An exploratory study of male ex-prisoners' experiences of health and healthcare in prison and the community

A thesis submitted for the degree of Doctor of Philosophy

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Declaration

Candidate's declarations:

I, James Irvine Fraser, hereby certify that this thesis submitted in partial fulfilment of the requirements for the award of Doctor of Philosophy (PhD), Abertay University, is wholly my own work unless otherwise referenced or acknowledged. This work has not been submitted for any other qualification at any other academic institution.

Signed [candidates signature]…….

Date…… *27 July 2017* ……..

Supervisor's declaration:

I, Dr James Moir hereby certify that the candidate has fulfilled the conditions of the Resolution and Regulations appropriate for the degree of Doctor of Philosophy (PhD) in Abertay University and that the candidate is qualified to submit this thesis in application for that degree.

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Certificate of Approval

I certify that this is a true and accurate version of the thesis approved by the examiners, and that all relevant ordinance regulations have been fulfilled.

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Dedication

This study is dedicated to my late mother Alexerena Taylor Fraser, nee Watson and my father, Hugh Alexander Fraser.

Abstract

Background: In November 2011, prisoner healthcare in Scotland became the combined responsibility of a partnership between the Scottish Prison Service and the National Health Service. Very little is known about the experience of male prisoners with regard to their health care while in prison and immediately following release.

Aim: Against the backdrop of organisational restructure, the purpose of this study was to investigate the experiences of male prisoners in order that future policy developments can be more grounded in their experience.

Methodology: The study was conducted from a phenomenological perspective. Data was gathered from semi-structured interviews with male ex-prisoners in the community. Interviews were audio-recorded and transcribed where consent was given; detailed field notes were made in interviews where consent was not given for audio-recording. Transcripts of the recorded interviews and field notes were analysed using inductive phenomenological analysis.

Findings: Twenty-nine ex-prisoners participated in semi-structured interviews. Nine consented to being audio-recorded. Analysis revealed the following themes:

1. **The meaning of health**. Participants experienced their own health predominantly as a physical phenomenon related to their ability to function physically in the world. Mental ill-health had been experienced and was spoken about in terms of stigma and ensuring/maintaining personal safety. Substance misuse was not seen as a health issue but more as an issue of poor service provision.

2. **Access to and use of healthcare provisions in prison and the outside community**. Problems were experienced regarding medication and the prescribing practices of doctors. Participants' experience of accessing healthcare services in prison was of a difficult and frustrating process that was controlled by nurses whose attitudes and use of power were perceived as a major factor in prisoners' ability to access and use the services available. All participants described professionals' 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 appeared to impact upon their perceived ability to access health care whilst in prison and the outside community.

3. **Difficulties in interagency communication of care**. Participants expressed experience of an increasingly bureaucratic process of access to health services characterised by form-filling. This was perceived to disadvantage and discourage prisoners with literacy difficulties. Participants expressed that new complaints procedures were not explained and appeared to be designed in a way to deliberately discourage and delay complaints. Participants expressed that the access arrangements for healthcare appointments were also bureaucratic, slow, and perceived to be designed to discourage them from accessing the healthcare services.

4. **Vulnerability and hope**. The role of the family and the support that they provide following liberation was stated to be important and helpful in preventing relapse into former health threatening behaviours. Such support was also described as helping to prevent participants from becoming embroiled in a revolving door syndrome of release and reoffending. The important mechanisms were identified as a source of accommodation and a permanent address, which was essential to access a number of healthcare services and benefits. Planned, consistent throughcare and opportunities were identified as helpful, especially those from the third sector.

Discussion: This study provides a voice to the participants. Healthcare in prison was largely experienced in terms of physical health; mental health is seemingly experienced as stigmatising. Ex-prisoners experience a communication failure among services Access to healthcare in prison is experienced as overly bureaucratic

Conclusion Ex-prisoner participants' experiential accounts raise problematic issues relating to the effectiveness of 2011 policy changes that were intended to ensure equity in health services for prisoners and ensure that they received improved opportunities to benefit from NHS care. The changes have not translated into an improved experience for prisoners during and following their incarceration A renewed commitment to providing equivalency of opportunity in healthcare for prisoners is required.

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Glossary of terms and abbreviations

Terms

EX-PRISONER refers to a man over the age of eighteen that had served a prison sentence of at least three months within a prison in Scotland.

HEALTHCARE refers to health services provided by the NHS or any third party organisation in Scotland. Third party and voluntary organisations including commercial firms, charities and councils.

THROUGHCARE refers to the continuity of healthcare throughout the time a person spends in prison and for a limited time post-liberation.

