WORKING IN UK PRISONS AND SECURE HOSPITALS DURING THE COVID-19 PANDEMIC.

Amina Memon and Nicholas Hardwick

Centre for the Study of Emotion and Law

Royal Holloway University of London

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INTRODUCTION

The closed nature of prisons means that the impact of the COVID-19 in prisons is less well understood than in other settings and has been subject to less independent academic study. At the start of the pandemic Public Health England predicted 2,700 prisoners might die in England and Wales if no action was taken.[1] In the event, by March 2021 the deaths of 116 prisoners in England and Wales were suspected or confirmed to be caused by COVID-19;[2] 11 prison and youth custody staff had died by 31 January 2021 where COVID-19 was suspected or confirmed to be the cause.[3] Deaths in prisons in Scotland[4] and Northern Ireland[5] have also been reported as less than feared. Distressing though these figures are, and despite concerns about the prisoners spending very long periods confined to their cells, the prison service and its staff have been praised for its response (see for example the House of Commons Justice Committee 2020 report on the prison service response to the pandemic)[6] but the toll this period has taken on prison staff has not yet been adequately assessed.

This paper presents a preliminary analysis of a confidential survey conducted in the early part of 2021 by the Centre for the Study of Emotion and Law at Royal Holloway University of POA members to attempt address that gap. The survey found high levels of anxiety and burn out. These feelings were exacerbated amongst respondents with caring responsibilities and those who had concerns about COVID-19 safety measure in their workplace. Respondents as a whole reported very low levels of emotional support in their workplace. 81% reported that their mental and physical health has deteriorated since the pandemic.

This was a cross-sectional survey and given the pressure on the work force at the time it was administered, the decision was made not to include any additional measures of physical or mental health. Survey documentation signposted mental health support services. To ensure anonymity respondents were not asked for any personal information that could identify

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[1] Ministry of Justice, Public Health England and Her Majesty's Prison and Probation Service. (2020). *Briefing paper - interim assessment of impact of various population management strategies in prisons in response to COVID-19 pandemic in England. Prepared by: Dr. Éamonn O'Moore, National Lead for Health & Justice, PHE and Director UK Collaborating Centre, WHO Health in Prisons Programme (European Region). Date: April 24, 2020.Commissioned by: Jo Farrar, CEO, HM Prisons & Probation Service on April 17, 2020.* GOV.UK https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/882622/covid-19-population-management-strategy-prisons.pdf

[2] Ministry of Justice and Her Majesty's Prison and Probation Service. (2021a). *HMPPS COVID-19 statistics : HM Prison and Probation Service COVID-19 Summary tables, March 2021 March 2021.* GOV.UK. https://www.gov.uk/government/statistics/hmpps-covid-19-statistics-march-2021. Table 1

[3] Ministry of Justice and Her Majesty's Prison and Probation Service. (2021b). *Her Majesty's Prison and Probation Service workforce quarterly: December 2020. HMPPS COVID-19 experimental statistics annex: 31 January 2021 tables.* GOV.UK. https://www.gov.uk/government/statistics/her-majestys-prison-and-probation-service-workforce-quarterly-december-2020. Table 1a

[4] Macnab, S. (2021, January 18). *Human rights watchdog raises COVID concerns over Scottish prisons*. The Scotsman. https://www.scotsman.com/news/politics/human-rights-watchdog-raises-covid-concerns-over-scottish-prisons-3104669

[5] Morris, A. (2021, April 27). *How Northern Ireland's prison service set the benchmark on handling COVID-19.* Belfast Telegraph. https://www.belfasttelegraph.co.uk/news/health/coronavirus/how-northern-irelands-prison-service-set-the-benchmark-on-handling-covid-19-40359346.html

[6] House of Commons Justice Committee. (2020) *Coronavirus (COVID-19): The impact on prisons*, 15 July 2020, HC 299

them or allow the collection of follow-up data. The research focus was restricted to working during the COVID-19 pandemic as the most urgent issue potentially impacting mental health and well-being.

