%, X2 = 24.3, p<.001) Drug misuse (48.7% vs.7.1%, X2 = 576.6, p<.001) Alcohol misuse (43.9% vs. 12.5%, X2 = 389.7, p<.001) Co-occurring disorders (76.8% vs. 26.6%, X2 = 290.6, p<.001) Predictors of veteran incarceration: Major depression (OR 1.85, 95%CI 1.22-2.81, p<.001) Drug abuse (OR 3.03, 95%CI 2.09-4.40, p<.001) Alcohol abuse (OR 2.88, 95%CI 1.98-4.18, p<.001)

Pandiani et al. (2003) *Law and Human Behavior*	Veteran recipients of VA behavioural health services compared with veteran recipients of or VA health services aged between 30-75 years. Study examined patterns of criminal involvement. Based in Tampa Bay region. Administrative data for the year 1997 was used for diagnosis and offending.	12805 (of which 2350 recipients of mental health services 601 recipients of substance use services 1008 recipients of both services 8846 recipients of medical services)	Veterans had greater risk of multiple arrests when diagnosed with: substance use only (RR 2.4, 95% CI 1.7-3.7) substance use and mental health (RR 5.1, 95% CI 3.7-7.36) Veterans had greater risk of single arrest during study when diagnosed with: Substance use only (RR 5, 95% CI 3.8-7.4) Substance use and mental health ((RR 2.7, 95% CI 1.8-4.9) Veterans with diagnosis of mental health only no greater risk of multiple or single arrest compared to veterans with medical problem. (RR 1.4, 95% CI 0.9-2.6; RR 0.9, 95% CI 0.5-2.3).

Influence of mental health, drug and alcohol on veterans' contact with criminal justice services

Reference	**Population studied**	**n**	**Findings**
Rosenheck et al. (2000) *Psychiatric Services*	Administrative data for veterans who used VA mental health services between 1994 and 1997, located in 16 north-eastern counties of New York state. Matched, using probabilistic population estimation against records of incarceration for the area. 16% of veterans incarcerated between 1994-97	5603	Estimate rates for incarceration: Dual diagnosis 25% (95% CI 13-37) Substance use 21% (95% CI 0-53) Mental health 11% (95% CI 6-17) Estimate for annual rate of incarceration: Dual diagnosis 13% (95% CI 9-16) Substance use 12% (95% CI 6-19) Mental health 4% (95% CI 2-5)
Fontana &	Contemporaneous and non-	Contemporaneous	Contemporaneous and non-contemporaneous analysis:

Rosenheck (2008) *Journal of Nervous and Mental Disease*	contemporaneous administrative data used to compare veterans who had sought inpatient and outpatient treatment for PTSD and who had been deployed to Iraq/ Afghanistan, Persian War, and Vietnam War. Contemporaneous data for the period April 2004 to December 2006 was used. Non-contemporaneous data for period June 1992 and October 1994 was used.	Outpatient veteran Iraq/ Afghanistan 6523 Persian 2376 Vietnam 20170 Inpatient veteran Iraq/Afghanistan 562 Persian 565 Vietnam 6217 Non-contemporaneous Outpatient veteran Persian 1045 Vietnam 17094 Inpatient veteran Persian 116 Vietnam 5909	Iraq/Afghanistan outpatient group least diagnosed PTSD, drug or alcohol abuse (p<.01) also least often incarcerated compared with Persian or Vietnam veterans (p<.01) Iraq/Afghanistan inpatient group least diagnosed with drug abuse Vietnam group most diagnosed. No difference in PTSD rates. No difference in rates for incarceration comparing inpatient Iraq/Afghanistan veterans with Persian war veterans, but difference significantly different from Vietnam veterans (p<.01).
Calhoun et al. (2004) *Journal of Trauma Practice*	Administrative data for Vietnam veterans with confirmed diagnosis for PTSD who attended VA PTSD clinic between 1997 and 2000. Average age 51 years.63% African American ethnicity. 58% married, 47% low economic status.	241	63% history of arrest since Vietnam War 54% multiple arrests Arrest history associated with: PTSD severity (p<.001) Depression (measured by Beck's Depressive Inventory score) (p<.001) Feelings of hostility (p<.01) Alcohol (p<.001) Drug use (p<.01) Factors independently contributing to arrest history PTSD severity (OR=1.02, p=.04) Illicit drug use (OR=3.13, p=.02) Factors independently contributing to frequency of arrest PTSD severity (IRR=1.01, 95%CI1.00-1.03)
Copeland et al.	Veterans with diagnosis of	435	2% reported being in jail in preceding 4 weeks

(2009) *American Journal of Public Health*	bipolar disorder who had received treatment from VA services. Participants approached between July 2004 and July 2006 86% were male, average age 49 years.77% white, 70% married 63% college education, 60 % impoverished & 55% lifetime history of homelessness		55% reported history of incarceration Homelessness independently associated with recent incarceration (OR=16.1; 95% CI 3.9-66.5) Homelessness independently associated with lifetime incarceration (OR=4.7; 95% CI 3.1-7.1) Associated with ever incarcerated: Binge drinking (F<.001) Substance use (F<.001) Recent incarceration related to: Binge drinking (p<.05) Factors predicting history of incarceration: Substance use (OR=2.8; 95% CI 1.7-4.6)
Wenzel et al. (1996) *The Journal of Nervous and Mental Disease*	Homeless veterans with a mental health, substance misuse, alcohol misuse, a combination of or no diagnosis. Based in West Los Angeles. Veterans previously admitted to a Veteran Affairs medical centre. 34% had a criminal conviction	429	More veterans with dual diagnosis reported 1 criminal conviction compared with other groups. Veterans with no diagnosis least likely to report criminal conviction. (dual diagnosis 47.4%, substance dependence 39.7%, serious mental illness 29.3%, or no diagnosis 12.9%, $X^2 = 20.71$, p=.0001)
Benda et al. (2003) *Alcoholism Treatment Quarterly*	Homeless veterans participating in VA substance use treatment programmes. Average age 45 years. Participants had on average 12 years of education. 50% were white, 37% black, remainder other	188	Factors that discriminate between veteran offenders and non-offenders: alcohol abuse, other drug abuse, the number of prior psychiatric hospitalisations, suicidal thoughts (all p<.05) Depression

	ethnic groups. Half were divorced, 2.7% married, 20% living with alcoholic, 15% cohabiting with person who abuses drugs. 45% depressed at time of study, 40% had been hospitalised for mental health problems in past & 45% had comorbid mental health and drug problem confirmed by psychiatrist.		Ego identity Resilience (all p<.01) Factors that discriminate between veteran nuisance and felony offenders: Locus of control Self esteem (both p<.01)

Influence of Influence of clinical interventions on veteran contact with criminal justice services

Reference	**Population studied**	**n**	**Findings**
McLellan et al. (1981) *American Journal of Psychiatry*	Narcotic dependent veterans who had been admitted for treatment to a Philadelphia VA treatment centre between 1978 and 1979, of which 36 obtained 45% of their income from illegal activities	165 total study participants 36 veterans with 45% of income from illegal activities	Following treatment: monthly income from illegal activities reduced ($623 pre-treatment decreasing to $247 post treatment, p<.01) Work related income increased ($194 pre-treatment increasing to $501 post treatment, p<.01)
Siegal et al. (2002) *Journal of Addictive Diseases*	Veterans with substance misuse diagnosis, excluding alcohol misuse, in receipt of substance abuse treatment between 1991 and 1994. Almost all were male. Average age 38 years. Majority (74% African	453	Legal severity score predictive of legal problems at 12 month treatment follow-up ($\beta = 0.242$, $p \leq .001$) Length of time participating in aftercare predictive of further legal problems ($\beta = 0.112$, $p \leq .05$).

