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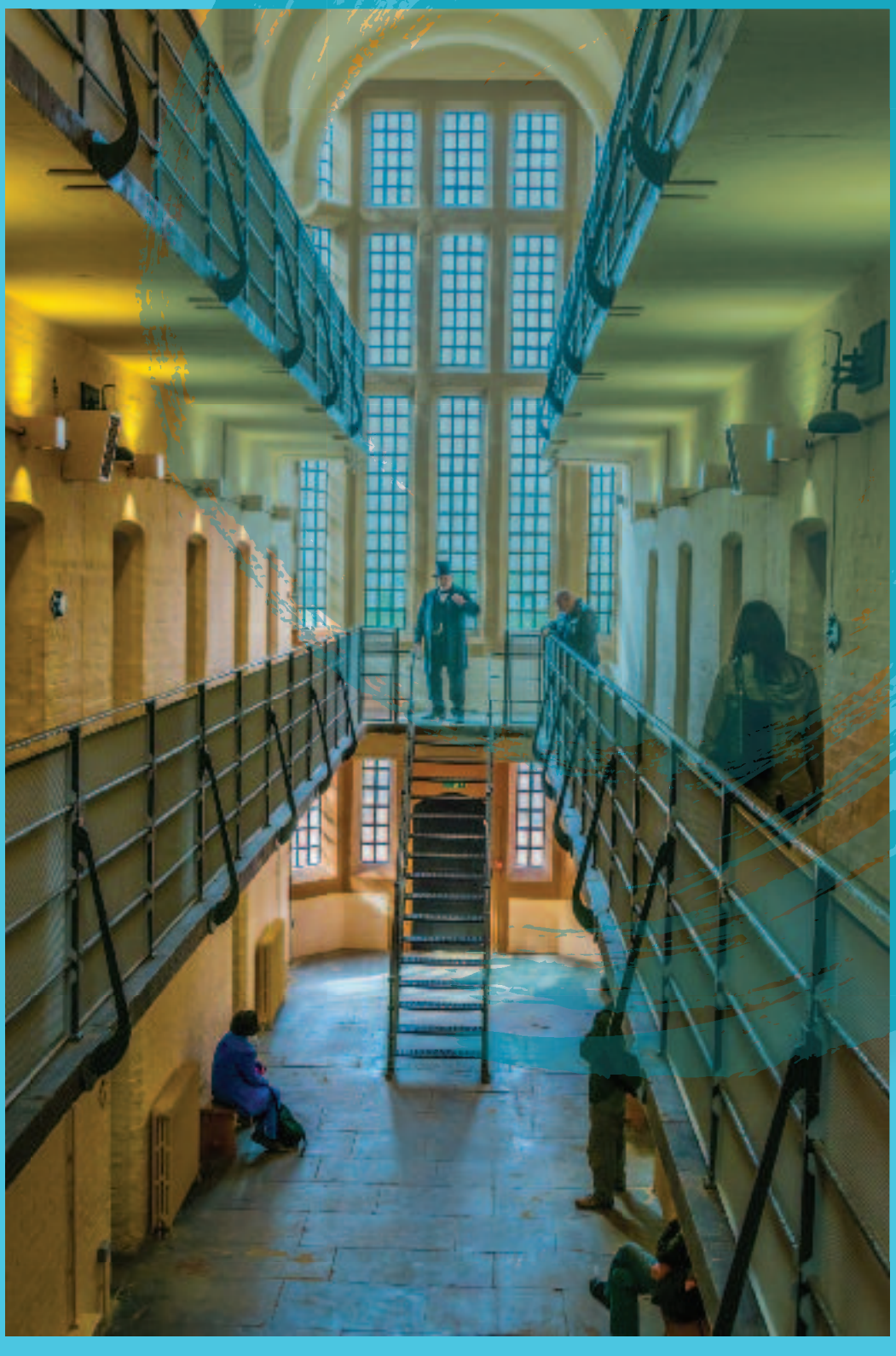

Ex-prisoners experiences of healthcare in prison and the community in Scotland

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Healthcare provision for prisoners presents unique challenges. Major health problems and behavioural-health issues linked to increased mortality and morbidity including blood borne viruses, circulatory disease, mental disorders, smoking, and substance misuse are over-represented in incarcerated groups [1] [2]. Healthcare provision has generally focussed on medical treatment of illness rather than on factors such as education, prevention, harm minimisation, sentencing diversion to avoid lengthy custodial sentences for non-violent crime, and childhood intervention to stop criminal development [3].

