Confronting the Disabling Effects of Imprisonment: Toward Prehabilitation

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> Your average offender, your stereotypical crim, is a person who is dysfunctional, who is disadvantaged… He's young, he lives in a certain postcode where if he were to return there would get into trouble invariably, regardless of how much they don't want to, they will. So for a person like that, you've got to habilitate them, you've got to create a pro-social community. (Sam)

> **disable**, *verb*: to deprive of legal right, qualification, or capacity; to make incapable or ineffective, especially to deprive of physical, moral, or intellectual strength. (www.merriam-webster.com)

In the opening quote, Sam (SW22),[1] a formerly imprisoned post-release support worker, is describing the typical prisoner: "disabled"[2] initially by life experiences of violence, marginalization, and exclusion in the community, and further by the experience of the violence, marginalization, and exclusion of incarceration.[3] Harm is embedded in every aspect of the prison: from its inception as an institution of punishment and correction, to the deprivations of prison and post-prison life (Clear 1994, Irwin & Owen 2005). On the inside, these include the suffering of "empty time" (Medlicott 1999, 220) and its links to self-harm and suicide; the fear and threat of physical violence and intimidation; the psychological violence of stigma and shame; and the emotional damage to individuals, families, and relationships. On the outside, the effects of institutionalization bring forth men[4] ill-equipped to deal with life in the community and facing homelessness, unemployment, and exclusion. On a broader scale, the racialized, gendered, epistemic, and structured harms of incarceration (Pollack 2012,

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Scott 2015) manifest in the overrepresentation of formerly enslaved and colonized peoples (Cunneen 2006; see Drake 2013), the "dispossessed and dishonored" (Wacquant 2001, 95), "the destitute, the disreputable and the dangerous, and all those who chafe in the lower regions of social space" (ibid., 382). How then can the prison—shaped and characterized by violence (Brown 2009)—possibly achieve the positive transformation[5] ("rehabilitation") of its inhabitants amid such conditions of abject negativity?

Recognizing that penal harms militate against prisons' rehabilitative aim and capacity, this article applies a therapeutic justice lens to argue for *pre*habilitation as a means of strengthening communities, protecting against criminogenic conditions and the disabling effects of imprisonment, and ultimately reducing the reliance on imprisonment as a supposed crime reduction strategy. From this perspective, stemming the tide of incarceration is a matter of not only addressing "criminogenic needs" or reducing individual reoffending risk, but also inoculating places and communities to withstand its undertow. This starts with examining the factors that make populations and places susceptible to poor health and, consequently, to penal harms (De Viggiani 2007). Penal harms may be characterized in different ways. This article explores two conceptualizations of the prison: in terms of *violence*—its physical, emotional, psychological, and relational forms, as well as the symbolic, institutional, structural, and epistemic violence it perpetrates and represents—and of *health*—prisons as sites of supposed rehabilitation or cure and as "sick places" (De Viggiani 2007, 115) of disadvantage, deprivation, disability, and despair, whose iatrogenic conditions bring forth populations further damaged and disabled by the experience of imprisonment. These different conceptualizations illustrate the various ways in which penal harms may be understood as disabling, but they also, importantly, locate the prison on a continuum of which violence and health are intertwined components.

From a therapeutic justice perspective, improving health and reducing violence are inextricably linked. Health is seen as the antidote to crime and violence as well as the violence of incarceration—a way to interrupt rather than entrench and exacerbate harms. Confronting the inherent harms of incarceration means focusing on the physical, emotional, mental, and social health needs and well-being of those imprisoned *and* their communities. This perspective decenters the prison as the point of intervention, locating it instead on a continuum of violence/health. Here, "violence" is shorthand for the range of harms and dysfunction produced, contained, and emanating in/from prison settings, whereas "health" describes social, emotional, and psychological well-being, capacity, and dignity.[6] To start to build a picture

of this continuum, I begin by canvassing the extent and nature of the disadvantage characterizing prisoner populations. After exploring the violence of the prison, I draw on data gathered through interviews with ex-prisoners and post-release support workers about men's experience of release from prison in Victoria, Australia, to illustrate the disabling effects of imprisonment and how they entrench and amplify damage and dysfunction, which then leaks out into the community. Finally, I show how a prehabilitation approach might inoculate against and thus mitigate the disabling effects of imprisonment. First, though, I briefly explain the therapeutic justice approach.

A Therapeutic Justice Lens

The principle of therapeutic justice draws on the field of therapeutic jurisprudence, which grew out of mental health law in the 1980s and has begun to inflect legal practices around the world (Wexler 2008, Wexler & Winick 1996). Therapeutic principles are discernible in localized penal practices (e.g., HMP Grendon in England; see Shuker & Sullivan 2010) and particular cultural carceral settings (e.g., Halden Prison in Norway; see Benko 2015), but overall, they have scarcely troubled the dominant penal paradigm and the violence it embodies. The related concept of justice reinvestment has had greater traction, particularly in the United States, perhaps because its fiscal rationale affords broad political appeal (Allen 2011). Therapeutic justice, "a philosophy of reorienting the jail experience from being mostly punitive to being mostly rehabilitative" (Clear et al. 2016, 185), similarly recognizes the harms and costs of incarceration but not solely in economic terms. Rather, a therapeutic justice lens highlights how and why prisons reconfigured as places that support growth and development—"anti-prisons" (Gilligan & Lee 2004)—have a greater capacity to reduce crime and violence than those emphasizing control through coercion. The key principle here is that prisons do cause harm (in fulfilling their punitive function of the deprivation of liberty), but they *can* operate in a way that is less harmful and more effective. That is, penal intervention can become therapeutic and abling, rather than destructive and disabling. The notion of prehabilitation, through this lens, takes in the wider social context of reoffending-reimprisonment cycles and highlights the need to work "upstream" of the prison to effect such changes.