	American ethnicity 24% current criminal justice involvement		
Hser et al. (2006) *Journal of Substance Abuse Treatment*	Substance dependent military veterans from West Los Angeles. Initially contacted in 1990-91 following treatment during 1988-89, then subsequent follow up again 2002-03. 68% African American, 24% white, 8% Hispanic, 86% 12+ year education, 61% in employment. At follow-up 52% achieved stable recovery	266 completed follow up	Non-stable recovery group had greater rates for: Depression ($p<.05$) Anxiety ($p<.05$) Obsessive Compulsivity ($p<.05$) Interpersonal sensitivity ($p<.05$) Alcohol use ($p<.05$) Marijuana use ($p<.05$) Non- stable recovery group reported greater arrests: 34% vs. 8% ($p<.05$) None-stable recovery group imprisoned in the previous year more often than stable recovery group 22% vs. 7% ($p<.05$)
Pandiani et al. (2010) *Psychiatric Services*	Veterans who had received VA health services or local Department of Mental Health services. Circa 90% male, most over 50 years. 80% diagnosis of mental health problem, 31% diagnosis for substance use only, 31% co-occurring diagnosis	1640 VA health service recipients 693 Department of Mental Health recipients	Mental health diagnosis & criminal conviction 5% VHA group, 8% DMH group Substance misuse diagnosis & criminal conviction 11% VHA group, 21% DMH group Co-occurring disorders & criminal conviction 11% VHA group, 10% DMH group. Post treatment criminal charging for both groups decreased compared to pre-treatment status ($p<.05$) Post treatment criminal charging for each diagnosis decreased compared to pre-treatment status (all $p<.05$)

Appendix 3: Example of Participant Information Sheet

Participant Information Sheet – Military Veteran Prisoners

Study Title: Military Veterans in prison

Phase 1 Part 1

Protocol reference number: 11/11 Dated: November 2011

Dear Sir

Thank you for considering taking part in our research study. This information sheet provides further information as to why the research is being done and what it would involve for you; therefore it is important that you read it fully. If you have any questions or wish to discuss this further please let a member of the prison staff know, they will then arrange for a member of the research team to speak with you. Additionally, you may want to talk to others about the study before making a final decision to take part.

This information sheet tells you about the purpose of the study, the different phases and parts involved and what will happen if you take part. It will then give you more detailed information about this part of the study.

<u>The overall purpose of this study</u>

The overall aim of this research is to see if military veterans in Scottish prisons have different mental health, substance misuse, social welfare and offending needs when compared to other prisoners. It also looks to find out if there are different reasons for military veterans ending up in prison, compared with other prisoners, and whether they require different types of support whilst in prison. Lastly, it also aims to better understand the experience of being a military-veteran in a Scottish prison.

In trying to answer the above, the research has to be broken down into a number of smaller studies. Each part contributes to obtaining a greater understanding of the needs of military veterans in Scotland's prison. This information sheet relates to the first of those smaller studies. For ease this is called Phase 1, Part 1.

<u>Why have you been invited?</u>

You have received this research pack because either you have previously declared your military veteran status to the SPS, or because you have requested the pack. To better understand whether there are differences in the needs of military veteran prisoners compared with other prisoners, Phase 1, Part 1 compares responses between military veteran prisoners with other prisoners to a number of questionnaires contained in the enclosed booklet

<u>Do you have to take part?</u>

It is up to you to decide if you wish to be involved in this research. This information sheet will tell you what is involved, should you participate. If you agree to take part, completing the questionnaire booklet and returning it will indicate that you have consented to be involved. However, you do not have to take part and doing so will not affect the treatment and support you currently receive. There is no payment or reward for participating.

What will happen to me if I take part?

To take part you must complete the questionnaire booklet to the best of your ability, place and seal it in the envelope provided and return it to a member of staff to arrange for it to be posted. Completing the questionnaire booklet may take around 30-40 minutes, but for some it will be less than this. The questionnaire booklet contains questions and self-report measures looking at general and mental wellbeing, personal resilience, childhood experiences, military service, combat exposure and the consequences of trauma. The questionnaire booklet is looking for typical and as well as uncommon responses. Once you have completed and returned the booklet, unless you request further information on participating in other parts of the research, your involvement with the research will be finished.

What are the benefits of taking part?

We cannot promise that taking part will help you individually or change the way military veterans in Scottish prisons are supported, but the information obtained from Part 1 will assist in conducting the remaining research studies. It will also improve understanding of similarities and differences between military-veteran prisoners, other military veterans and other prisoners. We are hoping to better inform SPS on this area of their work.

Will my taking part be kept confidential?

Yes. We follow ethical and legal practice and all information about you and from you will be handled in confidence. The questionnaire booklets do not ask you to provide your name or other personally identifiable information. All returned questionnaire booklets will be given a unique code number and be securely stored by the research team. You cannot be identified or traced from the data obtained from the questionnaire booklet. The data you provide will be examined along with information from around 200 participants to identify any similarities or differences between other participant groups. Results will be published in formal reports and academic papers but as there is no personally identifiable data being obtained the results will be anonymous. The data you provide will only be used in this study. Future studies or researchers will not have access to your replies. All questionnaire booklets will eventually be destroyed.

What will happen if I don't want to continue taking part after returning the questionnaire?

After completing the questionnaire booklet, sealing it in the envelope and handing it to prison staff you can still request it back and decide not to take part. However, once it has been posted, as there is no way for the researchers to identify a participant's questionnaire booklet the information cannot be withdrawn from the research.

What if there is a problem

If you have a concern about any aspect of the study, you should ask the prison to request that a member of the research team visits to speak with you. A member of the team will then visit the prison at the earliest opportunity to discuss your concerns.

Who has reviewed this study?

This research study has been looked at by several independent groups, called Research Ethics Committees, to protect your interests. This study has been reviewed and given favourable opinion by the Research Ethics Committee at the School of Nursing Midwifery and Health, University of Stirling and by the Scottish Prison Service Research and Ethics Committee.

What if something goes wrong?

If something goes wrong, or should you wish to speak to someone who knows about this study who is an independent advisor, please contact: [details removed]

Appendix 4: Example of Consent Form

UNIVERSITY OF STIRLING

SCHOOL OF NURSING, MIDWIFERY AND HEALTH

Protocol number: 11/11 Date: November 2011

CONSENT FORM

Title of Project: Military Veterans in prison

Name of Lead Researcher: James Taylor

Please read the statements below. If you agree with them please proceed to completing the questionnaire booklet, seal it in the stamped addressed envelope and give to a member of the prison residential staff who will arrange posting.