In Scotland, a commitment to move from a non-National Health Service (NHS), prison-based healthcare system and towards a shared Scottish Prison Service (SPS)/NHS-delivered model for incarcerated offenders was outlined in 2007[4].

The SPS and NHS now cooperate in the National Prison Health Network (NPHN), which was created with the signing of the 'National Memorandum of Understanding' document[5]. The main drivers and objectives for this partnership were to:

- reduce inequalities in health
- improve access for prisoners to NHS health care services
- provide a safe environment for the assessment and treatment of prisoners
- reduce harm and preserve life
- work with other organisations

This significant policy change, subsequently enacted in 2011, underpinned the study. Given the policy change described, and in that context, this study aimed to understand ex-prisoners' experiences of health and healthcare in prison and in the community.

The main objective and purpose of the study was to explore the healthcare experiences of males who had passed through the criminal justice system and re-joined the community in an effort to illuminate their experience of service provision from an insider perspective. The exploration and interpretation of prisoners' healthcare experiences were the focus of this study because the literature under represents works that reflect prisoners' own voices during the process of the legislative change. A desire to determine the perceived impact upon the participant group affected by policy change was a key concern underpinning this study. Failure to effectively incorporate service users' views and experiences may mean that any barriers to implementation remain unidentified and unaddressed. Any weaknesses or gaps arising from the conjunction of two large organisations, the NHS and SPS, may lead to the success of relevant policies being ultimately undermined.

Methodology

A qualitative, phenomenological study using interpretive phenomenology[6] was performed which utilised participants' narratives of their healthcare experiences as the source of data. Their stories were obtained using semi-structured interviews.

NHS Tayside serves a population a population of approximately 415,000 and is composed of the councils of Angus, the City of Dundee and Perth and Kinross[7]. It is a region which has urban and rural areas. The major population centres are the cities of Dundee and Perth. There are two prisons with Tayside; the closed secure prison at Perth (678 prisoners) and the only open prison in Scotland at Castle Huntly (285 prisoners) located

1. Tayler, F. (1997) 'Promoting health in prisons', Prison Service Journal., (November), pp. 18-19.
2. Graham, L. P. (2007) Prison health in Scotland: A health care needs assessment.. Edinburgh: Scottish Prison Service.
3. Marshall, T., Simpson, S. and Stevens, A. (2000) Health care in prisons: *A health care needs assessment*. University of Birmingham.
4. Scottish Government. (2007) *Potential transfer of enhanced primary healthcare services to the NHS. Report to cabinet secretaries for health and wellbeing, and justice.* Available at: http://www.scotland.gov.uk/Resource/Doc/924/0063020.pdf; (Accessed: 7 October 2019)
5. Scottish Government. (2011) National memorandum of understanding between the Scottish Ministers, acting through the Scottish Prison Service and NHS Scotland. Available at: http://www.scottish.parliament.uk/S4_JusticeCommittee/Inquiries/20130226__FINAL_revised_MOU_Prison_Healthcare_HIS_December_2012.pdf (Accessed: 7 October 2019)
6. Heidegger, M. (1962) Being and time. New York: Harper and Row.
7. NHS Tayside. (2017) Director of Public Health 2016/17 Annual Report. Available at: https://www.nhstaysidecdn.scot.nhs.uk/NHSTaysideWeb/idcplg?IdcService=GET_SECURE_FILE&dDocName=PROD_284941&Rendition=web&RevisionSelectionMethod=LatestReleased&noSaveAs=1 (Accessed: 7 October 2019)

outside Dundee. While participants had served time in prisons across Scotland, all had been housed in one of the two in Tayside prior to their release.

Participants were recruited within the Tayside region via three centres; a GP practice in Perth and health centre and substance misuse service centre in Dundee. In this study a purposive sample with inclusion/exclusion criteria was utilised. This was appropriate as purposeful sampling is widely used in qualitative research for the identification and selection of information-rich cases related to the phenomenon of interest; which in this study was the healthcare of ex-prisoners[8]. The inclusion criteria for participants were that they were males over the age of 18 years and had served a prison sentence greater than three months within a prison in Scotland. Excluded from the study were females, anyone under 18 years of age and those that had not served a sentence of at least three months within a Scottish prison.