This report begins with a brief review of the literature to put the findings in context followed by a summary of the sample characteristics and main findings. A peer reviewed full report of the findings will be available at a later date.

COVID-19, PRISON OFFICERS, AND STRESS AND ANXIETY

The COVID-19 pandemic has led to heightened concerns about the mental as well as the physical health of the UK population and of those groups that due to the nature of their work, cannot avoid social contact or work from home. Several surveys and reviews of the literature have attempted to document or scope the problem with a view to ensuring support is in place for those most vulnerable. Among first responders for example, social distancing policies have resulted in numerous changes and alterations in protocols including requirements to wear personal protection equipment (PPE), changes to shift schedules and work hours. First responders may react more strongly to the pandemic due to their responsibility for maintaining public safety, risk of exposure through interactions with the community, and the concern of exposing family members to the virus[7]. Interviews with police officers for example, about their worries about COVID-19 support this finding[8] and a US analysis of officer stress, mental health and resiliency following events such as the 9-11 terror attacks and HIV epidemic all point to the likelihood that COVID-19 will compound occupation related stress.[9]

The consequence of the pandemic for the mental health of prison officers is notably missing from the literature however. There is reason to expect those working in the prison sector are more vulnerable to occupational stressors and strains than many other professional groups. A 2017 study of 12 prison officers working in prisons in England, Wales Northern Ireland and Scotland found three-quarters of those sampled met the met the diagnostic criteria for referral for mental health problems and at a higher rate than many other 'highly stressed' occupational groups, including other emergency and security services.[10] Research evidence from the UK[11] and USA[12] indicates that prison officers suffer from more psychological and physical health problems as compared to other occupational groups

[7] Stogner, J., Miller, B. L., & McLean, K. (2020). Police Stress, Mental Health, and Resiliency during the COVID-19 Pandemic. *American journal of criminal justice : AJCJ*, 1–13.

[8] De Camargo, C. (2021). 'It's tough shit, basically, that you're all gonna get it': UK virus testing and police officer anxieties of contracting COVID-19. *Policing and Society*, 1-17.

[9] Stogner, J., Miller, B. L., & McLean, K. (2020). Police Stress, Mental Health, and Resiliency during the COVID-19 Pandemic. *American journal of criminal justice : AJCJ*, 1–13.

[10] Kinman, G., Clements, A. J., & Hart, J. (2017). Job demands, resources and mental health in UK prison officers. *Occupational Medicine*, *67*(6), 456-460

[11] Harvey, J. (2014) Perceived physical health psychological distress and social support among prison officers, Prison Journal, 94, 242-259.

[12] Schaufeli, W. B., & Peeters, M. C. W. (2000). Job stress and burnout among correctional officers: A literature review. *International Journal of Stress Management, 7*(1), 19–48.

Among the terminology used to refer to mental health and psychological distress are terms such as work stress, trauma and burnout.[13]

Another reason to be concerned about prison staff mental health is their vulnerability when it comes to general health. In a survey of 100 British prison officers who were asked how they viewed their mental and physical health, 83.8% scored below average on general health, 52.0% below average on physical health (specifically health problems which limited their usual work activities) 50.0% below average on bodily pain, and 32.0% below average on physical functioning. Social support from within the prison service was correlated with a reduction in psychological distress in line with previous research indicating a protective effect on health and burnout that comes from support within the organisation.[14]

In a systematic review of eight studies looking a stressors in prison settings high workload has consistently emerged as a major source of stress along with lack of personal safety, poor physical working conditions, pay, long hours, low autonomy and role difficulties.[15] Other studies included in this review highlighted interpersonal stressors, such as a lack of social support from managers and co-workers and lack of communication between management and staff as among the most stressful features of front-line correctional work. An earlier literature review on burnout and stress among correctional officers lists role problems, work overload, demanding contacts (with prisoners, colleagues and supervisors) and poor social status as primary stressors. Support from the organisation for the job emerged as a potentially important avenue for reducing job stress and burnout in correctional institutions.[16]

A qualitative study in which prison officers discussed their experiences of direct and indirect trauma suggests they may be particularly vulnerable to work related stressors and developing trauma symptoms.[17] The officers referred to both direct and indirect experiences of trauma coming from empathic connections with prisoners who had been victimised as well as being offenders, knowledge of offences as well as splits within the staff team affecting workplace experiences. Interestingly participants also spoke about the normalisation of trauma within the prison setting.