Abbreviations

AUDIT Alcohol Use Disorders Identification Test

CARAT Counselling, Assessment, Referral, Advice and Throughcare

COCO Custody, Order, Care and Opportunities

CVD cardiovascular disease

HAART Highly active antiretroviral therapy

HDC Home Detention Curfew orders

HIPP Health in Prisons Project

ICC Internal Complaints Committee

ICM Integrated Case Management

IMU Intelligence Management Unit

IPA Interpretative Phenomenological Analysis

MDT Mandatory Drug Test

NHS National Health Service in Scotland

NIDA National Institute on Drug Abuse

NMC Nursing and Midwifery Council

NPHN National Prison Health Network

OPD Out Patient Department

PCTs Primary Care Trusts

PER Personal Escort Record

PIS Participant Information Sheet

PPC Prisoners Personal Cash

PRISMA Preferred Reporting Items for Systematic Reviews and Meta-Analyses

PR2 Prisoner Records Management System

SPS Scottish Prison Service

TA Thematic Analysis

TSO Throughcare support Officers

UKCC United Kingdom Central Council for Nurses, Midwives and Health visitors

WHO World Health Organisation

YOI Youth Offenders Institution

Introduction

Prisoner Healthcare

Providing healthcare for prisoners presents unique challenges. It has generally been based upon the traditional medical model and focussed on illness and abnormality than on broader health factors (Smart 1985). Research has found the major health problems within prison to include conditions and behaviours such as blood borne viruses, circulatory disease, smoking, substance misuse and mental illness. (Tayler 1997, Graham 2007).

Prisoners in Scotland form a unique population. They are young (mean age 33), white (98%) and male (95%) (Graham 2007). In her report for the SPS, Graham (2007) attempted to assess the needs for health care of Scotland's prisoners, in comparison to the Scottish population, with the ultimate aim of assisting the Scottish Prison Service (SPS) to make decisions supporting the health care of prisoners. The report was focussed on thirteen areas of "main concern" which were:

- Blood borne viruses.
- Drug problems.
- Alcohol problems.
- Tobacco use.
- Mental health.
- Sexual health.
- Dental health.

- Epilepsy.
- Diabetes.
- Accidents.
- Coronary heart disease.
- Asthma.
- Dyspepsia.

The report was compiled over a short time frame and, although it included a broad assessment of prisoner, health needs, it failed to inspect the wider factors of prisoner health. The report itself acknowledges its limitations thus:

"It is acknowledged that there is a wide spectrum of determinants that can affect the health of prisoners life circumstances such as unemployment; poor housing; limited education as well as risky lifestyles. Prison itself may well have a detrimental impact on aspects of prisoner health with, for example, overcrowded conditions; loss of privacy and disruption from family and relationships. It was beyond the scope of this study to measure and assess these broader determinants through, for example, description of prison culture and seeking prisoner views." (Graham 2007, p.85)

Although responsibility for secondary healthcare (care requiring hospital facilities) provision for prisoners has typically resided with the NHS, responsibility for primary care in Scottish prisons lay with the SPS until November 1, 2011 when it came within the domain of the National Health Service (NHS). This change of responsibility created a situation where two large organisations; the SPS and the NHS, are responsible for prisoners health care. The

SPS have 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.

The focus of this study was to review the literature, regarding prisoners' experiences of healthcare in and out of prison, and explore the effects the changes, such as the range of services provided, access arrangements and complaints procedures, had upon individuals. However, in order to fully appreciate the results it is useful to have an understanding of why some of these may have occurred. A review of the history and background of prison healthcare will now be presented in order to illuminate and illustrate the changes that prison healthcare in Scotland is currently experiencing.

Review and background of Prisoner healthcare

The Scottish Prison Service (SPS), established 1993, is an agency of the Scottish Government based in Edinburgh. The SPS's principal priority is security with its main function being the custody of people convicted by the courts. The SPS Corporate plan for 2012 to 2015 (Scottish Prison Service 2012) states that the priorities of the SPS are Custody, Order, Care and Opportunities (COCO). The document is concerned with custody, order and how the SPS can conduct its business more effectively within the criminal justice system while the issues of healthcare and opportunities are barely mentioned. 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 SPS now collaborates with the NHS in the National Prison Health Network (NPHN), which was created with the signing of the "National

Memorandum of Understanding" document (Scottish Government 2011). The drivers 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 organisations

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.

Prisons are not nurturing places. Generally, the environment is functional, bland and unstimulating (Nurse, Woodcock and Ormsby 2003). Even the shortest of journeys within prisons involve passing through multiple sets of locked gates. The prison population is a demanding population to treat, as its health needs are diverse, with many health problems.