Phase 1 Part 1

1. **I have read and understand the Participant Information Sheet dated November 2011 (protocol version number – 11/11) providing details of the above study and in particular Phase 1, Part 1. I have had the opportunity to consider the information and ask any questions.**

2. **I understand that my participation is voluntary and that the questionnaire booklets will be anonymous.**

3. **I understand that by completing and returning the questionnaire booklet I am consenting to participate in this part of the study.**

Appendix 5: Example of Questionnaire Booklet

Cover page

Protocol Number: 11/11 Date: November 2011

UNIVERSITY OF STIRLING

SCHOOL OF NURSING, MIDWIFERY AND HEALTH

Military Veterans in prison

Phase 1, Part 1

Questionnaire Booklet for Military Veterans in Prison

Section 1

General questions about you.

This section contains questions about you, your background and history. It includes questions on education, growing up as a child, where you used to live, employment, military experience and prison/ offending history.

These questions allow direct comparisons between the personal histories and experiences of each individual in each group, and between each group. Please answer all questions in this section.

All information provided will be completely confidential.

I would like to ask you some brief questions about yourself – this information, like all the information you provide within this questionnaire booklet will be completely anonymous

1. What was your age on your last birthday? ________years

2. What was your postcode at the point of imprisonment? _____________

3. If you are a military veteran what was your postcode at the time of leaving military service? If homeless state this. _____________

4. How would you describe your marital family status?
(please circle the answer that best describes you)

married	living with partner	single	divorced	widowed	other
4a.No.of dependent children _____					

5. Have you been in prison before?
(please circle one answer)

YES	NO	DON'T KNOW

6. What is your sentence status (please circle which describes you):

Sentenced	Remand (un-convicted)	Remand (convicted awaiting sentence)

a What is your current offence (charge / conviction)?

(please enter)… …

b If SENTENCED, How long is your sentence?

(please enter … … … … … … … … … … ……………………………………………………………………………… .

7. Look at the table below. What was your working situation before coming into prison?
(circle the option that describes you best)

Full time Employment	Part-time Employment	Casual Employment	Training Scheme
Unemployed/on benefits	Full time Education	Military Service	Other

8. Who brought you up before the age of 17?
Below is a list of **Parent Figures** please circle all who brought you up in childhood for at **least one year.**

Mother Figures	Father Figures
Birth Mother	Birth Father
Step Mother	Step Father
Female relative	Male Relative
Family friend (e.g. Godmother)	Family friend (e.g. Godfather)
Foster Mother	Foster Father
Adopted Mother	Adopted Father
Other	Other

8a. Were you ever in a children's home or institution before the age of 17?

(please circle one) **Yes / No**

8b. If yes, what was the total length of time? _____years

9. Please look at the education qualification list below. Place an X next to the number that best describes your current level of educational attainment.

1		School leaving certificate, NQ Unit
2		Standard Grade, O Grade, GCSE, GCE O Level, CSE, National Qualification, Access 3 Cluster, Intermediate 1 or 2, Senior Certificate or equivalent
3		GNVQ/GSVQ Foundation or Intermediate, SVQ Level 1 or 2, SCOTVEC/National Certificate Module, City and Guilds Craft, RSA Diploma or equivalent
4		Higher grade, Advanced Higher, CSYS, A level, AS Level, Advanced Senior Certificate or equivalent
5		GNVQ/GSVQ Advanced, SVQ Level 3, ONC, OND, SCOTVEC National Diploma, City and Guilds Advanced Craft, RSA Advanced Diploma or equivalent
6		HNC, HND, SVQ Level 4, RSA Higher Diploma or equivalent
7		First Degree, Higher degree, SVQ Level 5 or equivalent
8		Professional qualifications e.g. teaching, accountancy
9		Other school examinations not already mentioned
10		Other post-school but pre Higher Education examinations not already mentioned
11		Other Higher Education qualifications not already mentioned
12		None of these qualifications

10. In prison I mix and socialise with non-veteran prisoners.... (please circle one answer)

1	2	3	4	5
None of the time	Some of the time	Unsure	Most of the time	All of the time

11. In which armed forces did you serve? (please circle one answer)

Army	Air Force	Navy	Other

a. Please state your rank _____

12. In what year did you join the Armed Forces? _____

13. In which conflicts did you serve? (please circle one answer)

Northern Ireland	Falklands	Gulf	Balkans	Iraq	Afghanistan	Other

14. In what year did you leave the Armed Forces? _____

15. When you left the Armed Forces were you (please circle one answer)

Honourably Discharged	Medically Discharged	Other

16. Look at the table below. What was your working situation after leaving military service?
(circle the option that describes you best)

Full time Employment	Part-time Employment	Casual Employment	Training Scheme
Unemployed/on benefits	Full time Education	Voluntary Work	Other

Please proceed to next section

Section 2

Resilience, General Wellbeing and Mental Health

This section contains a number of short questionnaires and rating scales concerning your sense of personal resilience, health and wellbeing. .

You may think that some or all of the following questions in this section may not be relevant to you; however we are looking for TYPICAL and ATYPICAL experiences. Therefore, please attempt all questions in this section.

All information will remain completely confidential.

General Self Efficacy (GSE) Scale

Using the 4-point scale below please indicate how true you think the each of following statements are with regards to you. Please record your answer in the space next to each question.

1	2	3	4
Not at all true	Hardly true	Moderately true	Exactly true

1. _____ I can always manage to solve difficult problems if I try hard enough.

2. _____ If someone opposes me, I can find the means and ways to get what I want.

3. _____ It is easy for me to stick to my aims and accomplish my goals.

4. _____ I am confident that I could deal efficiently with unexpected events.

5. _____ Thanks to my resourcefulness, I know how to handle unforeseen situations.

6. _____ I can solve most problems if I invest the necessary effort.

7. _____ I can remain calm when facing difficulties because I can rely on my coping abilities.

8. _____ When I am confronted with a problem, I can usually find several solutions.

9. _____ If I am in trouble, I can usually think of a solution.

10. _____ I can usually handle whatever comes my way.

Please proceed to next questionnaire

Global Belief in a Just World Scale (GBJWS)

Using the 6-point scale below please indicate your level of agreement on how you think the following statements applies to you and others. Please record your answer in the space next to each question.

1	2	3	4	5	6
Strong disagreement	Moderate disagreement	Slight disagreement	Slight agreement	Moderate agreement	Strong agreement

1. _____ I feel that people get what they are entitled to have

2. _____ I feel that a person's efforts are noticed and rewarded

3. _____ I feel that people earn the rewards and punishments they get

4. _____ I feel that people who meet with misfortune brought it on themselves

5. _____ I feel that people get what they deserve

6. _____ I feel that rewards and punishments are fairly given

7. _____ I basically feel that the world is a fair place

Please proceed to next questionnaire

General Health Questionnaire-GHQ12

Please read the questions below and each of the four possible answers. Circle the response that best applies to you.