In March 2020, the prevalence of anxiety, depression and trauma symptoms in the UK population were examined by the Covid-19 Psychological Research Consortium (C19PRC) with an initial sample of 2025 adults[18] and a follow-up with a portion of the sample in April

[13] Halim, A., Altinas, E, Rusinek, S Fantini-Hauwel, C. & Hautkeete, M. (2013) Inmates-to-Staff Assaults, PTSD and Burnout: Profiles of Risk and Vulnerability. Journal of Interpersonal Violence 28(11) 2332– 2350

[14] Harvey, J. (2014). Perceived physical health psychological distress and social support among prison officers, Prison Journal, 94, 242-259.

[15] Finney, C., Stergiopoulos, E., Hensel, J., Bonato, S., & Dewa, C. S. (2013). Organizational stressors associated with job stress and burnout in correctional officers: a systematic review. *BMC public health*, *13*(1), 1-13.

[16] Schaufeli, W. B., & Peeters, M. C. W. (2000). Job stress and burnout among correctional officers: A literature review. *International Journal of Stress Management, 7*(1), 19–48

[17] King, A. and Oliver, C. (2020) A qualitative study exploring vicarious trauma in prison officers Prison Service Journal Nov 2020, 251.

[18] Shevlin, M., McBride, O., Murphy, J., Miller, J. G., Hartman, T. K., Levita, L., Mason, L., Martinez, A. P., McKay, R., Stocks, T., Bennett, K. M., Hyland, P., Karatzias, T., & Bentall, R. P. (2020). Anxiety, depression, traumatic

2020 (Wave 2) and July 2020 (Wave 3).[19] Symptoms of generalised anxiety were measured using the Generalized Anxiety Disorder 7-item Scale (GAD-7), a widely accepted measure. Those who scored greater than 10 on the GAD were categorised as screening positive for anxiety disorder. The percentage of participants meeting the clinical criteria for anxiety-depression was 20.7% at Wave 1 and there was no significant change at Wave 2 (18.6%) or Wave 3 (20.0%). An important finding was that COVID-19 anxiety was correlated with reports of physical health problems in the two weeks preceding the survey and remained so even when controlling for any pre-existing health problems.[20] The C19PRC data suggest the anxiety that people are suffering due to the pandemic is a unique contributor to the physical health problems they are experiencing with fatigue emerging as one of the strongest symptoms.

THE CURRENT SURVEY

On the 10th of December 2020, a survey link to a study on the effects of the pandemic on the wellbeing of members was sent via the Prison Officers Association (POA) to all of its over 30,000 members in England, Wales, Scotland and Northern Ireland including secure hospitals. Members were sent two reminders and the survey closed at the end of February 2021, with 594 completed responses. The survey period coincided with the third wave of the pandemic. Prisons were locked down again on 4 January and COVID-19 related deaths and infections were significantly greater than in previous waves of the pandemic.[21] The timing of the survey is likely to have affected responses.

Three-quarters of survey sample were prison officers from England (N=444), fifteen percent were from Scotland (N=87), 2.5% from Wales (N=15) and 8% from N. Ireland (N= 46). We had only 2 respondents from secure hospitals in England. Unless otherwise stated the results as they appear below are based on the entire sample from all countries.

Seventy percent of the respondents were male and 29% female with average ages of 46 years and 43 years respectively. The men had worked in the sector for an average of 18 years and females 13 years. All but 12 of those who responded defined themselves as white British. *Please view Table 1 as an illustration of how our sample compares to the HMPPS workforce.* Our sample contained a greater proportion of older, male and white staff than prison staff (in E&W) as a whole and these results need to be assessed in the knowledge that the literature suggests people with these characteristics are ought to suffer COVID-19 related anxiety than those with some other characteristics.

