Understanding help seeking behaviour among male offenders: qualitative interview study

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EDITORIAL by Mezey

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ABSTRACT

Objective To explore the factors that influence help seeking for mental distress by offenders.

Design Qualitative study based on in-depth interviews with prisoners before and after release.

Setting One category B local prison in southern England.

Participants 35 male offenders aged 18-52, a quarter of whom had been flagged as being at risk of self harm.

Results Most respondents reported that they would not seek help from a general practitioner or other healthcare professional if experiencing mental distress. When followed up after release, none had sought medical help despite the fact that many had considerable emotional problems. Many participants were hesitant to seek help because they feared being given a formal diagnosis of mental illness. Some of these men feared the stigma that such a diagnosis would bring, whereas others feared that a diagnosis would mean having to confront the problem. Lack of trust emerged as the most prominent theme in prisoners' discourse about not seeking help from health professionals. Distrust towards the "system" and authority figures in general was linked to adverse childhood experiences. Distrust directed specifically at healthcare professionals was often expressed as specific negative beliefs: many perceived that health professionals (most often doctors) "just don't care," "just want to medicate," and treat patients "superficially." Those men who would consider going to a general practitioner reported positive previous experiences of being respected and listened to.

Conclusions Distrust is a major barrier to accessing health care among offenders. Like most people, the respondents in this study wanted to feel listened to, acknowledged, and treated as individuals by health professionals. By ensuring that a positive precedent is set, particularly for sceptical groups such as ex-prisoners, general practitioners and prison doctors may be able to encourage future help seeking. Information specifically designed for prisoners is needed to help to de-stigmatise mental illness, and preparation for release should include provision of information about access to health and social services. Awareness training for health professionals is recommended: trust might be fostered in this population by seemingly trivial gestures that indicate respect.

INTRODUCTION

Men who have been incarcerated have significantly higher rates of mental illness and suicide and under-use mental health services compared with the general population.[1-4] Despite the psychological profile and risk factors that characterise this group—low socioeconomic status, increased levels of impulsivity and aggression, limited coping skills, social isolation, a history of self harm and attempted suicide[5]—no qualitative studies have focused specifically on the perceptions and beliefs that influence help seeking for this vulnerable group. A positive previous encounter with a health professional may predict help seeking in future, although the nature of such encounters has not been explored.[4] Our primary aim was to learn more about the factors that influence help seeking behaviour among men leaving custody, in order to inform the development of health and social care services.

METHODS

Interviews

We did 35 in-depth, face to face interviews with sentenced male prisoners from one category B local prison (second in the four categories of severity of offence) in southern England. The sample included young and middle aged participants, prisoners with short and long offence histories, and those who had currently or previously been convicted for minor or serious offences. We preferentially interviewed prisoners who were flagged by prison staff as being at risk for suicide or self harm. We drew participants from prisoners who were scheduled for release each week, sampling them until we reached 35 cases, with a view to achieving data saturation within the scope of the study.[6-8]

We developed the study design and interview topic guide in partnership with the Revolving Doors Agency, a voluntary sector organisation that provides services to ex-offenders with mental health problems (www.revolvers.org.uk). The pre-release interview schedule covered topics in four primary domains (family background, coping with stress and difficulties, perceived mental health and suicidal ideation, help seeking behaviour). We encouraged participants to digress from the schedule to talk about other matters that were relevant to them. The interview lasted between one and two hours.

The first four to six weeks after release from prison are particularly hazardous with regards to risk of suicide and self harm.[3 9] We planned to interview all participants approximately four to six weeks after release. The second interview focused on the experience of transition from prison into the community, experiences of mental distress, and specific barriers to use of health services. Where necessary, we made some follow-up contacts by letter, telephone, or text messaging.

Data analysis

We audiotaped and transcribed all interviews. We analysed data thematically by using principles of grounded theory, including the constant comparison method. We identified deviant cases or exceptions to the emerging pattern of relations between codes.[10] We used other

Age and sentence information of prisoners (n=35)

Characteristic	Mean	Median (range)
Age (years)	30	27 (18-52)
Length of sentence (months)	6	4 (1-30)
No of previous convictions	18	12 (0-116)
No of previous times in prison	5	3 (0-32)

techniques such as open coding of the early data,[11] reflexivity methods, and peer group reviews.

