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# ‘You wake up sore, you wake up angry’: A commentary on why sleep quality is important in institutional settings

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## Abstract

Sleep is a key factor in health and well-being outcomes, but its issues and opportunities are under-explored in institutions. The prevalence of poor sleep quality and insomnia is higher in institutionalised populations than in the general population, stimulating adverse mental and physical health and well-being outcomes, including violence. With supporting evidence from an ethnographic study in an adult male prison, this policy-oriented commentary discusses the relationship between sleep and behaviour, the lived experience of sleeping in institutions, and the opportunities to improve behavioural outcomes. It concludes that sleep deprivation contributes to a downward spiral and proposes three areas of intervention to promote a more person-centred sleeping environment for health and safety.

## Keywords

Sleep, institutions, prisons, well-being, health

## Introduction

Sleep contributes to health and behaviour, but it is often overlooked when policymakers consider how to address issues, such as violence and recovery, in institutions. This paper draws attention to the contemporary context of sleeping in an institution of confinement and proposes novel opportunities and insights for improving the sleep quality of occupants.

This commentary defines an institution of confinement as a setting where people experience limited agency to affect their conditions. These include prisons, immigration removal centres,

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hospitals, homeless shelters, asylum facilities, and, inter alia, refugee camps. These places simultaneously confine and control movements, culminating in a flow of people that, for varying periods, are limited in where and how they live. They may seem isolated from wider society, but these spaces are critical to public health and personal safety. We attend to the various forms of institutions to highlight the broader landscape and connections between these settings. In particular, how poor sleep quality among institutionalised populations is a threat and opportunity to improving health and well-being outcomes.

Sleep is an underexplored issue in institutions. While poor sleep quality is more prevalent among institutionalised populations than the general population (Sheppard and Hogan, 2022), current approaches to health promotion and rehabilitation focus on daylight hours, such as therapeutic interventions, healthcare, and substance misuse support. These are undoubtedly important for addressing behavioural issues. However, many of these approaches overlook the physical–emotional–environmental nexus. This paper contends that what happens at night is as vital to addressing health and well-being issues as what happens during the day.

In 2020, the first author conducted ethnographic research in a Victorian-era prison, HMP Clarendon (a pseudonym) to understand how security policy is implemented in an adult male prison. Fieldwork consisted of 10 weeks (~200 h) of observations from January to March and then three weeks of 28 semi-structured interviews with (15) staff and (13) prisoners in September. Thematic analysis before and during the pandemic highlighted an unexpected but significant pain of imprisonment among participants[1]: sleeping. In the following section, we draw on some of these voices to establish the importance of addressing poor sleep. However, given the findings are indirect, meaning that they were not the initial focus of the original study, their lived experience is supplemented by extant institutional literature to highlight the shared experience of sleeping in institutional settings. This article concludes by providing some novel policy-oriented recommendations that address how to improve sleep quality among institutionalised people.

## The relationship between sleep, behaviour, and health

> Prisoners prepare for bed. Peering through a few observational panels the cells are already dark as the sun has set. It's cold, my exhaled breath is visible, and prisoners are huddled under their blankets. Some have duvets that they would have bought but most don't (or can't). It's meant to drop below zero this week … Maurice, a wing orderly (cleaner), sees me and seems to read my mind: 'Bloody cold innit.' I ask what it's like to sleep here, '… It really depends on who you are. I know some lads really struggle… it's what you're sleeping on. It's pot-luck what you get given. The mattresses, sheets, pillow, they aren't made for us oldies, they aren't made for the change of weather. They give you nothing but pain, a lot of pain, neck, back, everything. You wake up sore, you wake up angry because it's like sleeping on the floor. It shows they don't care about us'. (Field notes, 13 January 2020)

Being in an institution can be both physically and psychologically demanding. In 1961, Goffman cited sleep loss as a deprivation that causes personal harm among patients. Around 60 years later, the ethnographic field notes above indicate that sleep deprivation remains prevalent in institutions. Their social and physical design removes autonomy from their occupants as prisoners, patients, and other groups are coerced to comply with institutional norms, such as when to move, eat, and sleep. Prisons, in particular, can be harsh and austere, representing a loss of public empathy for prisoners' crimes (Moran et al., 2016). Maurice explained, 'It shows they don't care about us'. Social attitudes shape the institutional experience but disregard the effects of physical conditions on behaviour and

health. This section highlights the shared lived experience of sleeping in institutional settings and its relationship with behavioural outcomes, explaining why sleep matters before exploring how it can be addressed.