What Does Prison Do?

As an arguably universal criminal justice goal, reducing reoffending offers a reasonable measure of whether prison "works" or not. Recidivism rates

across the United States and beyond, however, indicate that imprisonment does not reduce reoffending and can actually have the opposite effect (Chen & Shapiro 2007; Ritchie 2011, 2012). Return-to-prison rates attest to the limited rehabilitative capacity of the prison: In Australia, for example, 44 percent of prisoners return to custody within two years of their release (Productivity Commission 2016), and 56 percent of prisoners have been previously imprisoned under sentence (ABS 2016). In the United States, 55 percent of inmates return to prison within five years (Durose et al. 2014, 15). Bhati (2006, 40) found incarceration to have "merely incapacitative" effects for 56 percent and criminogenic effects for 4 percent of his US prisoner sample. Earlier research showed that, among 56 percent of prisoners who were first-timers, two-thirds were rearrested post-release, whereas a higher proportion—nearly three-quarters—were rearrested among the group who had been previously imprisoned (Langan & Levin 2002, 10). The effects of imprisonment are multiple, recursive, and cumulative, which explains in part why so many prisoners return and why an individual's likelihood of reincarceration increases each time they are released. The cycle of imprisonment adds to and exacerbates the cycle of disadvantage and dysfunction through the serial depletion of resources (Baldry et al. 2003, Grunseit et al. 2008), the whittling away of the personal, social, and economic capacity of individuals and of the families and communities to which they return, each time they return. For these reasons, as Sam hints, confronting the disabling effects of imprisonment requires looking beyond the prison to the communities and neighborhoods that feed into prison populations, the places where "trouble" is endemic and embedded. It means applying restorative and preventive strategies that build capacity rather than strip it away.

Amplifying Disadvantage and Ill-Health

A cursory scan of prisoner health and disadvantage suggests that "imprisonment is … less tethered to the crime rate than to other social processes" and inequalities (Wakefield & Uggen 2010, 392). Prisons' "permeable boundaries and transient populations" (De Viggiani 2007, 119) draw particularly on areas of concentrated disadvantage (Clear 2007, Sampson & Loeffler 2010). In Australia, for example, 50 percent of Victoria's prisoners come from 6 percent of the state's postcodes, where disadvantage prevails (Victorian Ombudsman 2015). Such communities are further weakened by the prison's drain on their human capital and sapping of their social capital (Clear 2007, Morenoff & Harding 2014, Wakefield & Uggen 2010).

The well-documented disadvantage characterizing prisoner populations reflects housing insecurity (Baldry et al. 2003), poverty, unemployment, and educational under-attainment (Pew 2010, Visher et al. 2008, Western 2002). Just a quarter of Australian prisoners hold a non-school qualification, most commonly a trade certificate (AIHW 2010), with significantly lower attainment among Indigenous prisoners, echoing racial disparities in the United States (Pew 2010, Western 2002). Imprisonment also affects families and children in material and emotional ways (Clear 1996, Tomkin 2009), with disproportionate impacts in African-American (King 1993, cited in Clear 1996) and Aboriginal communities (Quilty 2005). Incarceration disrupts household income, limits employability, reduces economic mobility, and reinforces social inequalities that—along with the increased risk of criminalization—become intergenerational (Western 2002, Western & Pettit 2010).

Legal problems—debts, unpaid fines, unresolved family law matters—frequently beleaguer prisoners and ex-prisoners, as do the rupturing effects of imprisonment on housing, parenting arrangements, employment, and business (Grunseit et al. 2008). Imprisonment hinders prisoners' access to justice and their ability to resolve these issues in both the short and longer term, as trust in the law and legal process diminishes and skills and confidence are eroded (Grunseit et al. 2008). Legal cynicism pervades communities affected by imprisonment (Kirk 2016). In addition, police behavior affects health via racial bias, over-policing, and the "stress of microaggressions" (see Williams & Mazzie 2017), which can affect entire neighborhoods and cultural groups.

Physical ill-health and disability mark imprisoned populations. One in four Australian prison entrants report chronic disease, with nearly half taking prescribed medication (AIHW 2010). An earlier study of prisoner health found that, compared to the general population, prisoners exhibited significantly higher levels of hepatitis A, B, and C, dental problems, gum disease, sexually transmitted diseases, mental distress, self-harm, and history of abuse (Deloitte 2003). Blood-borne virus transmission through the sharing of injecting equipment and tattooing means that hepatitis C affects less than one percent of the general Australian population yet nearly half of the prisoner population (AIHW 2010, Deloitte 2003, Hellard et al. 2004). Prisoners' hazardous/harmful use of alcohol and other drugs—far greater than among the general popoluation (Indig et al. 2010, Makkai & Payne 2003)—has implications for post-release mortality (Kariminia et al. 2007a). Given that racially and ethnically marginalized people experience higher rates of morbidity and mortality (Williams 2012), over-incarcerated

minority groups are doubly susceptible to illness, impairment, and death (Kariminia et al. 2007b).

Prisons multiply existing mental health problems. The prevalence of psychiatric disorders is reported to be three to five times higher among prisoners than in the wider community, with even higher rates among unsentenced detainees (Butler & Allnutt 2003, Deloitte 2003, Ogloff et al. 2007). Anxiety, including post-traumatic stress disorder, is the most commonly reported mental illness, and prisoners with psychiatric diagnoses manifest higher degrees of disability (Butler & Allnutt 2003), including traumatic brain injury (TBI). In prison, where violence and impulsive behavior are rife, the high number of disadvantaged young men with TBI and mental illness combines with the pressure of prison life to increase the likelihood of further injury and impairment (Belcher & Al Yaman 2007). Overcrowding intensifies these conditions.