RESULTS

Characteristics of respondents

All prisoners approached consented to be interviewed. Of the 35 interviews done before release, six were with young offenders (aged 18-20 years) (table). All but one of the participants were unmarried, and 97% of the sample were white British. We did post-release interviews with 19 (54%) of the 35 original participants. We collected basic information on participants' general circumstances and wellbeing from relatives for a further 10 participants.

A quarter of the participants had been flagged by a staff member as being at risk of suicide or self harm during their time in the prison. Twenty two of the respondents reported attempting suicide at some point in their lives. Several respondents reported a formal mental health diagnosis, and many said that although not formally diagnosed they were concerned that they had a mental health problem. These respondents reported symptoms such as anxiety, hearing voices, or prolonged periods of depression. Several respondents who reported mental health problems commented that entering prison interrupted their drug treatment cycles.

Factors that inhibit help seeking

Of the 35 prisoners interviewed, 21 said that they would not consider consulting a general practitioner about mental health problems, seven said that they would consider doing so, and the remaining seven said that they would consider it under certain conditions. We identified three inter-related themes as factors that inhibited help seeking for most of this group: chaotic upbringing, distrust, and fear of a diagnosis of mental illness.

Chaotic family background

Most of the respondents had tumultuous personal histories characterised by split families, physical abuse or neglect, and frequent drug and alcohol use in the home (box 1). Most respondents talked about their childhood experiences generally, but several drew connections between their past experience of abuse or neglect and their present inability to trust others.

Distrust

Within this context, how distrust emerged as a major theme in the analysis is understandable. Scholars understand that trust is built on the normality, predictability, and reliability of one's social environment.[12] When the rules governing social interaction have been significantly eroded, trust is likely to deteriorate. Several types of distrust characterised this sample. Many men expressed a general distrust of almost all people; some reserved trust only for the closest of family members. Others proclaimed a distrust for everyone, including relatives. The most common types of distrust were a generalised distrust towards "the system" and distrust directed specifically at healthcare professionals (box 2). The second type was often expressed as specific negative beliefs; for instance that healthcare professionals (most often doctors) "just don't care," "just want to medicate," or "treat patients superficially." Many respondents based these perceptions on negative experiences with healthcare professionals, whereas others discussed these feelings more generally, not referring to actual experiences. Some respondents expressed a combination of these sentiments: "They don't care one bit, they really don't care. They must have a flippin' . . . programme to follow or something, where they must have to tick boxes or something" (respondent 27).

A subset of men in this group were less angry but simply did not feel comfortable discussing personal problems with healthcare professionals because no previous relationship existed. Other respondents lacked confidence that general practitioners or mental health professionals could do anything to help. Some based this lack of confidence on previous experiences in which they felt that they were not taken seriously, which often led

Box 1 | Chaotic family background

Respondent 3: "I don't talk to my dad." Interviewer: "Why?" R3: "He raped my sister for 6 years and beat the crap out of me and my brothers for 6 years. So now I don't talk to my dad. He beat the crap out of his missus even when we lived with him. My stepmom when I was 3 or 4. She was a bitch, I hated her." I: "Really?" R3: "Yeah. When he wasn't beating us, it was her, but my mum, she never laid a finger on me in my life, she never would, she wouldn't dare. She's still messed up in her own little way. Well, mum introduced me to drugs."

I: "So why did you get fostered when you were 14?" R24: "'Cos my mum went on a bender. (Laughs.) She went on a mad one. And I was sick of living in fields and in buses and stuff, so I ended up getting put into foster care."

R18: "Mother and father were divorced before I was born. Mother was only 16 when she had me, so really young. Dad was only young as well. My mother's dead, she was killed in a car accident a few year back. She was dead with drinking, though. I'm a heavy drinker myself, me father was a heavy drinker."

Box 2 | Distrust as a barrier to seeking help

Respondent 20: "Er, well the GPs in England are not, um, very helpful in that way. They would rather just look at you and go: right well you can have that tablet. I've tried committing suicide in here a few times and they say we'll take you to healthcare for the night, you'll see the doctor—and the doctor says, oh, how are you feeling, you look all right to me, and he sends me back to the wing. They don't really understand what people are going through—they pretend that they do, but all they're doing is saying, oh, we don't want you over here, you can go back to the wing."

Interviewer: "What's your experience of GPs been like?" R24: "Err . . . rubbish really, they just try and pawn me off with drugs that don't actually help the situation. The government's answer is use medication to fuck the nation. (Laughs.) They either want to take blood from me or they want to give me drugs, which I'm not interested in."