Have you recently:

1. **been able to concentrate on what you're doing?**

better than usual (0)	*same as usual* (1)	*less than usual* (2)	*much less than usual* (3)

2. **lost much sleep over worry?**

not at all (0)	*no more than usual* (1)	*rather more than usual* (2)	*much more than usual* (3)

3. **felt that you are playing a useful part in things?**

more so than usual (0)	*same as usual* (1)	*less so than usual* (2)	*much less than usual* (3)

4. **felt capable of making decisions about things?**

more so than usual (0)	*same as usual* (1)	*less than usual* (2)	*much less than usual* (3)

5. **felt constantly under strain?**

not at all (0)	*no more than usual* (1)	*rather more than usual* (2)	*much more than usual* (3)

6. **felt you couldn't overcome your difficulties?**

not at all (0)	*no more than usual* (1)	*rather more than usual* (2)	*much more than usual* (3)

General Health Questionnaire-GHQ12 (continued)

7. been able to enjoy your normal day to day activities?

more so than usual (0)	*same as usual* (1)	*less than usual* (2)	*much less than usual* (3)

8. been able to face up to your problems?

more so than usual (0)	*same as usual* (1)	*less than usual* (2)	*much less than usual* (3)

9. been feeling unhappy or depressed?

not at all (0)	*no more than usual* (1)	*rather more than usual* (2)	*much more than usual* (3)

10. been losing confidence in yourself?

not at all (0)	*no more than usual* (1)	*rather more than usual* (2)	*much more than usual* (3)

11. been thinking of yourself as a worthless person?

not at all (0)	*no more than usual* (1)	*rather more than usual* (2)	*much more than usual* (3)

12. been feeling reasonably happy, all things considered?

more so than usual (0)	*same as usual* (1)	*less than usual* (2)	*much less than usual* (3)

Please proceed to next questionnaire

Patient Health Questionnaire – PHQ9

Over the last 2 weeks how often have you been bothered by any of the following problems?
(Please use an X for each question to indicate your answer)

	Not at all (0)	Several days (1)	More than half the days (2)	Nearly every day (3)
1. Little interest or pleasure in doing things				
2. Feeling down, depressed, or hopeless				
3. Trouble falling or staying asleep, or sleeping too much				
4. Feeling tired or having little energy				
5. Poor appetite or overeating				
6. Feeling bad about yourself – or that you are a failure or have let yourself or your family down				
7. Trouble concentrating on things, such as reading the newspaper or watching television				
8. Moving or speaking so slowly that other people could have noticed. Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual				
9. Thoughts that you would be better off dead, or of hurting yourself in some way				
Add columns:				
Total:				

Please proceed to next questionnaire

Global Assessment of Functioning (GAF) SCALE

GAF SCALE	
This questionnaire considers psychological, social and occupational functioning on a hypothetical continuum of mental health – illness, rated from 90 to 01. Select the rating that best describes your LOWEST LEVEL OF FUNCTIONING IN THE PREVIOUS MONTH for symptoms and for disability. Use intermediate codes when appropriate (e.g. 45, 68, 72). Place your 2 answers in the box below the scale	
Absent or minimal symptoms (e.g. mild anxiety before an exam), good functioning in all areas, interested and involved in a wide range of activities, socially effective, generally satisfied with life, no more than everyday problems or concerns (e.g. an occasional argument with family members).	90 to 81
If symptoms are present, they are transient and expectable reactions to psychosocial stressors (e.g. difficulty concentrating after family argument); no more than slight impairment in social, occupational or school functioning (e.g. temporarily falling behind in school work).	80 to 71
Some mild symptoms (e.g. depressed mood and mild insomnia) OR some difficulty in social, occupational or school functioning (e.g. occasional truancy, or theft within the household), but generally functioning pretty well, has some meaningful interpersonal relationships.	70 to 61
Moderate symptoms (e.g. flat affect and circumstantial speech, occasional panic attacks) OR moderate difficulty in social, occupational, or school functioning (e.g. few friends, conflicts with co-workers).	60 to 51
Serious symptoms (e.g. suicidal ideation, severe obsessional rituals, frequent shoplifting) OR any serious impairment in social, occupational or school functioning (e.g. no friends, unable to keep a job).	50 to 41
Some impairment in reality testing or communication (e.g. speech is at times illogical, obscure or irrelevant) OR major impairment in several areas, such as work or school, family relations, judgement, thinking, or mood (e.g. depressed man avoids friends, neglects family and is unable to work; child frequently beats up younger children, is defiant at home and is failing at school).	40 to 31
Behaviour is considerably influenced by delusions or hallucinations OR serious impairment in communication of judgement (e.g. sometimes incoherent, acts grossly inappropriately, suicidal preoccupation) OR inability to function in almost all areas (e.g. stays in bed all day; no job, home or friends).	30 to 21
Some danger of hurting self or others (e.g. suicide attempts without clear expectation of death, frequently violent, manic excitement) OR occasionally fails to maintain minimal personal hygiene (e.g. smears, faeces) OR gross impairment in communication (e.g. largely incoherent or mute).	20 to 11
Persistent danger of severely hurting self or others (e.g. recurrent violence) OR persistent inability to maintain minimal personal hygiene OR serious suicidal act with clear expectation of death.	10 to 0

Symptom GAF score	
Disability GAF score	

Please proceed to next section

Section 3

Childhood experiences

This sections concerns aspects of childhood not covered previously.

Some or all of the following questions in this section may appear not to be relevant to you; however we are looking for TYPICAL and ATYPICAL experiences. If possible please attempt all questions in this section.

All information provided will remain completely confidential.

(Selected Questions from the Childhood Experience of Care and Abuse Scale, CECQ3) (Bifulco, Bernazzani, Moran, & Jacobs, 2005)

Childhood experiences

LOSS OF A PARENT BEFORE THE AGE OF 17

	MOTHER		FATHER	
Did either parent die before you were age 17? (please circle one answer for each parent)	Yes	No	Yes	No
If yes, What age were you	Age _____ years		Age _____ years	
Have you ever been separated from your parent for one year or more before age 17? (please circle one answer for each parent)	Yes	No	Yes	No
If separated, at what age were you first separated?	Age _____ years		Age _____ years	
How long was this separation?	_____ years		_____years	
What was the reason for this? (please circle all that apply)	Illness		Illness	
	Work		Work	
	Divorce/separation		Divorce/separation	
	Never knew parent		Never knew parent	
	Abandoned		Abandoned	
	Other		Other	

Childhood experiences

AS YOU REMEMBER YOUR MOTHER FIGURE IN YOUR FIRST 17 YEARS:

Please circle the appropriate number. If you more than one mother figure, choose the one you were with longest, or the one you found most difficult to live with.

WHICH MOTHER FIGURE ARE YOU DESCRIBING BELOW?
(mark with an X)

1. _____ Birth mother
2. _____ Step-mother/father's live-in partner
3. _____ Other relative e.g. aunty, grandmother
4. _____ Other non-relative e.g. foster mother, godmother
5. _____ Other (describe).....