Sleep is a relatively understudied and underappreciated subject matter in institutional literature. Sleep can account for between 20% and 40% of the day, but there are only a few known studies into sleep quality in the institutional context of the UK. These suggest that sleep issues among institutionalised people are systemic. In secure training centres, just under half (48%) of children said it was quiet enough to relax or sleep at night (HMIP, 2020). In adult male prisons, more than 88% of adult male prisoners reported poor sleep quality (Dewa et al., 2017). Among refugees and migrants, the prevalence of sleep disorders ranged between 39% and 99% (Richter et al., 2020). In hospitals, studies reveal that 'Sleep wake dysfunction' and 'sleep disorders' are common among patients and contribute to public and personal health and safety issues, inhibiting recovery from illness and engagement with support (Morse and Bender, 2019). These issues extend beyond the UK.

In Switzerland, 44% of prisoners experienced poor-quality sleep (Elger, 2004). In Nigeria, this was almost 38% (Fakorede et al., 2015) and in Ethiopia, it was more than half of prisoners (53.9%) (Getachew et al., 2020). There were similar stories of sleeplessness among prisoners in South Africa (Van Heerden, 1996), China (Geng et al., 2020), Italy (D'Aurizio et al., 2020), and America (Morris et al., 2021). These findings accord with other institutionalised populations, such as migrants and asylum seekers (Leech, 2021; Richter et al., 2020) and hospital patients (Morse & Bender, 2019). The breadth of studies in the last three decades suggests that institutions globally fail to address issues of sleep.

Qualitative studies highlight the depth of issues. Absence of privacy, loss of control, and sedentary lifestyles are some of the key drivers affecting sleep quality. The loss of privacy is a large part of the institutional experience (Goffman, 1961). A prisoner in Clarendon explained that the loss of privacy was painful:

> The lack of privacy is 'one of the toughest things' to adapt to in prison: 'Honestly, it's like sleeping with a bunch of strangers, it is. Here, most of us get our own spaces but really, here and there [another part of prison], you're bunking with someone. That's weird, isn't it? You do everything in front of someone, I mean everything! There's no peace, no moment to yourself. A lot of people can't cope with that. It's taken me some time. There were days when I just couldn't sleep. The snoring! Man, seriously, if one person snores on a landing, forget it! So many days were just write-offs'. (Fieldnotes 10 February 2020)

The constant and invasive proximity of others deprived this prisoner of his privacy and sense of security, inhibiting his sleep quality. Sleep is an important coping strategy, enabling imprisoned people to 'reduce' the psychological burden of imprisonment (O'Donnell, 2014) but sleep deprivation inhibits a person's resilience. Without sleep, days were 'just write-offs'. This refers to how daytime sleepiness and sleep loss can have negative effects on cognitive performance, particularly reduced attention, executive functioning, and memory (Maquet, 2001). It is likely to affect recovery and rehabilitation, therefore sleep is critical to achieving institutional aims.

Without privacy, sleep quality deteriorates. Visual privacy is limited in institutions by windows in doors, unrestricted access for staff, pervasive surveillance technologies, and sharing facilities with others. Room sharing deprives occupants of control in their space, and a sense of selfhood, and exposes them to sensory intrusions, such as noise and smells (Schliehe and Crewe, 2022). This loss of personal control and privacy is critically related to health, where lower privacy

increases healthcare demand (Moore, 1980) and violence. Disrupted or poor-quality sleep 'correlates with increased frequency and intensity of self-reported anger, hostility, and aggression' (Kamphuis et al., 2012: 239). In a review of overcrowding, Clements (1979) highlighted that relentless surveillance and intimacy produce a sense of losing dignity, indecency, and health issues, such as diseases, anxiety, and stress. These are issues experienced across institutions and countries (Leech, 2021; Reid, 2022; Wener, 2012) and exacerbated by a loss of control.