Continuity with healthcare is undermined by regular prisoner transfers between prison estates and short sentences. Violence, drugs, and harassment are common in prison (Small et al. 2005, Edgar 2014). Prisoners have to rely on prison staff for everything and have limited opportunities to influence factors that may affect their health such as diet, exercise and accommodation.

Prisons are politically sensitive places and this can be challenging for the prison staff. The public views of the people imprisoned and their experience can be misrepresented in the media, which tends to focus on stories of prisoners receiving excessive privileges and lenient sentences (Jewkes 2007). As a consequence, health schemes in prison run the risk of being perceived as too good for prisoners, who are depicted as unworthy. For example, some prison estates conduct cooking classes as part of their education/health education programmes in which prisoners learn about healthy eating/cooking (NHS Forth Valley 2016).

The prison population

The number of people in Scottish prisons exceeded 8,000 in August 2008 and reached a record level of 8,420 on 8 March 2012 (Scottish Government 2015). The prison population has increased to an annual daily average of 8,058 for 2012-13. This illustrates a steady growth over the past decade and the population levels remain high relative to the current capacity of 7,942. Data are based on the Scottish Prison Service information management system archived aggregate tables. Figures published were based on datasets managed by Scottish Government Justice Analytical Services.

The latest set of projections, suggest that the prison population in Scotland will increase from an annual average of 8,300 in 2012-13 to 9,500 by 2020-21. These projections are

based on past trends and do not take into account the effect of future practice and policy changes (Scottish Government 2015).

Prison population figures fail to illustrate fully the public health impact of prison health. In 2007, Dr Andrew Fraser, Director of Health and Care at the Scottish Prison Service said, "In any one year, over 23,000 individuals are prisoners in Scottish prisons. The Scottish Prison Service information system contains records for over 100,000 prisoners, most of them Scottish residents. On that basis, 2% of the Scottish population have been prisoners at some point in the past 12 years." (Graham 2007, p.ii). This illustrates that prison healthcare has a much wider public health function and not just that of the resident prison population.

Bearing in mind the wider public health provision, these statistics, should they prove to be accurate, illustrate that the present prison and healthcare infrastructure will be unable to accommodate the growing numbers of people being imprisoned.

A Brief History of Healthcare in Scotland's Prisons

Healthcare for prisoners in the Scottish Prison Service (SPS) has traditionally been provided by its own medical service, similar to provision in England and Wales until 2006 (Jewkes 2007). Most healthcare services were provided "in house" by doctors employed as prison medical officers; supported by part time medical practitioners, usually local general practitioners, and prison healthcare officers, who were usually non-nurse qualified personnel undertaking duties such as medication management and health assessment. SPS' development of this approach can be traced to the 1960's (Scottish Prison Service 1991). It began with Prison Officers being selected to undertake enrolled nurse training at the Royal Infirmary of Glasgow and, subsequently, in the Colleges of Nursing in Glasgow, Edinburgh

and Aberdeen. Opinion at the time was that the duality of roles (discipline and healthcare) was both desirable and cost effective. Officers who underwent nurse training were paid their prison officer salary plus a “specialist” allowance of £922 per annum. This coincided with other “specialist” roles such as caterers and officers within the prison workshops. This approach fitted in well with the SPS concept of a unified service and was the operating model until the publication The Mackay Review (Scottish Prison Service 1991). Mackay identified that this model of healthcare provision effectively isolated prison nurses from their community and hospital colleagues because, although trained in NHS establishments, when they qualified they worked solely for the in-house SPS health service based solely within their estates. As a result, it was thought that the prison nurses were professionally less skilled than their community colleagues.

The review of nursing and medical services in the SPS chaired by Dr Mackay in 1991 was important as it recognised the professional status of SPS nurses and separated their duties from the discipline duties performed by prison officers. The impact of this was that the healthcare needs of the prisoners were then given greater priority and nurses could focus on healthcare rather than operational issues such as security, custody and order.

Until publication of The Mackay Review, the SPS did not recognise the professional status of the nurses working in its service despite the publication of the Nurses, Midwives and Health Visitors Act 1979 (UK Parliament 1979). The result of this was that professional organisations such as, the Royal College of Nursing struggled to gain representation in matters connected to disputes over pay, conditions of service or professional issues. It was not until the amendment of the Nurses, Midwives and Health Visitors Act in 1992 (UK Parliament 1992) that the SPS nurses’ status was acknowledged with the consequent

accountability of staff, including registration with the United Kingdom Central Council for Nursing, Midwifery and Health Visiting, being recognised. The lack of professional awareness in the years before the 1992 Act had contributed to the development of prison nursing being likened to that of psychiatric nursing in the 1970's as, similar to the old psychiatric institutions with its Medical Officer who controlled all the treatment and regimes within the hospital, nursing matters in the prison were still expected to be prescribed by the Medical Officer appointed to each prison.