	Yes Definitely		Unsure		No, not at all
1. She was very difficult to please.....	5	4	3	2	1
2. She was concerned about my worries.....	5	4	3	2	1
3. She was interested in how I did at school.	5	4	3	2	1
4. She made me feel unwanted.....	5	4	3	2	1
5. She tried to make me feel better when I was upset.....	5	4	3	2	1
6. She was very critical of me.....	5	4	3	2	1
7. She would leave me unsupervised before I was 10 years old.....	5	4	3	2	1
8. She would usually have time to talk to me	5	4	3	2	1
9. At times she made me feel I was a nuisance	5	4	3	2	1
10. She often picked on me unfairly.....	5	4	3	2	1
11. She was there if I needed her.....	5	4	3	2	1
12. She was interested in who my friends were	5	4	3	2	1
13. She was concerned about my whereabouts.	5	4	3	2	1
14. She cared for me when I was ill.....	5	4	3	2	1
15. She neglected my basic needs (e.g. food and clothes)	5	4	3	2	1
16. She did not like me as much as my brothers and sisters.....(Leave blank if no siblings)	5	4	3	2	1

Childhood experiences - continued

The following items describe some behaviours that can occur from parents.
Did your mother/mother figure ever act like this towards you?
(Please circle the appropriate response)

				How Frequent?			
1. She would tease me	Yes	Unsure	No	Never	Once	Rarely	Often
2. She made me keep secrets	Yes	Unsure	No	Never	Once	Rarely	Often
3. She undermined my confidence	Yes	Unsure	No	Never	Once	Rarely	Often
4. She would confuse me by telling 5. me to do contradictory things	Yes	Unsure	No	Never	Once	Rarely	Often
6. She played on my fears	Yes	Unsure	No	Never	Once	Rarely	Often
7. She liked to see me suffer	Yes	Unsure	No	Never	Once	Rarely	Often
8. She humiliated me, put me down	Yes	Unsure	No	Never	Once	Rarely	Often
9. She would shame me in front of others.	Yes	Unsure	No	Never	Once	Rarely	Often
10. She was very rejecting	Yes	Unsure	No	Never	Once	Rarely	Often
11. She took away the things I cherished	Yes	Unsure	No	Never	Once	Rarely	Often
12. She would make me eat things I didn't like until I was sick...	Yes	Unsure	No	Never	Once	Rarely	Often
13. She would deliberately deprive me of light, food or company	Yes	Unsure	No	Never	Once	Rarely	Often
14. She would not let me mix with people I wanted to see	Yes	Unsure	No	Never	Once	Rarely	Often
15. She would make me feel guilty so I would do what I was told	Yes	Unsure	No	Never	Once	Rarely	Often
16. She threatened to hurt the people dear to me to get what she wanted	Yes	Unsure	No	Never	Once	Rarely	Often
17. She forced me to steal or break the law for her	Yes	Unsure	No	Never	Once	Rarely	Often
18. She said she wanted me dead	Yes	Unsure	No	Never	Once	Rarely	Often

Childhood experiences - continued

AS YOU REMEMBER YOUR FATHER FIGURE IN YOUR FIRST 17 YEARS:

Please circle the appropriate number. If you more than one father figure, choose the one you were with longest, or the one you found most difficult to live with. If you had no father in the household then please leave this section

WHICH FATHER FIGURE ARE YOU DESCRIBING BELOW?
(mark with an X)

1. _____ Birth father
2. _____ Step-father/mother's live-in partner
3. _____ Other relative e.g. uncle, grandfather
4. _____ Other non-relative e.g. foster faster, godfather
5. _____ Other (describe).....

	Yes Definitely		Unsure		No, not at all
1. He was very difficult to please.....	5	4	3	2	1
2. He was concerned about my worries.....	5	4	3	2	1
3. He was interested in how I did at school.	5	4	3	2	1
4. He made me feel unwanted.....	5	4	3	2	1
5. He tried to make me feel better when I was upset.....	5	4	3	2	1
6. He was very critical of me.....	5	4	3	2	1
7. He would leave me unsupervised before I was 10 years old.....	5	4	3	2	1
8. He would usually have time to talk to me	5	4	3	2	1
9. At times he made me feel I was a nuisance	5	4	3	2	1
10. He often picked on me unfairly.....	5	4	3	2	1
11. He was there if I needed him.....	5	4	3	2	1
12. He was interested in who my friends were	5	4	3	2	1
13. He was concerned about my whereabouts.	5	4	3	2	1
14. He cared for me when I was ill.....	5	4	3	2	1
15. He neglected my basic needs (e.g. food and clothes)	5	4	3	2	1
16. He did not like me as much as my brothers and sisters.....(Leave blank if no siblings)	5	4	3	2	1

Childhood experiences - continued

The following items describe some behaviours that can occur from parents.
Did your father/father figure ever act like this towards you?
(Please circle the appropriate response)

				How Frequent?			
1. He would tease me	Yes	Unsure	No	Never	Once	Rarely	Often
2. He made me keep secrets	Yes	Unsure	No	Never	Once	Rarely	Often
3. He undermined my confidence	Yes	Unsure	No	Never	Once	Rarely	Often
4. He would confuse me by telling 5. me to do contradictory things	Yes	Unsure	No	Never	Once	Rarely	Often
6. He played on my fears	Yes	Unsure	No	Never	Once	Rarely	Often
7. He liked to see me suffer	Yes	Unsure	No	Never	Once	Rarely	Often
8. He humiliated me, put me down	Yes	Unsure	No	Never	Once	Rarely	Often
9. He would shame me in front of others.	Yes	Unsure	No	Never	Once	Rarely	Often
10. He was very rejecting	Yes	Unsure	No	Never	Once	Rarely	Often
11. He took away the things I cherished	Yes	Unsure	No	Never	Once	Rarely	Often
12. He would make me eat things I didn't like until I was sick...	Yes	Unsure	No	Never	Once	Rarely	Often
13. He would deliberately deprive me of light, food or company	Yes	Unsure	No	Never	Once	Rarely	Often
14. He would not let me mix with people I wanted to see	Yes	Unsure	No	Never	Once	Rarely	Often
15. He would make me feel guilty so I would do what I was told	Yes	Unsure	No	Never	Once	Rarely	Often
16. He threatened to hurt the people dear to me to get what he wanted	Yes	Unsure	No	Never	Once	Rarely	Often
17. He forced me to steal or break the law for him	Yes	Unsure	No	Never	Once	Rarely	Often
18. He said she wanted me dead	Yes	Unsure	No	Never	Once	Rarely	Often

PHYSICAL PUNISHMENT BEFORE AGE 17 BY PARENT FIGURE OR OTHER HOUSEHOLD MEMBER

1. When you were a child or teenager were you ever hit repeatedly with an implement (such as a belt or stick) or punched, kicked or burnt by someone in the household?

(please circle one answer)

YES / NO

UNWANTED SEXUAL EXPERIENCES BEFORE AGE 17
(Please circle as appropriate)

2. When you were a child or teenager did you ever have any unwanted sexual experiences?

YES / NO / UNSURE

3. Did anyone force you or persuade you have sexual intercourse against your wishes before age 17?

YES / NO / UNSURE

4. Can you think of any upsetting sexual experiences before age 17 with a related adult or someone in authority e.g. teacher?

YES / NO / UNSURE

Please proceed to next section

Section 4

Trauma, Anger and Substance Use

This section contains a number of short questionnaires and rating scales concerning exposure to traumatic events, feelings of anger and aggression, and the use of alcohol or drugs.

Some or all of the following questions in this section may appear not to be relevant to you; however we are looking for TYPICAL and ATYPICAL experiences. If possible please attempt all questions in this section.

Combat Exposure Scale (Keane et al 1989)

Veteran participants only. For each question please circle the number above the answer that best describes your experience.