In the United States, incarcerated people are three to four times more likely to have disabilities than non-incarcerated people (Bronson et al. 2015). In Australia, intellectual disability (ID) is highest among Indigenous prisoners and reflects lengthier histories of juvenile detention, previous adult incarceration, longer time on remand, higher rates of self-harm, literacy needs, and homelessness (Holland et al. 2007). People with mental health disorders and cognitive disabilities (CD) are commonly imprisoned for lower-level offenses such as theft, traffic/vehicle violations, breaching of orders, and minor assault; public order and alcohol-related offenses are common for people with CD (Dowse et al. 2009), meaning that the harms they suffer far outweigh the harms they cause. This snapshot shows how prison populations across the globe are afflicted by high levels of pre-prison ill-health and disadvantage, which are then reinforced and exacerbated by the violence of incarceration. This is not to pathologize prisoners, per se, or to essentialize every prisoner as dysfunctional. Rather, my aim here is to highlight the ways in which the penal system tends to punish poverty and deepen disadvantage.

The Violence of the Prison

Jack Henry Abbott (1982, 32), who spent most of his life behind bars, described prison as "a violent whirlwind of moral, mental and physical destruction." As Abbott implies, the violence of incarceration takes different forms: direct physical violence and the threat or fear of violence; the institutionally structured violence (Scott 2015) inherent in the pains of

imprisonment; and invisible but pervasive forms of cultural and epistemic violence. Let's explore each briefly.

Physical Violence

Overwhelming evidence points to the criminogenic nature of the prison, demonstrating that it provokes and produces violence, even in those imprisoned for nonviolent offenses (Gilligan & Lee 2004, Levan 2012, Morin 2016a, Scott 2015). Gilligan (2009, 244) links violence to "shame and humiliation, inferiority and impotence," which social deprivation and marginalization can foster and punitive prison settings certainly magnify. Rising prison violence is largely attributed to overcrowding, endemic due to the increase in prison populations in recent decades: In the UK, prisoner-on-prisoner attacks have increased by 30 percent in the last year alone (Ministry of Justice 2017), reflecting similar increases in violence and overcrowding in Australian prisons (Productivity Commission 2016). Assaults on staff rose by 40 percent, and serious assaults have trebled since 2012 (Ministry of Justice 2017). State-raised youth, "the prison's bastard children," fare particularly poorly, in that "easily provoked to violence … they provoke prison staff to use violence" (Johnson 1987, cited in Wright 1991, 6).

UK deaths-in-custody figures suggest suicide is ten times more likely in prison than in the general population (Ministry of Justice 2017). Self-harm in prisons is increasing in the United Kingdom too: The year 2016 saw a record high of 37,784 incidents reported (Ministry of Justice 2017). In the United States, Toch and Kupers (2007, 9) describe "an epidemic of self-mutilation in prison" linked directly to segregation. These figures reflect the prevalence of mental health disorders among prison entrants, compounded by the everyday pains of imprisonment (see below). Schappell, Docherty, and Boxer (2016) link preexisting mental health problems and the experience of prison victimization to post-traumatic stress symptoms. In addition, the negative attitudes and emotions of prison staff—from indifference to hostility—and their lack of skills and training are found to exacerbate the likelihood of self-harm and emotional distress among prisoners (Bennett & Dyson 2014).

Morin (2016a, 45) reflects on different forms of violence—"from mental abuse to racial slurs to sexual predation and rape, … systems of coercion, constant surveillance, … lack of privacy, crowding, excessive noise, the 'violence' of resignation and despair," as well as perceived and actual physical threats—and highlights how under-reporting and normalization make

these harms difficult to quantify. Nevertheless, day-to-day reality reflects the extent to which prisons are infused with pain, frustration, anger, and distress: "During an average week prison staff across the [United Kingdom] will have dealt with: almost 600 incidents of self-harm; at least one self-inflicted death, probably more; approximately 350 assaults—including 90 on staff" (Gleeds 2016, 10).

Institutionally Structured Violence

Institutionally structured violence (Scott 2015) manifests in different ways, with more or less disabling effects: from the economic and moral implications of exploitative prison labor—demoralizing at best, slavery at worst (De Viggiani 2007, Morin 2016b)—to pharmacotherapeutic management that leaves released prisoners adrift and unwell (Bowen et al. 2009), to the deresponsibilization that prison time-space management engenders (Pryor 2001). Prison life's "worst aspects" are the "dehumanization, deprivation, and danger" (Haney 2012, 58), which produce extreme psychological distress and lasting post-release effects. These are most pronounced in prisons whose "moral performance" is low (Liebling 2011), where cultures of cruelty and harm prevail (Haney 2008), and where violence is enacted—by prisoners and officers alike—through "mechanisms of fear" (Poulantzas 1980, cited in Sim 1991, 114). From the "electronic coffins" (King & Elliott 1977, 3; cited in Sim 1991, 111) of the super-max and the segregation cell to the deadening distortion of time (Medlicott 1999, Scott 2015), the pains of imprisonment constitute the everyday institutional violence of incarceration.

Morin (2016b, 2, 17) compares the "disciplinary regimes and structures of violence" of human carceral settings with animal captivity, illustrating parallel "oppressions." This author highlights the harms of animalizing humans, whereby imprisoned bodies are reduced to the disposability of bare life (after Agamben). The use of solitary confinement as a punishment or behavior management strategy exemplifies such dehumanizing practice, as Abbott (1982, 52–53) describes: "You sit in solitary confinement stewing in nothingness, not merely your own nothingness but the nothingness of society, others, the world.… Solitary confinement in prison can alter the ontological makeup of a stone."