The Scottish Prison Service Nursing Services Review in 2003 radically changed the logistics of services provision within the SPS and placed nursing at the core of healthcare to prisoners. This review created the provision of nursing and primary care services that were funded and provided by the SPS, although a number of services were provided under contracts with the local NHS healthcare trusts. The NHS continued to be responsible for the funding and delivery of secondary care to prisoners within the Scottish Prison Service. One positive effect of this review was that it made prisoner healthcare a priority and an action plan was mobilised to critically assess the model of nursing used to deliver care, improve governance, professional development and leadership with further aims to improve partnership and integration with the NHS. However, the report states in the terms of reference that it was to "identify current and probable future appropriate nursing needs of the prisoner population in relation to promoting prisoners' health, meeting prisoners' physical and mental health care needs "(Scottish Prison Service 2003). This was a demanding aim but the methods that were utilised in producing the report did not include consulting patients/prisoners about their health needs or the services that they felt they required.

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 “(NHS Scotland 2012). 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.

The Change in Responsibility for Prison Healthcare

The model of healthcare provision for prisoners is changing. In 2007, at the behest of the Scottish Government, the transfer of healthcare services from the SPS to NHS primary care trusts was initiated by the Prison Healthcare Advisory Board. It produced a document “Enhanced Primary Healthcare Services in Scottish Prisons” (Scottish Government 2007c) which explored the feasibility of transferring the primary healthcare services in the SPS to the National Health Service. Their subsequent report, “Potential Transfer of Enhanced Primary Healthcare Services to the NHS” (Scottish Government 2007b) was presented later that year to the Scottish Government cabinet ministers. These documents were key to the changes that were implemented in order to integrate the SPS healthcare service with Scotland’s 17 Primary Healthcare Trusts and recommended the transfer of responsibility for the health care of prisoners to the NHS with the contractual matters that had to be addressed. Crucially, this process of change had already begun with the SPS nursing review in 2003 (Scottish Prison Service 2003) when strategies to promote greater integration and partnership had been investigated and proposed in the report. It is perhaps unsurprising

then that the Scottish Government in 2007 recommended that the healthcare of prisoners should become the NHS's responsibility.

The rationale for change arose alongside the assertion by the Scottish Government that there was a need to tackle the health inequalities that existed within the nation's health (Scottish Government 2005), in order to meet the accepted international standards for prison health within a framework of developing and improving the continuity of care. While the SPS had developed its primary healthcare service, it required more investment and access to specialist resources in order to bring its service up to credible national standards. This required access to a wider range of healthcare expertise and professionals than was feasible at the time (Scottish Government 2007b). This would perhaps have posed difficulties because, as a relatively small organisation, the SPS's ability was limited in attracting the range of skills required to deal with the changes in the NHS. The only way for the service to be maintained was for integration into a larger service with the support of a broader available clinical expertise, together with community-based services to serve the needs of the prison population (Scottish Government 2007b). This had been discussed in the SPS review in 2003 when it explored the possibilities of partnerships with other organisations (Scottish Prison Service 2003). This change was deemed feasible in the Report of The Prison Healthcare Advisory Board, which stated:

"There are a number of drivers for change that have informed Ministers' considerations. Prisoners have extremely poor health and poor prospects for good health. There is a need to tackle health inequalities, to meet accepted international standards, and to develop and improve continuity of care to minimise the potential for re-offending. These need access to

the wider clinical expertise of the NHS. Additionally, present arrangements within the SPS for primary healthcare are not sustainable for the foreseeable future.

The Board has arrived with the view that transfer of responsibility for primary healthcare services to NHS Boards is feasible. There are risks associated with any transfer of responsibility. These risks are manageable with careful preparatory work, effective planning and the appropriate project management arrangements. Effective working relationships with national and local partnerships between SPS and the NHS will be essential "(Scottish Government 2007b, p.3).

There were two international standards passed regarding prisoner healthcare that influenced the change of responsibility for healthcare of prisoners in Scotland. The first was the United Nations Basic Principles for the Treatment of Prisoners (The United Nations. 1990) Article nine, which stated, "Prisoners shall have access to the Health Services available in the country without discrimination on the grounds of their legal situation". The second was the World Health Organisation "Moscow Declaration" in which it stated that prison "health must be an integral part of the public health system of any country" (World Health Organisation 2003). When these two standards were passed, prisoners in Scotland received their primary healthcare from a system that was an integral part of the SPS and not the NHS. As a result, each prisoner had an SPS healthcare record separate from their NHS record and little or no communication between the two organisations with regard to long term healthcare planning. In Scotland, until November 2011, prisoners did not have access to the same range of health services as the general population. Given that NHS procedures and guidelines did not apply to SPS healthcare, and that the SPS did not have access to the wider

range of clinical skills available in the NHS, this meant that the international standards were not met until the NHS took over responsibility for prison healthcare in November 2011. However, for some services, such as Blood Borne Virus testing and treatment, it could be argued that the international standards were well exceeded by those of the SPS.