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stress and COVID-19-related anxiety in the UK general population during the COVID-19 pandemic. *BJPsych open*, *6*(6), e125. https://doi.org/10.1192/bjo.2020.109

[19] Shevlin M et al (2021). Refuting the myth of a 'tsunami' of mental ill-health in populations affected by COVID-19:evidence that response to the pandemic is heterogeneous, not homogeneous. Psychological Medicine 1–9. https://doi.org/10.1017/S0033291721001665

[20] Shevlin, M., Nolan, E., Owczarek, M., McBride, O., Murphy, J., Gibson Miller, J., Hartman, T. K., Levita, L., Mason, L., Martinez, A. P., McKay, R., Stocks, T., Bennett, K. M., Hyland, P., & Bentall, R. P. (2020). COVID-19-related anxiety predicts somatic symptoms in the UK population. *British journal of health psychology*, *25*(4), 875–882. https://doi.org/10.1111/bjhp.12430

[21] Ministry of Justice et al. (2021a) *See footnote (3)*

The C19PRC data suggested that the presence of children in the household and estimates of personal risks of infection were predictive of COVID-related anxiety. In the current survey most of the sample (88%) lived with others, predominantly a partner (78%), 43% were living with children; 20% with children over 18 and 32%, similar to the population as a whole, with children under 18.[22] Four percent lived with parents and other family. Thirty percent had caring responsibilities outside the household, compared with 10% of the population as a whole[23] and this may indicate a greater susceptibility to COVID-19 related anxiety in the sample as a whole.

Most of the men and women worked in a male closed prison or high security prison and 43% were Band 3-4 Prison Officers (Please *see Table 2 for employment characteristics*).

Forty percent had GCSE or equivalent 32% had A levels or equivalent, 20% an undergraduate degree, 7% post-graduate qualifications. Overall the sample appeared to have a lower level of educational qualifications held than the population as a whole[24] and this may be a further indicator of greater susceptibility to COVID-19 related anxiety.

COMPLIANCE WITH COVID SAFETY MEASURES

When asked about the effectiveness of COVID-19 workplace safety measures just over half the sample as whole thought they were acceptable or good, only 6% thought they were very good while 35% thought practices were poor or very poor (see Table 3). There did not appear to be any difference in perceptions by country. In England, 34% reported the measures were poor, in Scotland 38 % felt the measures were poor.

Staff were asked about compliance with the COVID safety measures in their facility. Looking at the entire sample, 89% of prison staff reported that they themselves sometimes or always comply with the safety measures. On the other hand, 72% of respondents indicated that prisoners only sometimes or rarely comply. Females were more likely to report their colleagues were complying but apart from that there were no gender differences.

In terms of country differences, In Scotland 94% (as compared to 88% in England) reported they often or always complied with safety measures, 63% that colleagues were complying and 28% reported that prisoners were often complying. In England, 47% reported their colleagues were often or always complying with the safety measures and 16% in England reported that prisoners were often or always complying. Thus in Both England and Scotland

[22] Office for National Statistics. (2014). *Households and Household Composition in England and Wales: 2001-11.*
https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/families/articles/householdsandhouseholdcompositioninenglandandwales/2014-05-29

[23] Office for National Statistics. (2013). *2011 Census Analysis: Unpaid care in England and Wales, 2011 and comparison with 2001.*
https://webarchive.nationalarchives.gov.uk/20160109213406/http://www.ons.gov.uk/ons/dcp171766_300039.pdf

[24] Department for Education. (2016). *Qualifications in the population. Level of highest qualification held by people aged 19-59/64 in England: March 2015*. GOV.UK. https://www.gov.uk/government/statistical-data-sets/fe-data-library-qualifications-in-the-population-based-on-the-labour-force-survey

respondents reported that colleagues are not seen to be complying as much as individuals themselves and prisoners even less so. There may be a positive response bias here.

In terms of the COVID measures and perceptions of COVID safety, there are no gender differences.