In a recent American Civil Liberties Union report (ACLU 2017) on the harms of isolation for people with disabilities, a prisoner describes 23-hours-a-day solitary confinement as "inhumane" and conducive to the creation of further physical and mental disability:

> [T]hey are creating animals.… The lack of mobility and human contact over a long period of time has destroy[ed] my mind and health … I have develop[ed] extreme paranoia … and violent thoughts.… I've lost the ability to interact with others. (D.R., quoted in ACLU 2017, 24)

Toch and Kupers (2007, 9) relate prisoners' practice of cutting to such torment, "driven by uncontrollable anxiety or a need to see blood to know that he or she is human." For prisoners already vulnerable or unwell, especially, such conditions are indeed cruel and disabling. Given prisons' inability to deal with mental or physical illness (Caraher et al. 2002, Irwin & Owen 2005), and the conditions that aggravate ill-health, "penal institutions are generally sick places" (De Viggiani 2007, 115), neither equipped nor oriented to meet prisoners' rehabilitative or health needs.

Cultural Violence

Cultural violence operates within and through the prison form. Within penal settings, cultural consent for domination and intimidation is conferred by constructing prisoners as pathologically violent and desperate, which allows prison staff to justify violence—either using it or turning a blind eye to its use—as a legitimate way to maintain the good order and discipline of the prison (Edney 1997, Sim 1991). The objectification of the prisoner "breeds a climate of rampant fear and violence within the prison walls … directed as much against the minds and souls of the inmates as against their bodies" (Sowle 1995, 501). From the outside, the image of the prison as a place of danger and brutality underscores the closed nature of the penal institution as a place of exile and otherness, "impervious to [and ignored by] the society outside" (Sowle 1995, 503).

The othering of prisoners allows the prison form to persist as a legitimate means of containing, managing, and protecting society from this inherently risky population, despite the harms it engenders. Cultural violence thus legitimizes the violence of the prison and enables a degree of indifference to the suffering contained within (Edney 1997, Sowle 1995). As Brown (2009, 21) contends, most of us are "penal spectators," gazing upon the pain of others as "bystander[s] and outsider[s]" rather than "engaged participant[s] or witness[es].". Confronting the violence of incarceration and its disabling effects means first acknowledging that "we are *all* complicit in the … death and injuries suffered by prisoners everywhere" (Pollack 2012, 109). This includes the social and civil deaths of men and women excluded long after serving their time.

Cultural violence operates through the prison in the form of the state's power to use legitimate violence to punish its citizens, but also as a manifestation of a different kind of violence: the domination of particular ways of knowing. This epistemic violence occurs through the privileging of hegemonic perspectives and knowledge (Spivak 1988, Teo 2014). The voices and experiences of marginalized groups—the subaltern—are silenced and subordinated (Spivak 1988), their testimony "quieted" and "smothered" (Dotson 2011, 237); the voices of the imprisoned are frequently sidelined by mainstream criminology (Edney 1997, Sim 1991). Scholars have linked the cultural violence of incarceration to historical processes of colonization (e.g., Cunneen 2009, 2011), and the experience of Indigenous women, in particular, to the cultural violence of colonial patriarchy (Baldry & Cunneen 2012, 2014). The failure to recognize the historical context of the over-imprisonment of Indigenous and formerly enslaved peoples can also amount to the "violence of neglect" (Cunneen 2009, 209), in terms of both institutional negligence and societal indifference.

Penal Harms: Post-Prison

So, if penal harms range from physical/psychological violence and destruction to deresponsibilization, demoralization, and despair, what happens when prisoners get out? I turn now to interviews with formerly imprisoned men to illustrate how the violence of prison has post-prison effects that can become disabling. These data, along with interviews with post-release support workers, were gathered for a research on men's experience of release from prison in Victoria, Australia (Johns 2017), which was part of the Australian Prisons Project (Cunneen et al. 2013). This qualitative study included interviews with 12 ex-prisoners (given aliases, to protect and privilege their subaltern voices) and 14 post-release support workers (coded as SW##) across four transitional support programs in Melbourne, two of whom were formerly imprisoned (including Sam). Interviews (average length 90 minutes) were transcribed verbatim to capture the voices of the formerly imprisoned and those supporting post-prison transitions. First, I consider the "positive" health effects of imprisonment and how even these can be disabling in a post-release sense, in that pre-prison disadvantage is reinforced and individual capacity diminished, as the data reveal. Examples of the physical/psychological effects of imprisonment then further illustrate how prisoners' capacity is curtailed and their circuits of exclusion maintained (Rose 2000), which thus perpetuates the violence of the prison.

Prison as Cocoon

Prisons are different and have different effects (Haney 2012, Liebling 2011). Prisons are violent and destructive places, but they can also serve rehabilitative ends; imprisonment "is not a wretched experience for everyone" (De Viggiani 2007, 119). In removing violent men from families, interrupting addiction, and providing health care, for example, prison *can* be "stabilizing and restorative" (Wacquant 2002, 388). There are some people that others are "kind of glad to get rid of for a while" (Clear 2007, 124). For many, "being 'inside' offers an ideal opportunity to address … health needs and break the cycle of offending so often connected with mental illness and substance misuse" (Spencer 2001, 18; cited in Sheen 2002, 9). For men, in particular, the routine, regular diet, exercise, and restricted access to substances often mean that "the modern prison is a good place to maintain general health" (Irwin & Owen 2005, 95). As Ben admits:

> [J]ail has been good for me in a way.… It's kept me healthy I suppose. It's been years there where I've been off drugs and living a healthy life. Every time I go in I get right into weights and eating good, and so yeah it's kept me healthy I suppose…

For many, "the community is a very difficult place to live. It's very demanding, and you have to be very highly functioning to be able to work in it" (SW12). Prison can thus become a haven, a place of safety, stability, and familiarity in contrast to the pressures of life in the community. Reentry can mean a rapid transition from a place of belonging to a place of isolation, as post-release support worker SW12 describes:

> Prisons are comfortable and modern and there's things going on and you're a prisoner and you're one of the boys, and the next minute you're nothing in a world of nothing and miles from anywhere with no money in your pocket because you're paying $10 a pack of cigarettes.