It should be noted that all participants had served sentences in more than one prison within Scotland so had experienced healthcare within different prisons. All of them had also been convicted and served sentences before and after 2011 which, from their experiences, allowed grounds for making pre-post 2011 comparisons within the research.

Ethical approval to conduct the study was obtained from the ethics committees of Abertay University and East of Scotland Research Ethics Service (Part of NHS Scotland).

Participants' had to give written consent to participate, to record the interviews and for their quotations to be used pseudonymously within any related publications. Participants were also advised that they should not divulge any material about any criminal activities as this would be passed on to the relevant authorities.

Recruitment centre managers were given details of the study including inclusion criteria. Potential participants were identified in the GP practice and health centre by the GP personally using the NHS computerised patient's records system while the substance misuse service used their initial assessment process documents. Potentially eligible participants were provided with study information including a contact phone number for the researcher.

Semi-structured interviews were used for collecting data between April 2014 and April 2015. Prior to commencement, participants were given the opportunity to answer any remaining questions about the study and provided written informed consent. Interviews are most effective for qualitative research and questions were open-ended so that in-depth information was collected[9]. A semi- structured interview schedule was utilised with the main questions. The order of the questions varied depending upon the participant and their individual experiences. Interviews lasted approximately one hour.

Interviews were audio-recorded if consent was given to do so; and contemporary written notes taken where consent for audio-recording not given. Audio tapes were transcribed verbatim with the transcriptions creating the text for analysis together with written notes. Recordings and transcripts were kept securely on a password protected University computer drive.

Some of the participants experienced being treated like 'second class citizens.' Not only do the participants belong to a vulnerable group, but a number also expressed feeling isolated

The meaning of health.

The participants had all expected that the prison and community healthcare systems would provide the necessary care and help to maintain their health when required. However, their experiences did not correspond with their initial expectations. Participants experienced health predominantly as a physical phenomenon related to their ability to function physically in the world. Mental ill health had been experienced by participants and was spoken about in terms of stigma and ensuring/maintaining personal safety.

Some of the participants experienced being treated like 'second class citizens.' Not only do the participants belong to a vulnerable group, but a number also expressed feeling isolated, especially upon liberation, when they have to live with the effects of the labelling and stigma, which society places on ex-prisoners. This has affected their self-esteem.

Participants were very aware of the stigma that was attached to those who had served a prison sentence and felt that they were treated like second-class citizens, which also occurred within the healthcare

8. Lavrakas, P.J. (2008) Encyclopedia of Survey Research Methods. Thousand Oaks CA: Sage Publications.
9. Alshenqeeti, H. (2014) 'Interviewing as a Data Collection Method: A Critical Review', English Linguistics Research, 3(1), pp. 39-45.

establishments in the outside community. In particular, shortcomings from the Criminal Justice as well as the healthcare systems have not minimised the effects of labelling and stigma, which has exacerbated the barriers experienced in relation to accessing healthcare in the outside community following liberation. Contributing experiences include the use of handcuffs on participants while they were being escorted to healthcare facilities outside the prison during their time of incarceration, which not only enhanced stigma, but also caused pain and discomfort.

The care required is not being experienced as forthcoming by the participants. Participants experienced having little power, control or choice about their care within the prison. However, in the outside community they still perceived that they had limited control over certain situations; for example, when collecting their Methadone prescriptions from the pharmacy. This harms their self- esteem. As a result of exacerbated power dynamics, offenders struggle to assert choices in relation to their healthcare, as they face difficulties in negotiating care/treatment with healthcare professionals. It is interesting that the document Your health, your rights The Charter of Patient Rights and Responsibilities states: 'Communication and participation: the right to be informed, and involved in decisions, about health care and services '[10]. This document also detailed patients' rights to access of services, communication and participation in their care and treatment, confidentiality of personal health information, right to be treated as an individual with dignity and respect, the right to safe and effective care and to give feedback, make comments, or raise concerns or complaints about the health care they receive. This applies to all patients served by the NHS in Scotland regardless of their status in society and, therefore, should include those in prison. However, it would appear that prisoners are not involved in healthcare service decisions and it is with this point in mind that this study was performed.

Participants gave differing accounts of their experiences within the prison healthcare system, which may help to account for the mixed reactions and expectations towards the new SPS/NHS healthcare partnership and the impact that it could possibly make upon their health within the prison. The participants' had experiences of times when they had felt their health was poor and that their expectations of care and treatment had not been met. Consequently, many had made official complaints about their care. Many had experienced having had to make use of complaints procedures and indicated that this was a difficult to use. Hereafter, the complaints would not be dealt with seriously, as experienced by slow processing times and unsatisfactory replies/resolutions. In an effort to legitimise their complaints and bring about faster responses and satisfactory resolutions, many participants saw no other option than to have a lawyer to make the complaint on their behalf.