SUBJECTIVE RATING OF IMPACT OF COVID-19 ON MENTAL AND PHYSICAL HEALTH

When asked if they thought their mental and physical health had stayed the same or got worse, 81% (N=481) of our sample felt it had got worse (79% of men and 86% of female prison officers) with no difference among those with children under 18 and those without children under 18.

OBJECTIVE MEASURE OF ANXIETY (GAD-7)

We used the *Generalized Anxiety Disorder* (GAD-7) scale[25] which is made up of seven items measuring anxiety. It is generally accepted that scores ≥ 10, would be indicative of moderate or severe anxiety symptoms and worth further evaluation (see Table 5). The average GAD-7 score for the present sample was 8.86 but 43% of the sample fell into the ≥ 10 group and as indicated below this sub-set were also more likely to report suffering from burnout. Those with children under 18 (N= 188) scored significantly higher on GAD as compared to those who reported they did not have children under 18.

There were no differences in GAD scores between those who lived alone and with others, and between those who had received a positive COVID test (35% of the sample) and those who had not.

Those with caring responsibilities which were 30% of the sample showed a significantly higher GAD score, a mean of 10.08 as compared to an average of 8.34 for those without caring responsibilities.

There was a striking difference in the GAD scores depending on reports of how good the COVID safety measures were seen to be in the workplace such that the highest levels of anxiety were amongst those who saw the COVID safety measures as poor or very poor (35% of the sample) and the lowest anxiety levels in those who saw them as good or very good (26% of the sample). The 38% who selected the "safety measures are acceptable" option fell in between in their anxiety levels.

The response to the question about their own compliance with safety measures did not appear to be associated with anxiety although the seven individuals who reported they rarely complied had GAD scores well above the cut-off , a mean score of 12.57.

While there was no significant gender difference in GAD scores for the sample as a whole, in England the male scores were significantly higher than females (Means =8.64, and 8.42) and

[25] Spitzer, R. L., Kroenke, K., Williams, J. B., & Löwe, B. (2006). A brief measure for assessing generalized anxiety disorder: the GAD-7. *Archives of internal medicine, 166*(10), 1092-1097.

in Scotland the female scores were higher than the males (Means 10.1 and 7.87 respectively) though not statistically significant.

BURNOUT, WORRY ABOUT COVID-19 AND ANXIETY

A single question was used to assess burnout; 85% of the sample reported feeling burnt out on several days, more than half the days or every single day. There was a significant age difference with the under 30 age group reporting greater burnout than the 50-60 plus age group. The 40-49 age groups also reported more burnout than the 50-60 plus age group. There were no gender differences.

The survey also included a single general measure of worry. Participants were required to indicate how often they felt worried in the past week (e.g. regarding finance, family or health), on a scale of 0 (no time at all) to 8 (all the time). The average was 4.84 suggesting individuals experienced worrying thoughts about half the time.

Participants were asked to indicate on a scale from 0 (not worried) to 10 (extremely worried), how worried they were about the COVID-19 pandemic in general and the chance of their employment putting their loved ones at risk. Higher scores indicate more worry and once again the scores were high: 6.14 and 7.36 for worry about COVID and putting family at risk by going into work respectively. The older age groups 40-49 and 50-60+ reported more worry than the younger groups.

Further analysis is necessary but preliminary data suggest an association between burnout, worry about the COVID-19 and anxiety as measured by the GAD-7 scale (as found the C19PRC study of the UK population). Those whose GAD scores indicated severe anxiety also reported the most worry that going to work was putting their family at risk.

41% of the current sample reported COVID related deaths in their establishment. There was no link between the anxiety levels as measured by the GAD-7 and COVID deaths in prison or whether people were shielding. However, only 32 participants were shielding which presumably meant they were not in work.

There was no significant difference in the anxiety measure between those who believed they had had COVID-19 (either through experiencing symptoms or receiving a positive test) and those who hadn't developed COVID-19.