The identity that many imprisoned men take on as an adaptation to the carceral environment is magnified by the alienation they experience in the outside world. As Nick reflects: "In jail … I feel better … when you're in there you hate being in there, [but]… sometimes I feel safer in there … it's hard to relate to people out here."

Although prisons can be harmful and brutalizing, they can also provide respite from chaotic lives. Spaces are contained, routines enforced, and necessities provided. Prisoners "know how prison works" (SW09); it is

predictable and familiar. SW13 evokes in domestic terms the security that prison's "rules and instructions" prescribe: "'All right, time to get up. Time to have breakfast. Time to go to exercise. Time to do this'… So the prison is almost like a parent, a parent they never had."

Psychologically Disabling

Despite "living a healthy life" in prison, Ben emphasizes that "in another way it's devastated me and it's sort of set me back." Even when prison conditions are relatively humane, with clean, modern facilities, the psychological effects persist in that "prisons can gradually but profoundly and problematically shape the way that prisoners think, feel, and act" (Haney 2012, 2). Haney (2003, 38) identifies the "normal adaptations" prisoners make, to varying degrees, in response to the "abnormal conditions of prison life": dependence on institutional structures; hypervigilance, distrust, and suspicion; emotional over-control and psychological distancing; social withdrawal and isolation; exploitative cultural norms; diminished sense of self-worth and personal value; and post-traumatic stress reactions to the pains of imprisonment (ibid., 40–46). Living in an institutional environment marked by control, security, routine, and familiarity means that "invariably you become dependent" (SW22); "decision-making has been taken away from you for so long [that] it affects your psyche profoundly" (SW23). Prisoners "learn not to be able to do anything for themselves" (SW01). This means, particularly for "long-termers," that "everything they know … just comes unstuck when they get out" (SW09). As SW01 observes, "It's really hard for them to have to direct themselves … to just function in everyday life."

Cocooned within the confines of the controlled and (more or less easily) navigable prison environment, where possibilities are imagined and resolve is honed, men are buoyed by the thought of freedom. Yet their imagined horizons are uninterrupted by financial pressures, familial tensions, and the day-to-day difficulties of navigating public transport, attending appointments, finding work, or finding drugs. Their aspirations soon collapse as these elements converge post-release. Their determination fades, and they "go downhill, and … into depression" (SW14), which provides a footing for old habits, associations, and addictions to resurface. Ex-prisoner Scott describes these challenges:

> When you get out you think the sun's gonna shine every day, and you're gonna have a thousand dollars in your pocket every day, and everything's gonna be good and, you know, you're gonna be able to buy whatever

> you want. But you gotta pay bills and methadone, medication, and you find out you've got no money to live and … you're doing things like this [interview] to get a $20 food voucher, just so I'm not going out committing violence.

For Scott, the disabling effects of his years in prison relate to his criminal identity as a "druggie" and a "thief," cemented by an identity forged in the crucible of prison culture.

Violence Ingrained

Many people imprisoned repeatedly or for long periods adopt norms of violence and intimidation to survive the prison environment. I use Scott's story here to illustrate how normalized preemptive and retributive violence within prison settings becomes ingrained. At 35, Scott had spent most of his adult life behind bars. Here, he describes how he crafted some makeshift weapons in prison:

> I prefer … [to] snap open a razor blade and melt the blades into a toothbrush, shave the toothbrush bit off and melt the blades into it, melt about three or four blades in, all different ways, so no matter which way you get them … it will open up in two spots so it's harder for 'em to sew back together, and leaves a bigger scar, and you get 'em straight down the face and that way everyday they look in the mirror they know that it was you who done it.

Scott recognizes that, although functional in prison, such behavior is dysfunctional in the community: "That's the type of thing that I bring outside with me, and then I've gotta try and not be like that out here, you know?" He describes how being "like that" is "just ingrained in me," saying, "I've usually got an ice-pick and a box-cutter on me, just in case."

Violence, for Scott, is an automatic response: "It's like … over 20 bucks the other day I was gonna go to my mate's place and kick his front door in, with three other people, and … just wreck him over 20 bucks, man, you know?" His prison identity, donned as protective armor and then reinforced through repeated performance, has congealed around him like a carapace. Despite his regret at being "like that," Scott implies that his prison identity inhabits his whole being; he cannot imagine being any other way. Such "prison acculturation" (SW12) has the dual effect of weakening prisoners' connections to outside resources—housing, relationships, employment, and community ties—and diminishing their inner personal resources—confi-

dence, decision-making capacity, and social skills, for instance. As SW09 describes: "They're paranoid, they've got no confidence; they've got no control." Through the institutionalizing process, feelings of shame, humiliation, inferiority, and impotence (Gilligan 2009)—the roots of violence—can thus become embedded.