1. Did you ever go on combat patrols or have other dangerous duty?

1	2	3	4	5
No	1-3 times	4-12 times	13-50 times	51+ times

Were you ever under enemy fire?

1	2	3	4	5
Never	<1 month	1-3 months	4-6 months	7 months or more

2. Were you ever surrounded by the enemy?

1	2	3	4	5
No	1-2 times	3-12 times	13-25 times	26+ times

3. What percentage of the soldiers in your unit were killed (KIA), wounded or missing in action (MIA)

1	2	3	4	5
None	1-25%	26-50%	51-75%	76% or more

4. How often did you fire rounds at the enemy?

1	2	3	4	5
Never	1-3 times	4-12 times	13-50 times	51+ times

5. How often did you see someone hit by incoming or outgoing rounds?

1	2	3	4	5
Never	1-2 times	3-12 times	13-50 times	51+ times

6. How often were you in danger of being injured or killed (i.e., being pinned down, overrun, ambushed, near miss, etc.)?

1	2	3	4	5
Never	1-2 times	3-12 times	13-50 times	51+ times

Please proceed to next questionnaire

PCL-C (Weathers, Litz, Herman, Huska, & Keane, 1993)

Below are a list of problems and complaints that people sometimes have in response to stressful experiences. Please read each one carefully, put an X in the box to indicate how much you have been bothered by that problem **in the last month**

	Not at all 1	A little bit 2	Moderately 3	Quite a lot 4	Extremely 5
Repeated, disturbing memories, thoughts or images of a stressful experience					
Repeated, disturbing dreams of a stressful experience					
Suddenly acting or feeling as if a stressful experience were happening again (as if you were reliving it)					
Feeling very upset when something reminded you of a stressful experience					
Having a physical reaction (e.g. heart pounding, trouble breathing, sweating) when something reminded you of a stressful experience					
Avoiding thinking or talking about a stressful experience or avoiding having feelings related to it					
Avoiding activities or situations because they reminded you of a stressful experience					
Trouble remembering important parts of a stressful experience					
Loss of interest in activities that you used to enjoy					
Feeling distant or cut off from people					
Feeling emotionally numb of being unable to have loving feelings for those close to you					
Feeling as if your future will somehow be cut short					
Trouble falling or staying asleep					
Feeling irritable of having angry outbursts					
Having difficulty concentrating					
Being "super-alert" or watchful or on guard					
Feeling jumpy or easily startled					

Please proceed to next questionnaire

The Short Form Buss-Perry Aggression Questionnaire (BPAQ-SF) (Bryant et al, 2001)

Using the 5-point scale below please indicate your level of agreement on how you think the following characteristic statements apply to you. Please record your answer in the space next to each question

1	2	3	4	5
Extremely uncharacteristic of me	Uncharacteristic of me	Neither characteristic or uncharacteristic	Characteristic of me	Extremely characteristic of me

1. _____ I often find myself disagreeing with people
2. _____ At times I feel I have gotten a raw deal out of life
3. _____ My friends say I am somewhat argumentative
4. _____ Given enough provocation I may hit another person
5. _____ Sometimes I fly of the handle for no good reason
6. _____ I can't help getting into arguments when people disagree with me
7. _____ There are people who pushed me so far that we came to blows
8. _____ I have trouble controlling my temper
9. _____ Other people always seem to get the breaks
10. _____ I flare up quickly but get over it quickly
11. _____ I have threatened people I know
12. _____ I wonder why I sometimes feel bitter about things

Please proceed to next questionnaire

The Alcohol Use Disorders Identification Test: Self-Report Version (AUDIT) (Babor, Higgins-Biddle, Saunders, & Monteiro, 2000)

Alcohol can affect health and wellbeing, often interacting with medication and other treatments. Additionally drinking has commonly been associated with experiencing stress or trauma. For this reason we would like to ask you some questions about your alcohol use.

Please answer each question in the box at the end of each line.

If you are currently a serving prisoner these questions relate to your most recent time outside in the community.

	0	1	2	3	4	
How often do you have a drink containing alcohol?	Never	Monthly or less	2-4 times a month	2-3 times a week	4 or more times a week	
How many drinks containing alcohol do you have on a typical day when you are drinking	1 or 2	3 or 4	5 or 6	7 to 9	10 or more	
How often do you have six or more drinks on one	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you found that you were not able to stop drinking once you had started	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you failed to do what was normally expected of you because of drinking	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you had a feeling of guilt or remorse after drinking	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you been unable to remember what happened the night before because of your drinking	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
Have you or some else been injured because of your drinking	No		Yes, but not in the last year		Yes, during the last year	
Has a relative, friend, doctor, or other healthcare worker been concerned about your drinking or suggested you cut down.	No		Yes, but not in the last year		Yes, during the last year	
				Total		

Please proceed to next questionnaire

Drug Use Questionnaire (DAST-10)

The following questionnaire concerns information about your potential involvement with drugs, excluding alcohol and tobacco during the last 12 months. Carefully read each statement and decide if your answer is "No" or "Yes". Then, place an X in the appropriate answer beside each question.

When the words "drug abuse" are used they mean the use of prescribed or over the counter in excess of the directions and any non-medical use of drugs. The various classes of drugs may include: cannabis (e.g. marijuana, hash), solvents, tranquilisers (e.g. valium), barbiturates, cocaine, stimulants (e.g. speed), hallucinogens (e.g. LSD) or narcotics (e.g. heroin). Remember the questions do not include alcohol or tobacco.

Please answer every question. If you have a difficulty with a statement then choose the response that is mostly right.

These questions refer to that last 12 months

	No	Yes
1. Have you used drugs other than those required for medical reasons?		
2. Do you abuse more than one drug at a time?		
3. Are you always able to stop using drugs when you want to?		
4. Have you had "blackouts" or "flashback" as a result of drug use?		
5. Do you ever feel bad or guilty about your drug use?		
6. Does your spouse (or parent) ever complain about your involvement with drugs?		
7. Have you neglected your family because of your use of drugs?		
8. Have you engaged in illegal activities in order to obtain drugs?		
9. Have you ever experienced withdrawal symptoms (felt sick) when you stopped taking drugs?		
10. Have you ever had medical problems as a result of your drug use (e.g., memory loss, hepatitis, convulsions, bleeding etc.)?		

Thank you for completing this questionnaire booklet

Appendix 6: Focus Group Questions

Focus Group Questions

1. [Introductory] Can you tell me what it is like being in prison?
2. [introductory] What are the similarities and differences between being in prison and working in the Armed Forces?
3. [Linking] What challenges does being in prison bring to military veterans?
    a. [Supplementary linking] How do military veterans deal with these challenges?
4. [Key Question] I am interested to know what you think the main support needs are for military veterans who are in Scottish Prisons
    a. [Follow up] What support needs for military veterans do you think are specifically triggered by being in prison?
    b. [Supplementary] What support needs do you think are present before imprisonment?
    c. [Follow up] Do you think these needs contribute to military veterans being imprisoned?
5. [Key Question]I would like to know whether you think the main support needs of military veterans in prison are the same or differ from the non-veteran adult prison population?
    a. [Follow up] Can you describe how they differ?
    b. [Follow up] Can you tell me in what way they are similar?
6. [Key Question] What services or support do you think would best address the needs of military veterans in prison?
    a. [Supplementary] Are such services and supports available?
    b. {Follow up] What is you experience of accessing these?
    c. [Follow up] How do these services differ from the supports available to the non-veteran prison population?
    d. [Supplementary] If you were to implement and prioritise the services described, how would you do it?
7. [Linking] Can you tell me what you think would prevent military veterans from offending and being imprisoned?