Use of Healthcare Services

Marshall et al. (2001) reviewed the use of healthcare services in prisons in the United Kingdom and found that both male and female prisoners consult doctors at higher frequency rates than a demographically equivalent community population. Prisoners' consultations with other healthcare workers, defined as nursing staff, were 59 to 77 times greater than that of the general community (Marshall, Simpson and Stevens 2001).

The significance of these results suggests that men, while in prison, utilise healthcare services while those liberated from prison are less likely to do so. The reasons for this inequality are unclear but were thought to relate to the increased levels of disease experienced by prisoners or, it could be the easy accessibility of healthcare services within prison. However, it was noted that other institutional factors could be involved but there was no further evidence provided to prove or disprove this. These levels of consultation pose a real logistical problem for the NHS in the future, as it has implications for planning of the resources required to deal with these levels of consultation if required. As the NHS had only previously provided secondary care for prisoners, the present problem for the NHS is that it has to ascertain what care is required and delivered within prison and how it can be continued when prisoners are liberated. This study has shown that prisoners have reasons for consulting healthcare that are not related to their own health. This is usually centred on

obtaining a prescription for medication, which has a currency value within the prison. Results pertaining to this theme of medication will be presented in chapters four and five with subsequent discussion in chapter seven.

The results above are at odds with those found within the general population. (Scottish Government 2005) The Ministerial Task Force on Health Inequalities working group looked at health inequalities. In its report, recommendations were made on measuring health inequalities in Scotland. Overall, the report demonstrated that men's health is poorer than women's and poorer in lower social classes and in those living in less affluent postal code areas. It is also important that the report made the point that men access health services less frequently than women. This would suggest that men at liberty do not utilise healthcare services as much as those in prison and there appears to be a problem with the communication and continuation of prisoners care and access to community healthcare facilities following liberation.

Practical and conceptual challenges

The rhetoric of policy to practice may be hindered by practical and conceptual challenges. Since the prison environment is at odds with the values associated with health this is not surprising. How important values of health such as free choice, control and empowerment, are to be applied in the prison setting will be difficult as security issues govern all activities within its walls. Despite this, the Scottish Government stated in the *National Memorandum of understanding between the Scottish Ministers, acting through the Scottish Prison Service and 'NHS Scotland'* (Scottish Government 2011) that the SPS/NHS partnership would have a common purpose "To improve prisoners access to an appropriate range and quality of NHS

health care services according to their needs and reduce health inequalities." (Scottish Government 2011, p.4) while maintaining the common values of "Mutual respect for stakeholders and parties, encompassing health care and staff governance." (Scottish Government 2011, p.4) and "Openness in disclosure of necessary information, and reasonable notice of change."(Scottish Government 2011, p.5)

One of the core service values of the partnership would be:

"Equity in health services: prisoners will receive improved opportunities to benefit from NHS care in keeping with services provided to the local community; promoting seamless care to ensure integrated support to meet health care needs across settings" (Scottish Government 2011, p.5)

From these statements, it can be seen that the overall aim of the new healthcare arrangements were to implement greater equity, and presumably, choice, in healthcare provision with greater mutual respect for stakeholders, which in this case includes the offender population.

One of the main problems with health is its definition and how it is applied in prison. Prison health services have delivered a reactive and inefficient approach (Viggiani 2012) which is underpinned by a medical, rather than social, model of health. This viewpoint has the risk of hiding the wider factors that can have an impact upon prisoners' health.

Courtenay and Sabo's (2001) observation is that prisons do not foster a focus upon well-being and that healthcare is about treating illness after it occurs not before. Their view is exemplified when considering mental health promotion in prison. Interventions are often targeted as a way of coping with mental health as opposed to promoting positive mental

well-being (Courtenay and Sabo 2001). A commitment from the World Health Organisation (WHO) proposes that the mental well-being of prisoners is important. However, plans dealing with health issues remain reactionary; failing to fully address social, physical and psychological needs of individuals.