Circuits of Exclusion

The psychological and cultural imprints of imprisonment also manifest physically. Just as prison tattoos inscribe the skin, ways of being in prison permeate thinking and inhabit prisoners' bodies. As SW08 describes:

> When the guys come out of prison and they meet up here … they will often pace up and down … They will go this way, and then they turn right, and then go back and then turn left and go that way … and they won't even know they're doing it. They are conditioned to that sort of way of communicating with one another. They'll pace up and down; they'll dress like they are still in prison. They'll carry themselves like they're still in prison.

Evoked here is a robotic return to the way physical space is navigated and traversed in prison, as though its spatial patterns were ingrained through repetition. These, like habits of violence, are difficult to dislodge, particularly given the prevalence of trauma and substance-related cognitive impairment among prisoners. Prison institutionalization thus has multiple dimensions—temporal, spatial, cultural, cognitive—that combine with social stigma to reinforce the lines of social and economic exclusion.

Psychosocial disability—the experience of impairments and participation restrictions related to mental health conditions (NMHCCF 2014, 12)—describes the experience of many ex-prisoners for whom educational disadvantage, criminal records, and physical health problems also limit employment options. They are socially, psychologically, *and* economically disabled. The three ex-prisoners on whose experience I have drawn here—Nick, Ben, and Scott—are typical of prisoner populations in that they suffered preexisting mental health conditions that were exacerbated by their imprisonment. They also typify the social isolation of men without any "straight friends" (i.e., not criminally involved). These impacts are transmitted through generations, reproducing conditions of marginalization and magnifying the risk for the prisoners' children to become involved in the justice system. The high proportion of prisoners with juvenile justice history confirms this cycle, as Nick's story illustrates.

Imprisoning the Wounded Child

Nick, who had spent years in and out of youth and adult custody, was first locked up as an eight-year-old in "secure welfare": "I met people in there and that's where it started.… I started using heroin when I was about twelve, after me [*sic*] dad died [of a heroin overdose], and it just spiraled from there." He explains his cycle of reoffending and reimprisonment:

> I got sexually assaulted when I was really young … and as soon as that sort of stuff comes up, the way I deal with stuff is I go out and steal something and that makes me feel better about myself 'cos I know that I got away with it, and then the remorse and guilt kicks in and then I get worser [*sic*] and then I go and do it again to make myself feel better and it just goes and goes, and then I put myself in jail 'cos I feel better.

Nick's traumatic history of parental neglect, drug abuse, victimization, institutionalization, and few psychosocial resources typifies the experience of men for whom the criminal justice system is a constant presence, and sometimes the only source of health and stability in their lives. Yet correctional settings are also the most likely to impose "restrictive and coercive interventions" (Spivakovsky 2016, 4), such as behavior management through solitary confinement, which exacerbate these harms.

These stories illustrate the dysfunction and ill-health characterizing prisoner populations, and how these are deepened and exaggerated by the violence of the prison in its physical, psychological, and symbolic forms. These examples highlight the need to connect the prison and the community more visibly, to challenge our complacency about the harms that the prison generates and what this means for the most vulnerable in our communities, and to conceive restorative and preventive solutions as genuine alternatives to incarceration. We must confront the effects of imprisonment and rethink its function to avoid disabling future generations and to protect communities from penal harms.

A Rehabilitative Prison?

The discussion above has outlined the extent of prisoner marginality and ill-health and the inherent violence of the prison in its physical, psychological, and symbolic forms. Exploring these dimensions locates the prison on a violence/health continuum and draws attention to the intended and actual functions of imprisonment. Leaving aside the prison's supposed aim of deterrence, and its role in denouncing offending and incapacitating the

offender, what of the inherent conflict between punishment and rehabilitative aims? Prison environments convey a "symbolic message as to how we feel about [prisoners] … and what we expect from them" (Gilligan & Lee 2004, 312). Yet the harsher, more coercive, and more punitive a prison and its regime, the more hardened and violent we might expect prisoners to emerge. And given that the vast majority of prisoners will be released, this is surely the most pressing concern for communities aiming to reduce the risk of crime and violence. So, is a rehabilitative prison possible? And how might we conceptualize it in therapeutic justice terms?

Can we imagine a place where the punitive imperative is met solely via the deprivation of liberty, and where every other aspect hinges on promoting health and pro-social ability? Gilligan and Lee (2004) argue for "anti-prisons," that is, residential colleges and therapeutic communities that aim to meet prisoners' learning and health needs, so they may return to communities in better social, emotional, and physical health than before they went in. In this schema, "traditional prisons" would be "reserved exclusively" for those who threaten or enact serious violence (ibid., 313). From a therapeutic justice perspective, promoting anti-prisons and reducing reliance on traditional prisons encapsulates the harm minimization principle at its heart. This represents an important move toward tempering the institutionally structured violence of the prison and disrupting the conditions within which physical and psychological harms proliferate. But is this enough?

The preceding section illustrates the disabling effects of institutionalization, which can arise in the most humane of prisons (as Ben suggests) and which hamper rehabilitative efforts. If the most humane penal setting cannot bring about rehabilitation, what then? If we accept that rehabilitation, by definition, requires a preexisting level of health to be restored and that prison populations are marked by the opposite—by preexisting disadvantage and dysfunction—then we are obliged to reconsider our rehabilitative expectations. Given that "the seeds of poor health are sown for the majority long before they entered an institution" (Spencer 2001, cited in De Viggiani 2007, 119), this means working upstream of the prison, to *habilitate* its inhabitants and create pro-social communities, as Sam urged in the opening quote. This implies a broader emphasis on "health and well-being" as the "key[s] to successful rehabilitation and resettlement" (Hayton 2007, 15). Resettlement is a critical element of this broader perspective, since it is in the return-to-community stage that cycles of reimprisonment are either disrupted or reinscribed.