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Access to healthcare in prison and community.

Accessing healthcare services was a difficult experience for participants. There were problems with gaining access to healthcare services that caused participants to experience a lot of anger and frustration particularly with regard to waiting times.

Problems were experienced regarding medication and the prescribing practices of doctors, which were a source of discontent. Medication was talked of in terms of a currency and participants experienced difficulty in storing it in their cells along with the threat to their safety that was caused by bullying and the trade in medication. In order to prevent this, participants experienced various strategies such as supervised medications, medication checks and cell searches which were performed by staff, yet with limited effect.

Participants had experienced little health education/promotion within the prison. This is in contrast to the Scottish Governments plan presented in the document Your health, your rights The Charter of Patient Rights and Responsibilities[11] to build a 'Health Promoting Health Service' in which one of its purposes was to 'Help people to sustain and improve their health, especially in disadvantaged communities'. This was also meant to include offenders and ex-offenders as they are specifically mentioned in the document.

The participants also gave accounts that they had not experienced this within the outside community

10. Scottish Prison Service. (2012) Scottish Prison Service Corporate Plan 2012-15. Available at: http://www.sps.gov.uk/Corporate/Publications/Corporate6.aspx (Accessed: 7 October 2019)
11. ibid

either. Participants' also gave accounts that their experience of accessing healthcare services in prison was a difficult and frustrating process that was controlled by nurses whose attitudes and use of power were perceived as a major factor in prisoners being able to access and use the services available. All of the participants gave accounts of situations that reflected experience of a high level of mistrust in them and the issues surrounding their health status as a result of the phenomenon known as the credibility gap. This appears to have an impact upon their ability to access health care whilst in prison and the outside community.

The obfuscatory organisation.

Participants observed a lack of health service provision after office hours and they seemed to believe this had become more noticeable since the change in primary healthcare provision in November 2011. Out of hours healthcare is dependent upon the knowledge, skills and experience of the prison officer on duty. However, as the need for medical attention can arise at any time, this can result in inadequate handling of situations, especially when these occur outwith the general working hours of the more experienced and knowledgeable staff members. Due to this, participants have experienced mistakes having been made, which had resulted in unnecessary suffering for prisoners with painful conditions. Participants stated that serious conditions during 'out of hours' would see the prisoner transferred to a local hospital for assessment and appropriate treatment but delays can occur with this process. The transfer of prisoners to hospital appointments was a topic that aroused a lot of emotion amongst all the participants. Through their accounts, the ethical issues of privacy and confidentiality were highlighted when consulting with a specialist doctor at a hospital outpatient department. Participants voiced that G4S, the company responsible for all prisoner transfers (GEOAmey took over this function in January 2019), did not appear to have a proper assessment protocol or policy for the use of handcuffs during these consultations. Participants noticed that within the prison, the movement of prisoners to the health centre is the responsibility of the prison officers. As a result, participants seemed to believe that the officers are responsible for whether a prisoner attends their healthcare appointment or not.

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Prisoners' medication checks have been a feature of the prison routine for a number of years. Participants perceived a difference in this part of the prison routine following November 2011. This may be due to the different power and authority afforded to nurses within the prison. As nurses had their contracts of employment transferred to the NHS, they lost the authority they had under their previous SPS employment; namely the authority to check a prisoner's medication use and storage. Participants also voiced that the old process of accessing healthcare via the 'sick parade' had changed.

Participants expressed an awareness of access to health services becoming increasingly bureaucratic as it was now burdened with filling out forms. This disadvantaged and discouraged prisoners with literacy difficulties. Following November 2011, there were now separate complaints procedures for the SPS and NHS. Participants expressed the belief that these were not explained and appeared to be designed in a way to discourage and delay complaints being made.

Participants expressed that the access arrangements put in place to provide them with appointments appeared bureaucratic, slow and, it was reported that designed to discourage prisoners from accessing the healthcare services.

Vulnerability and hope.

There were a number of factors that participants had experienced, which they stated contributed to their feelings of vulnerability. The substance misuse services were explained to be inconsistent in their delivery of services. This was said to have an overall demotivating effect upon participants.