Institutions infantilise occupants. Patients and detainees depend on staff for almost everything vital to their existence (Goffman, 1961; Jewkes, 2018). Thompson, a Clarendon prisoner, explained that:

> (I'm) Not a frequent flyer, but over the last five years I've become a bit more dependent on the system, unfortunately, I've been coming here for a bit more of an extended stay… First, you hate these walls, then you learn to rely on them, in the end, you need them. (Thompson)

Thompson, like many of his peers, said that the prison rendered him powerless. It constrained his autonomy and maintained his subordination. Thompson had learned to 'rely' on the prison and 'need' it for his existence. Similar to how a parent dictates the mealtimes, bedtime, activities, food, and clothing of their child, prisoners are told what to do and when to do it (Crewe et al., 2023). Gellerstedt et al. (2014) identified how hospital regimes similarly institutionalise patients by constraining autonomy:

> If you could go to bed when you wanted instead of when they want you to, they expect that you go to bed at nine, which I would never do at home. Your own times for various things, it would have been nice to sleep a little longer in the morning when you had slept badly during the night but they always come to check. (p. 183)

The patient was coerced into following institutional norms. Rather than promoting recovery, the environmental conditions that allow people to flourish, including aspects of choice, autonomy, and control are missing in institutions. Aspirations of care, repair, and well-being are restricted by competing narratives and tensions, of social expectations and physical design (Jewkes, 2018). This produces 'behavioural atrophy' (Goffman, 1961) and increases one's dependence on the institution.

The loss of control is related to indoor isolation and sedentary lifestyles among institutional occupants. In Clarendon, some prisoners explained that being sedentary and unable to sleep affected their health:

> [I] Went to [prison], downhill, started cutting myself, suicide attempts, couldn't sleep, just ripped me off that jail did basically… [I] didn't sleep for 3–4 days at a time. (Felix)

> In Jail, that's the worst thing: lazying about, 'cause you won't be able to get a good night's sleep, 'cause you'll be full of like [energy]. Say you sleep in the day, if I sleep in the day, I can't sleep at night. No way, I've had too much sleep and that's my ADHD. (Jerry)

Many prisoners described spending more than 23 h a day isolated in their rooms before and during the pandemic, with a negative effect on their health and well-being. Recent evidence suggests that institutionalised people still spend considerable sedentary time inside their rooms in response to overcrowding and understaffing (Bingham & Pickles, 2021; HMIP, 2023; Koenders

et al., 2021). Thus, a room in an institution can function as a dining room, bedroom, sitting room, toilet, kitchen, and classroom (Herrity and Warr, 2023). In many settings, this bed-centric approach has become a culturally accepted practice for managing patients and detainees (Koenders et al., 2021) but turned many people nocturnal as they struggle to follow the daily regime. Cyclically, sleep deprivation affects mood, physical health, and behaviour.

Being sedentary indoors is an important environmental risk factor for health and sleep. Daylight is fundamental to general health, including mood and sleep (Burns et al., 2021) while activity is also critically related to sleep quality (Wang and Boros, 2021). Inversely, being isolated and sedentary is harmful, affecting the attitudes of people towards recovery (Stephenson et al., 2021), increasing morbidity and the length of hospital stay (Morse and Bender, 2019), increasing the risk of non-communicable diseases, and shortening life expectancy (Lee et al., 2012). Poor sleep quality is also associated with unhealthy behaviours, such as lifetime use of cigarettes and substance misuse (Getachew et al., 2020), and higher risks of suicidal behaviour (Uddin et al., 2020). Sleep deprivation is a spiral.

Improving sleep quality in institutions should be a priority to improve public health and safety. As part of a more person-centred approach, this could reduce hospital and prison demand, facilitate faster recovery and rehabilitative engagement, and reduce crime and health issues. This suggests that innovations targeting sleep quality are worthy of further investigation.

## Person-centred approaches to improving sleep

There are immediate opportunities to improve sleep quality in institutions. In this section, we provide policy recommendations that address the physical–emotional–environmental nexus. Appreciating that sleep hygiene education efficacy is limited and inconclusive (Irish et al., 2015), we focus on daytime activities, institutional design, and personal choice(s). We promote the importance of a holistic person-centred approach to creating safer and healthier institutional settings.

### *Promote daytime activity*

This recommendation advocates for more activity and time outside one's room to improve health, well-being, and safety outcomes. Being institutionalised is a time of low activity. Detainees should receive at least one and a half hours out of their room for showers, telephone calls, and socialising, 30 min of outside exercise, and time for education, employment, and workshop activity (IMB, 2020). Pandemic restrictions limited time out of cells to prevent infection but many detainees across England and Wales continue to spend more than 23 h a day in their cells (HMIP, 2023). A healthy lifestyle is inextricably linked with sleep quality (Stephenson et al., 2021; Uddin et al., 2020), but many institutionalised people are sleepless and restless in their rooms.