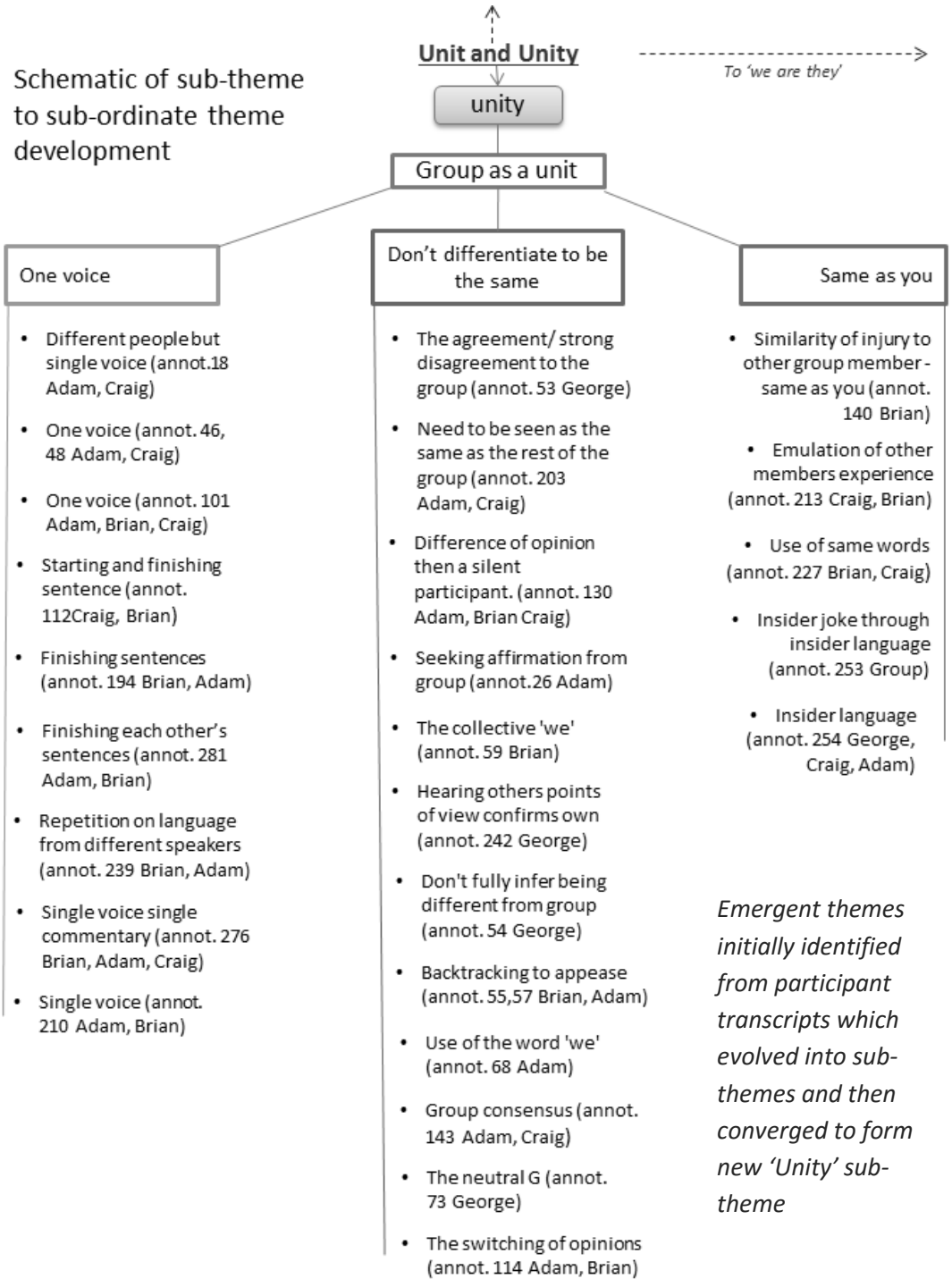
8. [Linking] Can you describe the experience of leaving the military service and becoming a civilian?
9. [Key Question] How do you think veterans will cope with the move from being in prison to living back in the community?
    a. [Supplementary Question] Can you tell me what you think would help military veterans currently in prison from reoffending when back in the community?
10. [Ending] Are there any other relevant comments, thoughts or experiences you would like to add that we have not covered?

Appendix 7: Focus Group participants' demographics and other characteristics

Focus group participants' demographics and other characteristics

Participant (anonymised)	Age	Marital Status	Prison before	Current sentence status	Current offence	Length of sentence	Work situation pre prison	Armed force served	Rank at discharge	Conflict theatres served	Joined and left service	No. years' service & no. years since left (to 2013)	Type of service discharge
Adam	35	Single 2 children	Yes	Sentenced	Recall for firearms offence	5 years	Full time employment	Army	Lance Corporal	Balkans Others	Joined: 1996 Discharged: 2001	5 years in service 12 years since leaving	Honourable discharge
George	40	Divorced	Yes	Sentenced	Armed Robbery	3 years and 9 months	Unemployed and on benefits	Army	Private	...	Joined: 1989 Discharged: 1992	3 years in service 21 years since leaving	Honourable discharge
Craig	29	Living with partner 2 children	Yes	Sentenced	Breach of the Peace	4 months	Casual employment	Army	Private	Others	Joined: 2002 Discharged: 2007	5 years in service 6 years since leaving	Honourable discharge
Brian	26	Single 3 children	Yes	Sentenced	Violent and threatening behaviour	10 months	Unemployed and on benefits	Army	Private	...	Joined: 2003 Discharged: 2005	2 years in services 8 years since leaving	Medical discharge

Appendix 8: Example of sub-theme to sub-ordinate theme development following focus group



Appendix 9: 1:1 Interview Questions

Interview Questions

1. [Introductory] Can you briefly tell me what you did in the Armed Forces?
2. [Introductory] Can you describe the experience of leaving the military service and becoming a civilian?
    a. [Supplementary] How do you think you coped with this period of transition?
        i. [Supplementary] How do you think military veterans are viewed by society?
3. [Key Question] Can you tell me what it is like being in prison?
    a. [Supplementary] Can you tell me what it means to you?
    b. [Supplementary] Can you explain what it is like mixing with other prisoners?
        i. [Supplementary] Do you spend time with non-veteran prisoners?
        ii. *If so…* [Supplementary] Do they know that you are a military veteran?
        iii. *If so…* [Supplementary] What do you think they feel or think about you and your past experiences?
        iv. [Supplementary] What do you think prison staff feel or think about you and your past experiences?
    c. [Supplementary] How does being in prison differ from being in the Armed Forces?
4. [Linking] How would you describe your main challenges whilst being in prison?
    a. [Supplementary] What do you do to overcome them?
    b. [Supplementary] Do you have regular contact with family/friends whilst in prison?
5. [Key Question] Can you tell me about your mental health, alcohol or drug difficulty?
    a. *If not covered* [Supplementary] Can you describe to me when this problem started?
    b. [Supplementary] How do you think it has impacted on your life?

i. {invite answers that cover period before prison if problem was present then, as well as impact since imprisonment}
ii. *If not covered* [Supplementary] Do you think it contributed to you ending up in prison?
iii. *If so and if not covered…* [Supplementary] Can you describe to me in what way you think it contributed to you ending up in prison?