The role of the family and the support that they provide following liberation was stated to be important as it provided emotional support and helped to prevent relapsing into former health threatening behaviours. It could also help prevent men from becoming embroiled in the pattern of prison and liberty known as 'the revolving door,' which can be difficult to escape. The family was also a valuable resource as it provided accommodation and a permanent address, which was essential to access a number of healthcare services and benefits.

Participants voiced the importance of a job as a source of physical exercise and mental stimulation. However, it also provided them with an income, which helped prevent them from selling their medication in exchange for other goods or to pay off debts. Lack of an income within prison can lead to an accumulation of debt, which can have an impact upon the lives of

prisoners, including additional labelling practices which impede healthcare access.

Planned, consistent throughcare and opportunities, especially those from the third-party sector, were voiced as helpful. These opportunities equipped participants with new knowledge and skills which allowed them to explore their lives, gave them confidence to make choices and move forward in a healthy manner.

The men expressed hope for the future, not only for themselves but also for the future generations. They expressed genuine hopes and beliefs regarding the possibility that an integration of education, particularly health education, would help prevent the mistakes they had made in their lives from being repeated by the younger generations. Finally, it was found that effective healthcare provision can contribute to hope and successful reintegration into the outside community post liberation.

Discussion

In the UK, responsibility for secondary healthcare i.e., that requiring hospital facilities provision for prisoners has typically resided with the NHS, responsibility for primary care provision in Scottish prisons lay with the SPS until November 1, 2011 at which point the 'National Memorandum of Understanding' document brought the situation into line with the rest of the UK. This change of responsibility created a situation where two large organisations; the SPS and the NHS, are responsible for prisoners healthcare. It is worth noting that the SPS are responsible for custody as well as having a duty of care to prisoners within the SPS estate but the NHS has the responsibility for providing healthcare services for the offender, regardless of whether they are in prison or the community. In the context of the above national policy changes, the focus of this study was to explore prisoners' experiences of healthcare in and out of prison.

The SPS, established in 1993, is an agency of the Scottish Government. The SPS Corporate plan for 2012 to 2015[12] states that the priorities of the SPS are Custody, Order, Care and Opportunities. This serves to illustrate that the major discourse within the SPS is that of security which is in stark contrast to that of healthcare within the NHS. The exception to this being the forensic services within the NHS where there is a strong risk discourse and a dual care/containment focus The SPS now collaborates with the NHS in the NPHN, which was created with the signing of the 'National Memorandum of Understanding' document. The objectives for this partnership were:

- reducing inequalities in health
- improve access for prisoners to NHS health care services
- provide a safe environment for the assessment and treatment of prisoners
- reduce harm and preserve life
- work with other community and healthcare services.

This document was of considerable significance as it set out the particular roles of the SPS and the NHS Health Boards in Scotland in providing primary healthcare for prisoners within the SPS estates. However, with many partnerships, there are difficulties setting common goals such as which health issues to address, responsibilities for harm reduction, information gathering and environments for health assessment and treatment. This is more difficult when the two organisations involved have different agendas; the NHS being primarily focussed on health and illness while the SPS on security. Failure of this partnership to work effectively, theoretically means prisoners may receive less equitable care to that of the general population and potentially could defeat the purpose of the shift of responsibility for healthcare in the first place.

Finally, it was found that effective healthcare provision can contribute to hope and successful reintegration into the outside community post liberation.

A literature review identified that there is a dearth of relevant literature about male prisoners own views about their involvement in health services and they are rarely asked their opinion or given much choice regarding the services they require. To date there has been no study in Scotland that has explored ex-prisoners' healthcare experiences in prison and the community using their accounts. The study presented here was not interested in generalisations; rather, it was interested in gaining insights through accounts or versions of experience. The participants gave their experiential accounts that raised the themes presented. These themes help to illuminate the way the participants experienced the healthcare system.

12. Scottish Government. (2012) Your health, your rights The Charter of Patient Rights and Responsibilities. Edinburgh: Scottish Government. Available at: https://www.ohb.scot.nhs.uk/sites/default/files/publications/Charter%20of%20Patients%20Rights%20and%20Responsibilities.PDF (Accessed: 7 October 2019)

There were studies[13] [14] [15] that, while looking at specific service provision and outcomes, took patients' overall experiences of the healthcare system into account. Although these studies were conducted within the UK, they were all performed in England where the NHS responsibility for prisoner healthcare took place six years before it happened in Scotland. The vast majority of studies were conducted within the prison environment and looked at primary care provided by doctors and nurses, mental health or addiction services. However, only three studies interviewed offenders about their experiences inside and outside of the prison; the first looked at the resettlement needs of women offenders in the UK[16], the second explored the help seeking behaviour in men in UK[17] and the third studied the care given to those with HIV after liberation in the USA[18].