EMOTIONAL SUPPORT

The literature stresses that creating an organisational culture, with support from supervisors and the organisation as well as material support (e.g. money, resources) is essential to reduce stress on the workforce and effectively and efficiently manage a public health emergency.[26] Indeed this is one of the most well documented protective factors in

[26] Laufs J, & Waseem Z. (2020) Policing in pandemics: A systematic review and best practices for police response to COVID-19. Int J Disaster Risk Reduct. Dec; 51:101812.

the context of mental health in first responders especially if it is perceived by those affected as supportive.[27]

When asked if they received emotional support to relieve pressures of the job only 23% of females and 17% of males responded affirmatively. In other words 80% of the sample had received no support. When asked if they had received *additional support during the pandemic* only 11.3% of men and 20% of females said they had received additional support. Therefore 86% of the sample as a whole reported they had received no additional emotional support during the COVID-19 pandemic.

In terms of country differences: 84% in England, 87% in N. Ireland and 92% in Scotland stated they received no additional support since the COVID 19 pandemic.

It is striking that less than a quarter of our sample reported they had received emotional support pre-pandemic (118) and even fewer (83) since the pandemic.

We asked those who responded "yes' to having received emotion support to select as many different sources of support that applied from a list we provided during the pandemic. Of the small number who indicated support, 70 selected the partner/family option, 52 checked friends, 48 checked colleagues, 27 checked supervisor 17 checked trade union and 36 the external organisation option. When giving the option to indicate 'Other' only 6 people made reference to any form of professional counselling.

SUMMARY

The aim of this survey was to get a snapshot of the psychological well-being of the HMPPS workforce at the height of the COVID-19 pandemic when there was still concerns about rising death rates and uncertainty about the vaccine roll-out. The emotional toll on those in the sector was likely to be high at this point so our survey included questions that enquired about mental health and support before and since the pandemic. Despite the likelihood that ill-health and/or work pressure prevented some from accessing or completing the survey, a reasonable sample was obtained. Our single objective measure of the prevalence of anxiety: the GAD-7 scale indicates that 43% of prison officers in our sample met the clinical criteria for anxiety. We compared our results with a nationally representative sample of UK adults tested in March, April and July 2020 (the C19PRC study). The latter used a combined anxiety-depression measure that included the GAD-7 with 20% of the UK sample meeting the clinical criteria. In addition to the substantially elevated rates of anxiety in our sample, our respondents reported burnout, worry and anxiety about COVID-19. Notable was the particular concern among the majority, who live with others, of putting family members at risk. Only a minority of our sample, indicated they had received emotional support pre-pandemic and even fewer reported they had received support during the pandemic.

[27] Prati, G.; Pietrantoni, L. The relation of perceived and received social support to mental health among first responders: A meta-analytic review. J. Commun. Psychol. 2010, 38, 403–417.

ANNEX

Tables containing preliminary results from the survey

Table 1. Demographic characteristics of prison/secure hospital staff sample and HMPPS workforce as of December 2020 (from Table 5a)[28]

	Sample Characteristics (n=594)		**HMPPS characteristics (n=53,182)**	
Variable	**N**	**%**	**N**	**%**
Age				
< 30	76	12.8	7, 341	20.5
30-39	106	17.8	8, 227	23.1
40-49	136	22.9	7, 053	20.0
50-59	243	40.9	9, 845	27.6
>60	32	5.4	3, 213	9.0
Gender				
Male	416	70	14,138	40.1
Female	171	28.8	21, 503	60.3
Prefer not to say*	7	1.2	N/A*	N/A*
Ethnicity				
Black Asian Ethnic Minority	12	2	2, 523	7.1**
White	571	96.3	27,731	77.8**
Other (unknown)	10	1.7	5, 387	15.1
Employment				
Full-time	545	91.8	31, 347	87.9
Part-time	49	8.2	4, 294	12.0
Caring responsibilities (outside of home)				
Yes	176	29.6	N/A	N/A
No	418	70.4	-	-

N/A HMPSS workforce statistics only provide data of the representation of males and females.*

*** HMPSS report a declaration rate of 85.8%, therefore the percentages of BAME and white employees was calculated using the sum of those who did declare their ethnicity*

[28] Table 1. displays the age, gender, ethnicity, employment status and caring responsibilities of the current prison/secure hospital sample. It also includes workforce statistics of age, gender, ethnicity and employment within the HMPSS as of December 2020, Table 5a). This table provides some evidence of our sample being representative of the current prison workforce, specifically in most age groups and the percentage of white participants. However, our sample does nott appear to be as representative regarding female and BAME employees. The table also indicates that approximately 30% of employees in the study sample have caring responsibilities outside of their home.