Practical challenges can also obstruct prison health care development. Healthcare within the SPS was under-resourced. This was highlighted in the Scottish Government report, *Potential Transfer of Enhanced Primary Healthcare Services to the NHS* (Scottish Government 2007b) as one of the key reasons for the integration of the SPS healthcare service into a partnership with Scotland's 17 Primary Healthcare Trusts. The report noted that healthcare staff working within the SPS did not possess the required range of knowledge, skills and professional development in order to provide the wider clinical expertise and services as that of the NHS. Thus, the SPS entering into a partnership agreement with the NHS would:

1. allow for NHS staff to be brought in to the prison
2. provide specialist clinics and services, for example, epilepsy clinics and substance misuse services
3. allow for knowledge, skills and professional development for staff within both organisations
4. utilise existing training facilities
5. provide job secondment opportunities

Secondly, prison staff who work with prisoners can treat health as additional work, something outside their professional remit or something to do only when time is available

from performing their regular duties (Caraher et al. 2002). The result of this is that health can be overlooked, as it is not prioritised over other prison duties.

Explaining prisoner health

Epidemiological and sociological studies have provided evidence of poor health in prisons such as drug misuse, mental illness, suicide, HIV, hepatitis B, tuberculosis, diet and nutrition, finally violence and bullying (Brooke et al. 1996, Bellis et al. 1997). This research suggests that prisoners experience a number of physical and mental health problems and require a range of health care needs (Graham 2007). The health trends seen in prison are similar to the general population, but more acute (Tayler 1997). A number of factors have been identified as health problems. However, there has been little attempt to define what constitutes a 'health problem' in prison or produce a clear definition of 'prison health'. The concept of 'health' is discussed by the SPS in relation to disease, illness, injury or disability, reflecting the dominant medical paradigm. This prioritises the efficient function and regulation of the body and mind (Naidoo and Wills 1994) and tends to ignore the broader determinants of health (Downie, Fyfe and Tannahill 1990).

The World Health Organisation's approach to public health and health promotion is based on the 'settings approach' (World Health Organisation 1991). Taking a healthy settings approach recognises that many risk factors are connected and can be addressed through programmes situated in the places where people live. Therefore, in many healthy settings programmes, action is usually focused in the following three areas:

1. creating a healthy working, living and learning environment
2. integrating health into the routine life of the setting

3. contributing to the health of the wider community

This settings approach acknowledges that health improvement requires support (World Health Organisation 1991). The WHO also promotes individual and social responsibility for health through participation and empowerment (World Health Organisation 1998). This has resulted in a range of factors now being recognised as important factors of health (Green, Poland, and Rootman 2000).

The United Nations “Basic Principles for the Treatment of Prisoners” Principle 9, A/RES/45/111 states that "prisoners shall have access to the health services available in the country without discrimination on the grounds of their legal situation" (The United Nations. 1990). This reinforced the principle that the highest attainable standard of physical and mental health is a fundamental human right of every human being without discrimination. This resolution led to the WHO establishing the Health in Prisons Project (HIPP) in 1995 to support member states in improving public health by addressing health and health care in prisons, and to facilitate the links between prison health and public health systems at both national and international levels (World Health Organisation 2011).

The Health In Prison’s Project’s (HIPP) gives technical advice to member states on the development of prison health systems and their links with public health systems. It also advises on technical issues related to communicable diseases (especially HIV/AIDS, hepatitis and tuberculosis), illicit drug use (including substitution therapy and harm reduction) and mental health. However, to date there has been no overall evaluation of its main activities. As a result, its effectiveness could be questioned.

The health experience of individual ex-prisoners was the focus of O'Briens (2003) study and the results reflect that prison has an effect, sometimes profound, on prisoner's health, with particular reference upon mental health. O'Brien (2003) identified problems with sleep, depression and a number of mental health issues among women prisoners in England and Wales. It was noted that 40% of the female participants reported that they had received treatment for a mental health problem in the twelve months prior to their imprisonment. As part of a survey of determinants of health among male prisoners, a high prevalence was also found in a study of self-reported anxiety and depression (Lester, Hamilton-Kirkwood and Jones 2003). Nurse, Woodcock and Ormsby (2003) conducted a qualitative study to explore both male and female prisoners' views on the impact of imprisonment upon their mental health. They used a focus group methodology and found participants described themselves as experiencing anxiety, anger and frustration in relation to drug withdrawal and extensive periods locked in cells.

A lack of autonomy in meeting health needs has been identified as a factor limiting well-being in prison (Willmott 1997, Sim 2002). Sim (2002) looked at the circumstances of physical and mental health during imprisonment and identified the following major stressors: limited access to information about prison routine, overcrowding and the inadequacy of such basic commodities as "fresh air". Factors that prisoners described as affecting their health were "threatening behaviour by other prisoners, cell conditions, physical violence and racism".