Box 3 | Fear of diagnosis as a barrier to help seeking

Respondent 33: "'Cos it's a hard thing to admit, isn't it? It's like saying you're weak basically. Interviewer: "You think so?" R33: "Yeah." I: "So you think it would be saying you're weak if you admitted it?" R33: "Yeah, saying that you can't handle everyday life really, so you're classed . . . to me, I would class myself as weak if I'd got to go and say I've got a problem. And if I don't admit it, I haven't got it. So that's the other way of looking at it, isn't it?"

R28: "Well, you're obviously a bit wrong if you've got a mental health problem, that's how some people see it—not myself personally, but you know yourself how some people see it. And to actually spill your guts and talk about your personal stuff to someone is another big barrier, isn't it? Nowhere in life are you encouraged to do that ever, so you've really got to take it on board for yourself—'well, actually I'm going to have to speak about all this stuff to get better.' That's a big barrier, I think."

R15: "I suppose it's because half the time people will tell you the truth, like if there's something wrong and they're telling you it's wrong, it's the truth (laughs), it's hard to handle sometimes. I don't know. I just don't like sitting there, being told this is wrong with you, that's all. I know what's wrong with me."

Box 4 | Factors that promote help seeking

Respondent 28: "Yeah we built up a good rapport, yeah, so she knew a lot about me. And I knew stuff about her as well . . . not so much her personal life, but just like little things about what she was going to do that day or something, so the next time I saw her I'd go, oh, did you go do such and such, and it was the basis for a conversation. She was just brilliant. Yeah I don't know where I'd be now without her."

R21: "I'd just go to the doctor like, he's fairly friendly, Mr N, he's great he is. I just go and see him like. And he's got time for everyone he has."

Interviewer: "Who would you contact if you were experiencing mental distress?" R20: "Err . . . my doctor, my family doctor, he knows I've been in prison and he knows I've been arrested, but he still treats me as a normal person, he doesn't try and talk down to you and he doesn't say, oh, you're all right, you go and do what you want to do. He tries to resolve the problem."

to a sense of hopelessness among interviewees. Others simply did not believe that the system had anything constructive to offer to solve their complex problems.

Fear of diagnosis of mental illness

Another impediment to help seeking for many participants was the fear of a diagnosis of mental illness. Many participants feared that being formally diagnosed as having a mental health problem would result in them being stigmatised by friends, family, or others. Others divulged that they were not personally ready to accept such a diagnosis because knowing would mean having to confront the problem (box 3).

Factors that promote help seeking

A few interviewees did report confidence in the ability of their general practitioner to help them with mental health problems. Some respondents trusted their general practitioners because they had established a previous positive relationship with them; others remarked that they had been treated with respect by a doctor or other healthcare professional in the past (box 4).

Participants spoke of the importance of characteristics that indicate respect, such as attentive listening or being dealt with in a compassionate manner. Several of the respondents who expressed a readiness to consult had been treated with respect by a healthcare professional at some point in their lives, and this had enabled them to establish a positive relationship with their general practitioner.

DISCUSSION

We used a qualitative approach to explain the dynamics that influenced help seeking behaviour among male offenders before entering and after leaving prison. All of the identified themes—a chaotic upbringing, a fear of diagnosis, and distrust of the system—seemed to influence the help seeking behaviour of this sample of incarcerated men. Difficult childhoods—characterised by violence, neglect, and abandonment—provide a fertile breeding ground for distrust of close relatives, "the system," and health professionals. For all but a few participants, the accompanying fear of stigma or of "self knowledge" resulted in a virtual absence of engagement with community based mental health services.

The 100% agreement to participate and the fact that a substantial number of participants were re-interviewed after release are strengths of the study. The generalisability of our findings is limited because the sample was drawn from a prison in southwest England that predominantly holds white British offenders with sentences of less than one year. The perspectives explored here, however, are illustrative of people commonly referred to as the "revolvers" or "churners," as they are frequently in and out of the prison system.

Emerging themes

Lack of trust emerged as the most prominent theme in prisoners' talk about their likelihood of seeking help from health professionals. Trust has traditionally been considered the "cornerstone" of the doctor-patient relationship.[13] Without it patients may be unlikely to disclose medically relevant information. Many of the respondents in this study did not feel that health professionals genuinely cared about them or had the ability to help with mental health problems. Other participants were hesitant to seek help because they feared a formal diagnosis of mental illness. Some of these men feared the stigma that such a diagnosis would bring, whereas others feared that a diagnosis would mean having to confront the problem.