Table 2. Employment characteristics of sample.

Demographic	N	Percent
Country of employment		
Works in a prison in England	444	74.7
Works in a prison in Wales	15	2.5
Works in a prison in Scotland	87	14.6
Works in a prison in Northern Ireland	46	7.7
Works in a secure hospital	2	0.3
Grade/Band – English Prison		
Band 2/operational support	32	5.4
Band 3-4/prison officer	257	43.3
Band 4/supervising office	76	12.8
Band 5/custodial manager	64	10.8
Band 6-8/managers	12	2
Welsh Prison		
Band 2/operational support	2	0.3
Band 3-4/prison officer	7	1.2
Band 4/supervising officer	3	0.5
Band 5/custodial manager	3	0.5
Scottish Prison		
Scottish prison officer (residential)	70	11.8
Scottish prison officer (operational)	16	2.7
Northern Irish Prison		
Senior officer	8	1.3
Main grade officer	19	3.2
Custody prison officer	18	3
Night customer officer	1	0.2
Type of establishment		
Male open prison	49	8.2
Male closed prison	193	32.5
Female open prison	7	1.2
Female closed prison	26	4.4
Male local prison	52	8.8
Male category B trainer	10	1.7
Male category C trainer	51	8.6
High security	133	22.4
Male juvenile closed YOI	21	3.5
Male young adult closed YOI	42	7.1
Secure hospital	2	0.3
Male open YOI	1	0.2
Immigrational removal centre	2	0.3
Headquarters or regional office	5	0.8

Table 3. Frequency table displaying perceptions of COVID-19 compliance in prisons and secure hospitals.

Variable	N	%
Effectiveness of COVID-19 safety measures in the workplace		
Very poor	40	6.7
Poor	168	28.3
Acceptable	228	38.4
Good	122	20.6
Very good	35	5.9
Individual compliance with COVID-19 safety measures in the workplace		
Never	0	0
Rarely	7	1.2
Sometimes	57	9.6
Often	268	45.2
Always	261	44.0
Colleague compliance with COVID-19 safety measures in the workplace		
Never	0	0
Rarely	43	7.3
Sometimes	256	43.2
Often	248	41.8
Always	46	7.8
Prisoner/patient compliance with COVID-19 safety measures in the workplace		
Never	40	6.8
Rarely	188	31.9
Sometimes	245	41.5
Often	106	18.0
Always	11	1.90

Table 4. Perception of burnout and mental and physical health characteristics of sample as self-reported with a single item on a rating scale[29]

Variable	N	%
I feel burned out		
Not at all	89	15.0
Several days	175	29.5
More than half of the days	156	26.3
Almost everyday	174	29.3
Physical and mental health		
Got worse	418	81.0
Stayed the same	103	17.3
Improved	10	1.70

Table 5. Cut off scores for anxiety as measured by the GAD-7 measure[30]

GAD-7 scores	N	%
0-9	336	56.57
≥ 10	258	43.43

[29] Table 4 presents the percentages of responses to a single question measuring burnout. Participants were required to indicate on a scale from 1 (not at all) to 4 (almost everyday), how often they felt burnout in the previous two weeks. Respondents were also asked to indicate if they felt their mental and physical health had declined with 3 response options.

[30] In Table 5 scores of ≥ 10, would be considered as demonstrating moderate or severe anxiety symptoms indicating clinical evaluation may be needed. The mean GAD-7 score for the present sample was 8.86 (SD = 6.21). Those with children under 18 (N= 188) scored significantly higher on GAD as compared to those who reported they did not have children under 18 $t(592)= -2.12$, $p=.034$