It has also been reported that some prisoners adopt more risky lifestyle behaviours while in prison. Boys et al. (2002) found that more than 25 per cent of heroin users in a national survey reported initiating use in prison. Substance misuse was mentioned by all of the

participants in this study. This had effects on the individual but was also responsible for a currency and culture that had effects not only on those using illicit substances but also on those that were prescribed medications for medical conditions. Prisoner healthcare reflected complexities in that it has effects upon the individual with the institutional influences that are complicated by the different, competing priorities of the NHS and the SPS (Boys et al. 2002).

Having introduced a brief history of the healthcare provision for prisoners in Scotland, I will now present my study which is an exploratory study of male ex-prisoners' experiences of health and healthcare in prison and the community. The thesis for the study is composed of seven chapters, which are summarised in the following section.

Structure of the thesis

In this study, the interview data are constructed between researcher and the participant. As a result, I have influenced the data through my presence, language and words. This means that it is impossible to undo my actions from the accounts that were given by the participants. In chapter one I will present the literature review and in chapter two, the methodology and methods used for the study. In chapters three to six I will present data extracts but these will not present all of the interaction that took place between the participants and me. It is acknowledged that this limits the reader's access to all of the material upon which I have interpreted the meaning of the participants' accounts. In order to address this issue, I have ensured that key extracts, illustrating the themes identified in the analysis, are presented in the results chapters.

The thesis comprises seven chapters. In chapter one I present the literature review. An explanation of how this was performed along with a discussion of the literature found is presented. A number of databases were utilised in the search for literature pertaining to the healthcare experiences of ex-prisoners. Primary, secondary, grey literature and meta-analysis sources were also searched for Government policies that affect prisoner healthcare.

Chapter two presents and discusses the design, methodology and methods employed for the study. Issues including the ethical principles and approval, participant recruitment, data collection and analysis methods are presented and discussed.

This study argues that prisoners healthcare issues are diverse and the health of a person can be influenced by several issues outwith their control, for example, the prison routine and the policies/procedures for accessing healthcare. These factors will be presented in the results of the study in chapter's three to six, with each chapter discussing a key theme found in the thematic analysis of the interview transcripts.

Chapter three presents the first part of the results of the healthcare-related experiences of adult males before and after release from prison: The meaning of health.

Chapter four presents part two: Issues related to access to and use of healthcare provisions in prison and the outside community.

Chapter five presents part three: Participants experiences of the difficulties in interagency communication of care.

Chapter six presents the final part of the results: Participants vulnerability and hope.

Following presentation of the study results, chapter seven follows with a discussion relating the identified themes to the existing literature. This chapter also includes the contributions to knowledge and practice made by the study, its strengths and limitations, implications for service provision and policy and recommendations for future research.

Chapter 1. Literature Review

1.1 Introduction

This literature review focuses upon the health of prisoners and their experiences of healthcare. It considers current literature connected to the prisoner group. This review is structured around two major sections. The first relates to the empirical research and the second with policy and the grey literature focusing upon a public health perspective.

In this review the terms “prisoners”, “offenders”, “inmates” or “patients,” will be included depending upon the context (prison, healthcare facility, or the outside community). Health care professionals are referred to as “health care workers” or “health care staff,” though specific positions identified within the category include “doctors” and “nurses,” which includes nursing staff of all grades registered and unregistered and “providers,” which includes the health boards, primary care health care trusts and third sector healthcare organisations. Finally, “staff” refers to all non-inmate personnel working in the prison, especially custody and health care staff. Custody staff refers to prison officers of all grades and healthcare staff refers to Doctors, nursing staff and all those belonging to professions allied to health such as, for example, physiotherapists and podiatrists.

This review defines health as stated in the Ottawa Charter for Health Promotion (World Health Organisation 1986), which identifies health as more than the absence of illness and disease:

“Health is created and lived by people within the settings of their everyday life; where they learn, work, play and love. Health is created by caring for oneself and others, by being able to tackle decisions and have control over one’s life circumstances, and by ensuring that the

society one lives in creates the conditions that allow the attainment of health by all its members.“ (World Health Organisation 1986, p.4)

This definition has been selected because it aligns with the Scottish Government healthcare improvement policy, Better Health, Better Care (Scottish Government 2007a). Furthermore, since prisoners are kept in a closed environment that affects health, it is important for the prison setting (Prison Reform Trust 2010). The experience of choice by patients in prison has been the subject of debate (Mol 2008), where the notion of freedom of choice sits awkwardly within the institutional prison environment, that is, assertion of their agency in an institution that seeks to remove it (Goffman 1958). As a result, prisoners' ability to control and choose a lifestyle that promotes health is severely constrained by the prison regime and routine.