Being active outside is a determining factor in the health and recovery of people (Burns et al., 2021). Avoiding a bed-centric approach emphasises the importance of prioritising personal needs in the social design and delivery of institutional settings. As the research suggests, what happens during the day matters as much to sleep as what happens at night.

### *Consider sleep in institutional design and standards*

To address external factors impacting sleep quality, we recommend design standards and principles that promote good sleep. Dwellings in wider society are governed by Government Building

Regulations 2010, but many institutional settings are certified by a setting-specific policy framework. The Ministry of Justice (2022), Home Office (2022) and NHS (2013) developed their own frameworks and guidance for certifying whether accommodation is suitable for holding people overnight. However, there is minimal reference in each document to factors affecting sleep, such as overcrowding, noise, temperature, and privacy (Rifkin et al., 2018; Reid, 2022; Wener, 2012). Rather, the standards are determined by access to sanitation, functioning electric lighting, a heating system, and 'adequate ventilation'. There are no standards for determining the final two measures or how accommodation facilitates good sleep or 'adequate health'. Sleep quality should be a key consideration in accommodation policy and building design.

Where systemic issues of overcrowding cannot be immediately redressed to protect the privacy of occupancy, measures should be taken to mitigate the impacts. Lived experience from institutionalised people indicates that overcrowding and sharing rooms are critically related to health, well-being, and sleep quality. Clements (1979) concluded that overcrowding 'brings out the worst in both individuals and systems' (p. 217). With climate change exacerbating temperatures and overcrowding producing forced cohabitation and invasive proximity, there is an urgent need to address the physical environment of institutions. Sleep quality can be improved by weather-related bedding, minimising room sharing, trialling different lighting, providing sound-reducing curtains, softer flooring, acoustic wall linings, insulated ceilings, and maintaining windows to ensure they seal tightly when closed. There are ways and means of immediately addressing conditions to improve sleep quality.

## *Choice(s) and agency*

To address internal factors, we recommend that institutionalised people have more choice and control over their sleeping conditions. Consumers outside institutions can choose the contents of their duvets, change them by the season, add mattress toppers to improve their comfort, fall asleep to the sound of bird songs or whale noises, or wake up to personalised music stations when they choose, where they choose, and how they choose. In institutional settings, choice is limited. Prison Rule 27 (1999) states, 'Each prisoner shall be provided with a separate bed and with separate bedding adequate for warmth and health', yet institutional sleeping materials do not generally consider individual needs or environmental conditions. With one thin pillow, a blanket, and a four-inch-thick mattress in a shared room, prisoners can 'wake up angry' in conditions not 'made' for their needs or external weather. This overlooks how agency and choice foster personal transformation and a positive sense of identity, autonomy, and hope (Jewkes, 2018). More agency and choice over bedding may reduce violence and issues of safety, such as self-harm.

Comfort is critical to sleep and manufacturers can modify mattresses and pillows to provide more options. In a survey of orthopaedic surgeons, 95% believed that mattresses played a part in low-back pain management, with 76% recommending a change in firmness (Levy & Hutton, 1996). Studies on pillows have observed that health issues, such as headaches, can be reduced with more support and higher satisfaction in comfort (Yamada et al., 2023). The contents of mattresses and pillows may be limited to maintain fire retardancy, but the firmness can be adapted through the manufacturing process, such as pre-crushing, altering the shape, or changing the contours. Even if these are not the panacea of good sleep, providing different options and evaluating their effect can enable adaptations and improvements to health and well-being.

## Conclusion

Institutions overlook the physical–emotional–environmental nexus between sleep quality and health outcomes. We acknowledge the systemic constraints of overcrowding and ageing infrastructure to stop room sharing, but a more person-centred approach is critical to public health and rehabilitation. We suggest a more active daytime regime, more sleep-informed physical conditions and policies, and more personal choice over bedding to improve sleep quality. These proposals won't resolve every problem, but more consideration of institutional design will contribute to a healthier social environment. Further longitudinal research measuring sleep quality among institutionalised people (and staff) is recommended to understand different individual needs and environmental impacts but there are immediate actions that can be taken to improve public health and safety.

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1. Participants are provided with pseudonyms to protect their identity. This was a condition of data collection and publication.

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