6. [Key Question] What has it been like trying to get help for your problem whilst in prison?
    a. [Supplementary] How easy has it been to access help for your problem?
    b. *If not covered* [Supplementary] Can you describe the services and types of support you have had access to?
7. [Key Question] Can you describe to me what services or supports you think you should have access to in prison that would help you address your mental health, alcohol or drug difficulties?
    a. [Supplementary] Are such services available?
    b. *If so…* [Supplementary] How easy is it to access these services and supports?
8. [Key Question] Do you think that as a military veteran you should have access to services and supports in prison that are specific to the needs of veterans?
    a. *If not covered* [Supplementary] Can you tell me the reasons for your answer?
    b. *If answered yes to above* [Supplementary] Are these the same services and supports you described earlier?
        i. *If yes move on…..If no* [Supplementary] What are these services and supports?
9. [Key Question] What do you think the future holds for you?
    a. [Supplementary] How do you think you will cope with eventually leaving prison and returning back to the community?
        i. [Supplementary] What would make this transition easier for you?
        ii. *If not covered* [Supplementary] What could the prison service do to make the transfer from being a prisoner back to being a civilian easier for you?

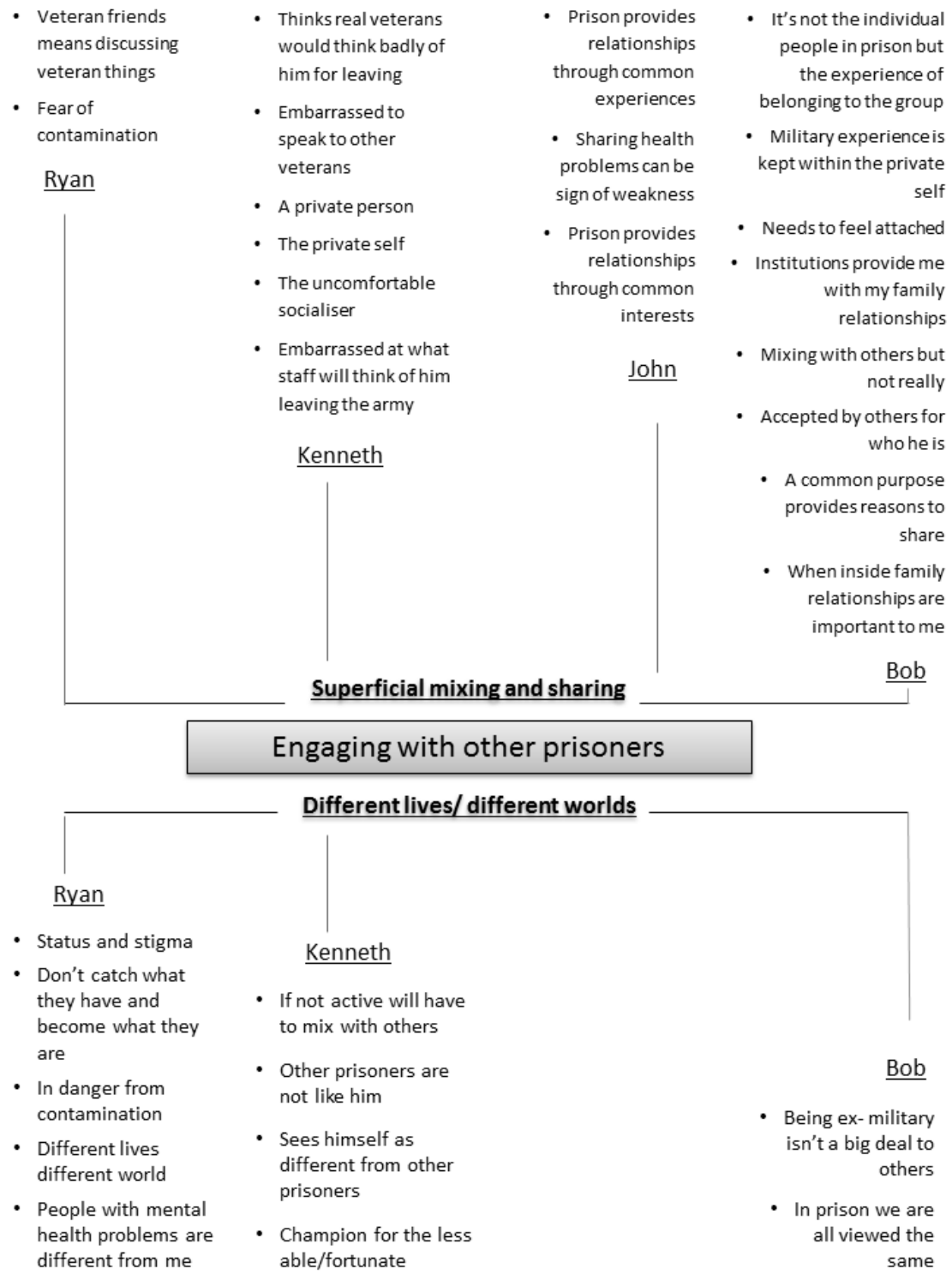
10. [Ending] Are there any other relevant comments, thoughts or experiences you would like to add that we have not covered?

Appendix 10: 1:1 Interview demographics and other characteristics

1:1 interview participants' demographics and other characteristic

Participant (anonymised)	Age and Marital Status	Mental health problem	Prison before	Current sentence status	Current offence	Length of sentence	Work situation pre prison	Armed force served	Rank at discharge	Conflict theatres served	Years joined and left service	Type of service discharge
Ryan	40 years of age Living with partner	Depression	No	Sentenced	Supply of Class A drugs	3 years and 4 months	Full time employment	Army	Corporal	Northern Ireland 1st Gulf War Balkans Conflict	Joined: 1991 Discharge: 1997	Honourably discharged
Bob	35 years of age Living with partner	Schizophrenia & suspected Post Traumatic Stress Disorder	Yes	Remand	Armed Robbery	N/A	Unemployed and on benefits	Army	Corporal	Northern Ireland	Joined: 1995 Discharge: 2000	Medically discharged
John	41 years of age Divorced	Alcohol misuse & Depression	Yes	Remand	Assault, Breach of the Peace, Carrying an Offence Weapon	N/A	Unemployed and on benefits	Army	Private	Northern Ireland	Joined: 1991 Discharge: 1997	Honourably discharged
Kenneth	37 years of age Single	Anxiety, Depression & Alcohol misuse	Yes	Sentenced	Serious Assault to Permanent Disfigurement	2 years and 6 months	Unemployed and on benefits	Army	Private	Other	Joined: 1992 Discharge: 1992	Other

Appendix 11: Examples of sub-theme to sub-ordinate theme development following 1:1 interview



Emergent themes initially identified from participant transcripts which evolved into sub-themes linked to 'Engaging with other prisoners' sub-ordinate theme