Rehabilitation and Prehabilitation

In 2010 the UK House of Commons Justice Committee (HCJC 2010, 8) pronounced:

> [T]he Government faces a choice of risks: either to muddle through with the current plans hoping that commitments made under the "predict and provide" model of penal policy will prove affordable (and not merely a self-fulfilling prophecy); or to make more radical decisions, and investments, putting the system on a sustainable footing over the longer term by shifting resources away from incarceration towards rehabilitation and "prehabilitation."

They conclude that rehabilitative efforts are important "while offenders are inside and in sight," and they also argue: "[A] more effective investment would be in a substantial programme of 'prehabilitation,' aimed at potential offenders and targeted on problem communities, with the objective of heading off the drift into crime and custody before it happens" (HCJC 2010, 67).

The term "prehabilitation" promises a truly radical health-based framing of penal policy. Targeting "potential offenders" and "problem communities," however, sounds more like justice reinvestment relabeled, which would be fine if that were enough. As we have seen, however, the violence of incarceration and its disabling effects do not simply arise out of the debris of marginalized communities, which nevertheless provide fertile criminogenic ground. Rather, they emanate from and are sustained by social and historical processes and inequalities that pervade wider society yet manifest symptomatically in "problem communities." Simply identifying "potential offenders" in such places tends to pathologize individuals and communities and renders invisible two critical factors in the imprisonment-reimprisonment cycle: the disabling function of the prison itself and the feedlines that radiate (directly or indirectly) from a range of settings—child health/welfare, out-of-home care, school, juvenile court, and custodial settings—into adult prisons. Seeing the prison on this continuum and considering how violence and health (and education) are inextricably linked, we can recognize several different points of potentially negative intervention in the lives of individuals, families, and communities (of which the prison is but one). At each of these sites, the "failure to exercise a required duty of care" amounts to the "violence of neglect" (Cunneen 2009, 209). From a therapeutic justice perspective, so-called justice or welfare interventions that corrode the well-being, strength,

and capacity of a community and its children amount to social harm that can become disabling. Thinking about the prison as an intervention on a violence/health continuum, let's pursue the prehabilitation concept to see where it might lead.

Prehabilitation

In medical terms, prehabilitation describes the process of improving an individual's functional capacity prior to stressful events, such as surgery, to increase their tolerance to stress and to enhance their ability to quickly return to independent functioning (Ditmyer et al. 2002, Gillis et al. 2014). Substituting "imprisonment" for "surgery" (assuming just and legitimate grounds for imprisonment) brings forth a compelling logic for rendering prisons entirely therapeutic and rehabilitative: Prison can only work (in a rehabilitative sense) to reduce crime and violence if the imprisoned are able and well enough to withstand its inherent harms, and imprisoning the already unwell and marginalized can only add to their dysfunction and marginality. It is important here to differentiate the small proportion of people sentenced for predatory violent offenses, for instance, for whom the "traditional" prison may be reserved (Gilligan & Lee 2004), from the majority of people charged with nonviolent offenses of whom rehabilitative outcomes might be reasonably expected.

In terms of the significant overrepresentation of people whose lives are marked by ill-health and dysfunction, the logic of prehabilitation assumes that: 1) the aim of penal intervention (notwithstanding the punitive function of the deprivation of liberty) is to improve an individual's health and functioning; 2) the desired outcome is rehabilitation, that is, to reduce the risk of reoffending by increasing individuals' skills, confidence, and ability to function well in the community; and 3) maximizing the rehabilitative capacity of the prison, and individuals' capacity to tolerate penal intervention and to recover in the shortest possible time, requires prehabilitative intervention.

In theory (see Figure 1 next page), prehabilitation increases individuals' functional capacity and fitness, at once preventing the need for imprisonment *and* affording prisons genuine rehabilitative potential. Key to maximizing the prison's rehabilitative capacity is its reconfiguration as a humane and respectful environment, one that models the desired outcome of positive social interactions through promoting health and dignity (Jacobson 2007).

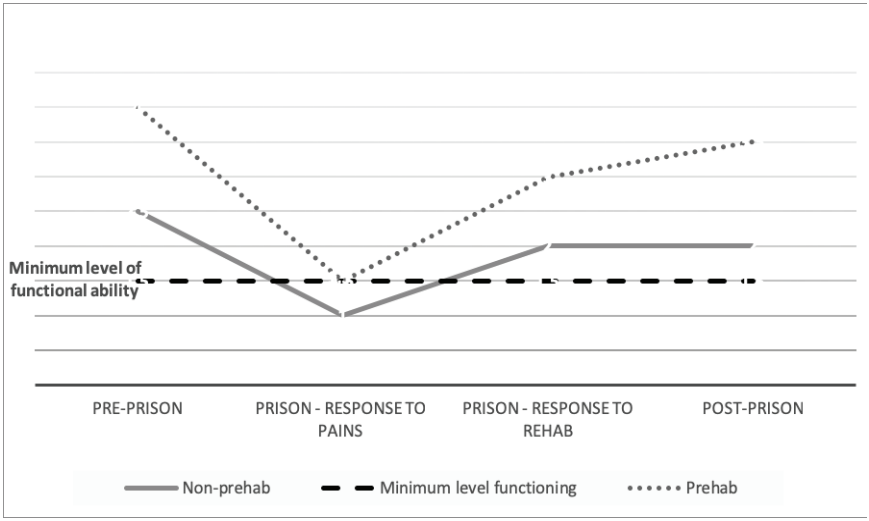

Figure 1. Theoretical effects of prehabilitation (adapted from Ditmyer et al. 2002, 46)

Restorative, Preventive Intervention: Toward Prehabilitation

Whereas in medical terms prehabilitation involves physical and cognitive activity (Cullley & Crosby 2015, Ditmyer et al. 2002), in a penal context this conceptualization works to shift our emphasis and expectations about the role and function of the prison in reducing crime and violence. A prehabilitative focus is not just a matter of risk factor identification, management, and reduction. It also necessitates strengthening and inoculating—building resistance, capacity, and resources within groups and individuals that will enable them to avoid those risks when they arise. It is "future proofing." This means intervening at every point along the violence/health spectrum—from infant welfare to schools and juvenile courts, for example—in ways that are positive and therapeutic. This involves non-justice actors as much as or even more so than officials invested with judicial or law enforcement power. It also starts with recognition of the potential for harm in every interaction. Children, adults, and families must be strengthened and supported through their systemic interactions, and not harmed in any way—outcomes for which officials and the state must be held accountable.