Our findings suggest that offenders are sceptical about the ability of doctors to offer anything other than palliative approaches for mental distress. Absence of stable, supportive relationships and the consequent lack of potential for lay referral may further explain these offenders' disinclination to consult, but for these troubled and needy men, an enduring relationship with a sympathetic general practitioner may serve as a lifeline.[14] For the few respondents who reported that they would turn to a general practitioner or other healthcare professional for mental distress, trust seemed to have an important role, and this was based on previous positive experiences of health care.

WHAT IS ALREADY KNOWN ON THIS TOPIC

Men who are, or have been, incarcerated have higher rates of mental illness and suicide risk than the general population and lower rates of use of mental health services

Limited information is available on the perceptions and beliefs that influence help seeking among this group

WHAT THIS STUDY ADDS

Barriers to help seeking among prisoners include a chaotic family history, distrust of "the system," and a fear of the social and individual consequences of a diagnosis of mental illness

These factors can make people distrustful of doctors and deter them from seeking medical help

General practitioners and other healthcare professionals have a role in facilitating help seeking by treating people with a criminal record in an attentive and respectful manner

Recommendations for care

Information specifically designed for prisoners and distributed within the prison may help to de-stigmatise mental illness among this group. Pre-release preparation might include group discussions about recognition of mental health problems, responses to distress, and the potential value of accessing health services. For offenders with an identified history of mental illness, individualised crisis plans and links with community based services could be developed.

The participants in this study wanted to feel listened to, acknowledged, and treated as individuals by their general practitioners. Trust can be established by seemingly trivial gestures that indicate respect. By ensuring that a positive precedent is set, general practitioners may be able to encourage future help seeking.

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CORRECTIONS AND CLARIFICATIONS

Minerva

The picture item in Minerva by K M Khashia and H Greenland (*BMJ* 2006;333:1228, 9 Dec, doi: 10.1136/bmj.39051.730463.47) wrongly states that the swelling was diagnosed as a pyoderma granuloma. It had been diagnosed as a pyogenic granuloma, and we should have been careful in reporting this correctly.

Comparison of treatment effects between animal experiments and clinical trials: systematic review

The captions for figures 3 and 4 of this research article by Pablo Perel and colleagues (published as Online First 15 Dec 2006; doi: 10.1136/bmj.39048.407928.BE) should have described the 95% confidence limits of global estimates of efficacy as blue rather than grey.

Screening strategies for chronic kidney disease in the general population: follow-up of cross sectional health survey

Owing to an error in our processes, a previous (and uncorrected) proof of the abridged version of this paper by Hallan and colleagues was published in the printed journal and posted on bmj.com (*BMJ* 2006;333:1047-50, 18 Nov, doi: 10.1136/bmj.39001.657755.BE). The authors had told us of an error in their analysis that meant the figures given for the UK chronic kidney disease guidelines in the abstract, results, and table were incorrect. Restriction of screening according to the UK guidelines detected 60.9% (59.1% to 62.8%) of cases [not 51.6% (49.6% to 53.4%) as stated]. The corrections were done for the full length version of the paper, and a faulty link to that version on bmj.com has been fixed.

Obituary: Florence Cadogan

An editorial lapse led to some confusion near the start of this obituary of Florence Cadogan, which was supplied by Hastings Carson and Jack Cadogan (BMJ 2006;333:1126, 25 Nov, doi: 10.1136/bmj.39034.670394.FA). The second sentence should have read: "She [Florence Cadogan] played a key part in the health service reorganisation that separated health and social services and focused on maternal and child health."

Cover of BMJ

We slipped up on the cover of the printed BMJ (2 Dec 2006)—we alerted readers to an article on p 1153 about rheumatoid arthritis, but what they found there was an article about rheumatic fever.

GMC should not have thrown out case against neurologist

This news article by Clare Dyer contained some inaccuracies (BMJ 2006;333:1190, 9 Dec, doi: 10.1136/bmj.39056.403484.DB). The title should have ended with the phrase, "Singapore Medical Council says." Also, the article said that Professor Simon Shorvon had been found guilty of serious professional misconduct by the Singapore Medical Council (SMC); in fact, the charge was of professional misconduct.

We have already published these corrections on bmj.com.