This study, specifically exploring offenders' healthcare experiences, is the first to have been performed in the UK since 2012 and certainly the only one that has taken a phenomenological approach. It is also the only study that explored the offenders' use and experience of other health services such as dentist, optician, chiropody and physiotherapy in the prison or community.

Conclusion

The NHS does not appear to be a flexible service and appears to be trying to fit the needs of prison patients into a service that is primarily designed for the wider public. The NHS is trying to get the 'patient to fit the service' rather than the 'service to fit the patient'. As a result, as a healthcare organisation it needs to look at the way it conducts its business within the secondary setting of prison.

While in prison there is opportunity for the health care services to do something different compared to the community. Prison healthcare can help those that are 'marginalised' if it 'engages with patients' as it can get them into treatment whether this is primary care, dental, mental, substance misuse, etc. There is also a need for a rapid response team in order to give easier access to care. This needs to be followed up with case conferences to review prisoners' care on a regular basis. In addition, Throughcare Support Officers are a new initiative which can provide valuable support for accommodation, continuity of healthcare upon liberation for example hospital and social work appointments. There is a need to link healthcare with social care to ensure a more holistic approach to care for the marginalised and disenfranchised.

Participants also raised the issues of their medication changing when they transferred between prisons, a lack of communication between the prison and community regarding medication at liberation and that different detoxification regimes were used at different prisons. There is a need for the National Prisoner Health Network to communicate and work with the SPS and NHS to address the varying care approaches and policies utilised within different prisons in an effort to try to minimise these issues.

One area that is in need of scrutiny is the complaints procedure within prison as prisoners are a litigious group and will complain when they are not listened to or informed about their care. At present, there are two systems, which are bureaucratic and confusing; one for the matters dealt with by the SPS and another for healthcare dealt with by the NHS. The NHS patient complaints system in particular needs reform. Complaints need to be dealt with by staff experienced in dealing with them as at present a lot of this burden is placed upon nurses. There is a need for a greater level of transparency of decision making in healthcare, for example, staff need to inform patients' why they are getting a certain treatment or not getting it, whatever the case may be.

Participants in this study frequently voiced difficulties that they had experienced with community healthcare services such as registering with GP surgeries and hostile attitudes with pharmacies. This implies that there needs to be a greater understanding and awareness of liberated prisoners' needs and the difficulties that they face within the community care services in an effort to minimise disruption to the continuity of their care. This could be facilitated by dissemination of information and educational strategies within each community health care trust.

The overriding conclusion to this study is that the participants' experiences of healthcare differ from the policy objectives of the UK and Scottish Governments19, NHS20 and SPS21 with particular reference to equity of service provision, health promotion and education, prisoner involvement with their care, and additionally links with the community and public sector.

13. Condon, L. et al. (2007) 'Users' views of prison health services: a qualitative study', Journal of Advanced Nursing, 58(3), pp. 216-226.
14. Plugge, E., Douglas, N. and Fitzpatrick, R. (2008) 'Imprisoned women's concepts of health and illness: The implications for policy on patient and public involvement in healthcare', Journal of Public Health Policy, 29(4), pp. 424-439.
15. Jordan, M. (2012) 'Patients'/prisoners' perspectives regarding the National Health Service mental healthcare provided in one Her Majesty's Prison Service establishment', Journal of Forensic Psychiatry & Psychology, 23(5-6), pp. 722-739.
16. Samele, C. and Keil, J. (2009) 'The resettlement needs of female prisoners', Journal of Forensic Psychiatry & Psychology, 20(S1), pp. S29-S45.
17. Howerton, A. et al. (2007) 'Understanding help seeking behaviour among male offenders: Qualitative interview study', British Medical Journal, 334(7588), pp. 303-306B.
18. Haley, D. F. et al. (2014) 'Multilevel challenges to engagement in HIV care after prison release: A theory-informed qualitative study comparing prisoners' perspectives before and after community re-entry', BioMed Central Public Health, 14(1253).
19. See note 4.
20. See note 10.
21. See note 5.