Confronting and subverting the violence of imprisonment requires prehabilitative work within communities. In this way, prehabilitation encompasses justice reinvestment aims and activities, redirecting funds into the disadvan-

taged communities from which prisons disproportionately draw. Decades of crime prevention research suggest that funding family support services, parenting programs, primary health care, drug and alcohol counseling, and youth development programs, for instance, can interrupt prison's feedlines. That such initiatives are led by "neighbourhood-based organizations with a vested interest in solving the problems in their high-stakes communities" (Allen 2011, 618) highlights the necessity of capacity building in ensuring sustainability. Such strategies can and do reduce violence within communities, as the example of New York's largest housing project attests: once a hotbed of violence and criminality, Queensbridge recently celebrated 365 days without a shooting (Dwyer 2017). Such intracommunity public health approaches disrupt imprisonment cycles and thus reduce the rate and reach of interpersonal and institutional violence. However, to confront the cultural violence that the prison represents demands wider intercommunity prehabilitative work. In this way, a prehabilitative agenda extends beyond justice reinvestment.

Notwithstanding the ascendant punitive doxa, faith in prisons' rehabilitative capacity persists (Listwan et al. 2008). However, as Cunneen and colleagues (2013, 195) note:

> [U]nless reform movements confront the highly selective nature of penality and the way it bears so disproportionately on marginalised groups, then any gains to be made through political and popular attitudinal shifts through widespread adoption of policies such as justice reinvestment … are likely to be limited in practice.

A prehabilitative agenda locates the prison on a violence/health continuum and demands a shift away from violence and dysfunction towards health and well-being. This means confronting the prison's dysfunction, which arises at the clash between its punitive and rehabilitative aims, as well as acknowledging—witnessing (Brown 2009)—the disabling realities and violence-producing implications of prisons as places of selective punishment and control. Targeting "problem communities" is a starting point, an acute intervention. Longer-term care, though, relies on identifying ways to "create a pro-social community" (Sam) through common goals of safety, respect, and well-being.

Conclusion

The multiple violence contained by, embedded in, and emanating from the prison causes harm to already disadvantaged, dysfunctional populations.

These harms are (overwhelmingly) released back into communities. Examples from interviews with ex-prisoners and post-release support workers reveal how prisoners' capacity to live well in the community is diminished by their experience of institutionalization and the dependence on the deresponsibilizing structures and rhythms of prison life. The sense of feeling safer inside than outside, for instance, is one of the disabling effects of imprisonment that speaks to this diminished capacity, and it also highlights the level of structural disadvantage on which prison populations disproportionately draw. The examples in this article illuminate the dysfunction of not only the imprisoned but also the penal institution itself. A prehabilitation approach involves thinking about the function of imprisonment differently. The prison can only function effectively as a site of penal/rehabilitative intervention if its subjects are in a reasonable state of preexisting health and strength. Prehabilitative logic demands that the "patient" (penal subject) is able (in the most literal sense) to endure penal intervention and recover.

Because the violence of the prison manifests at the interpersonal, institutional, and structural/symbolic level, it is along these different points of the violence/health continuum that prehabilitative work must be undertaken. This continuum places the prison in its sociocultural-political context, highlighting that its antecedents—violence, disadvantage, and ill-health—are mirrored in its consequences. Seeing this broader picture behooves us to confront the disabling effects of imprisonment and to move toward policies, practices, and settings that aim to reduce violence by promoting health and positive behavior in settings marked by dignity, respect, and an ethic of care. Dignity and respect become the tools with which to model and foster pro-social interactions, to reduce violence and disrupt its causes. Through a therapeutic justice lens, penal intervention becomes constructive and abling instead of destructive and disabling.

NOTES

1. A formerly imprisoned post-releasee support worker (SW22) interviewed by the author. All names used in the article are pseudonyms.

2. The term "disabled," describing many prisoners, was used by another post-release support worker (SW12) interviewed as part of the study on which I draw in this article.

3. In this article the terms "incarceration" and "imprisonment" are used interchangeably to refer to penal confinement or custody, whether under sentence or awaiting conviction. In Australia, unlike in the United States where they refer to different places, "jail" and "prison" are also used interchangeably.

4. I refer to men because the research on which this article draws focuses on the experience of men released from prison. There were two rationales for this: Prison populations are globally dominated by men, and prison masculinities have a particular impact in shaping the thinking and behavior of men imprisoned and released. This is not to say women are not equally "disabled" prior to and by the experience of imprisonment but, rather, that a specific focus on women is beyond the scope of this article.

5. This assumes the persistence of rehabilitative expectations as a "crack" in the supposed hegemony of the "get tough" penal harm movement (Listwan et al. 2008).

6. Jacobson (2007) differentiates between human dignity and social dignity to resolve the conceptual fuzziness of the term "dignity"; she shows how social dignity, in particular, underpins the promotion of health, justice, and positive social interaction, which also (implicitly) takes violence into account.

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