The Scottish prison population on June 30 2017 was 7466 (Scottish Prison Service 2017). This remains high in relation to the current capacity of 7,840. It is interesting that the prison population appears to be slowly decreasing when it had been projected that the daily prison population in Scotland would increase to an annual average of 9,500 by 2020-21. However, prison population figures fail to fully illustrate the public health impact of prison health. In 2007, Dr Andrew Fraser states, “In any one year, over 23,000 individuals are prisoners in Scottish prisons. The Scottish Prison Service information system contains records for over 100,000 prisoners, most of them Scottish residents. On that basis, 2% of the Scottish population have been prisoners at some point in the past 12 years.”(Graham 2007, p.ii). This illustrates that prison healthcare has a much wider public health function far outwith the resident prison population. It is, therefore, of interest from a public health perspective that the prisoner healthcare framework being delivered by the NHS/SPS partnership is

successful. These statistics, bearing in mind the wider public health provision, illustrate that the present prison and healthcare infrastructure may struggle to accommodate the growing numbers of people being imprisoned should these projections prove to be accurate. In order to fulfil the aims highlighted in Scottish Government policy, it is imperative that the voice of the consumers as stakeholders in their own health are given a voice. In this case, this involves the experiences and voices of offenders. This review was performed in order to establish research, in which offender experiences had been explored.

1.2 Literature search strategy

A systematic review is a type of literature review that collects and critically analyses multiple research studies or papers. In this study, a literature review was performed using the principles of the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA; (Liberati et al. 2009).

The literature review aimed to identify recent research studies, since 1974, with regard to prisoners' experiences of healthcare in prison and the community. Studies in the grey literature, for example unpublished theses and government reports, were included. A number of databases were searched via Summon (Appendix A) and EBSCOhost (CINAHL, Emabase, Medline and PsychINFO). The search terms used in SUMMON are contained within Appendix B. Search terms used in ESBCO host utilised truncation and wildcard symbols to ensure that all permutations of the terms were included (Appendix B). UK and Scottish Government, NHS, SPS and WHO websites were searched (Appendix A) for relevant policy and guidance documents related to prisoner healthcare provision.

Reference lists from identified studies were searched manually to locate any further papers. Titles and abstracts were reviewed and full text versions of papers were obtained for descriptions of potentially relevant studies. Searches were performed from January 1974 to July 2015.

1.2.1 Inclusion and exclusion criteria.

To be included in the literature review, the article had to describe an account of a study that explored prisoner/patient experiences of healthcare within the prison environment or post liberation in the community. The quality of the literature was assessed using the inclusion criteria listed in Table 1. Articles were all from peer reviewed journals, with primary qualitative/quantitative studies dealing with prisoner/ex-prisoner experiences in prison and the community holding most weight. Government policy and guidance documents related to the major changes in provision were also included in the overall search.

The inclusion and exclusion criteria are listed in Table 1.

Table 1. Parameters and inclusion/exclusion criteria for literature review.

Parameter	Inclusion criteria	Exclusion criteria
Population	Prisoner healthcare and/or patients aged 18+ years Studies about prisoner experiences and/or perceptions	General hospital and/or staff Studies about children, adolescents
Setting	Prisons and/or healthcare in community for ex-prisoners	Studies solely based in general hospitals
Focus	Studies focussing on patient experiences	Studies that do not consider patients experiences and/or perceptions.
Study type	Primary research Quantitative and/or qualitative studies Policy or Guidance documents	Opinions, newspaper articles, book reviews, literature reviews.
Language	English language	Not written in English

From the table above; papers from health, psychological and sociological sources from quantitative and qualitative research studies were included. Reports, policy and guidance documents were also included and obtained from government organisations. The search was limited from 1974 to 2015. This ensured that that it covered the period since the UN declared Principle 9 (The United Nations. 1990) stating that prisoners should receive the same healthcare as the rest of the population.[1]

[1] However, on a practical note, these were also the oldest archived documents that could be accessed via the EMBASE database. The search included international peer reviewed literature published in English as well as studies from other countries for the purpose of cross comparison.

1.2.2 Results

Initially, SUMMON and ESBCO host searches yielded over 48000 hits. However, after all the exclusion criteria, outlined in Table 1, had been applied, a total of 577 records were identified. Searches of the grey literature yielded 30 records. A total of 603 remained after removal of duplicates and non-English records. Abstracts were printed then reviewed. After applying the inclusion and exclusion criteria (Table 1) a total of 24 articles remained that were “prisoner experience of health and healthcare research” related.

The flow diagram in Figure 1 shows the numbers of papers following removal of duplicates and the application of the inclusion/exclusion criteria contained in Table 1.

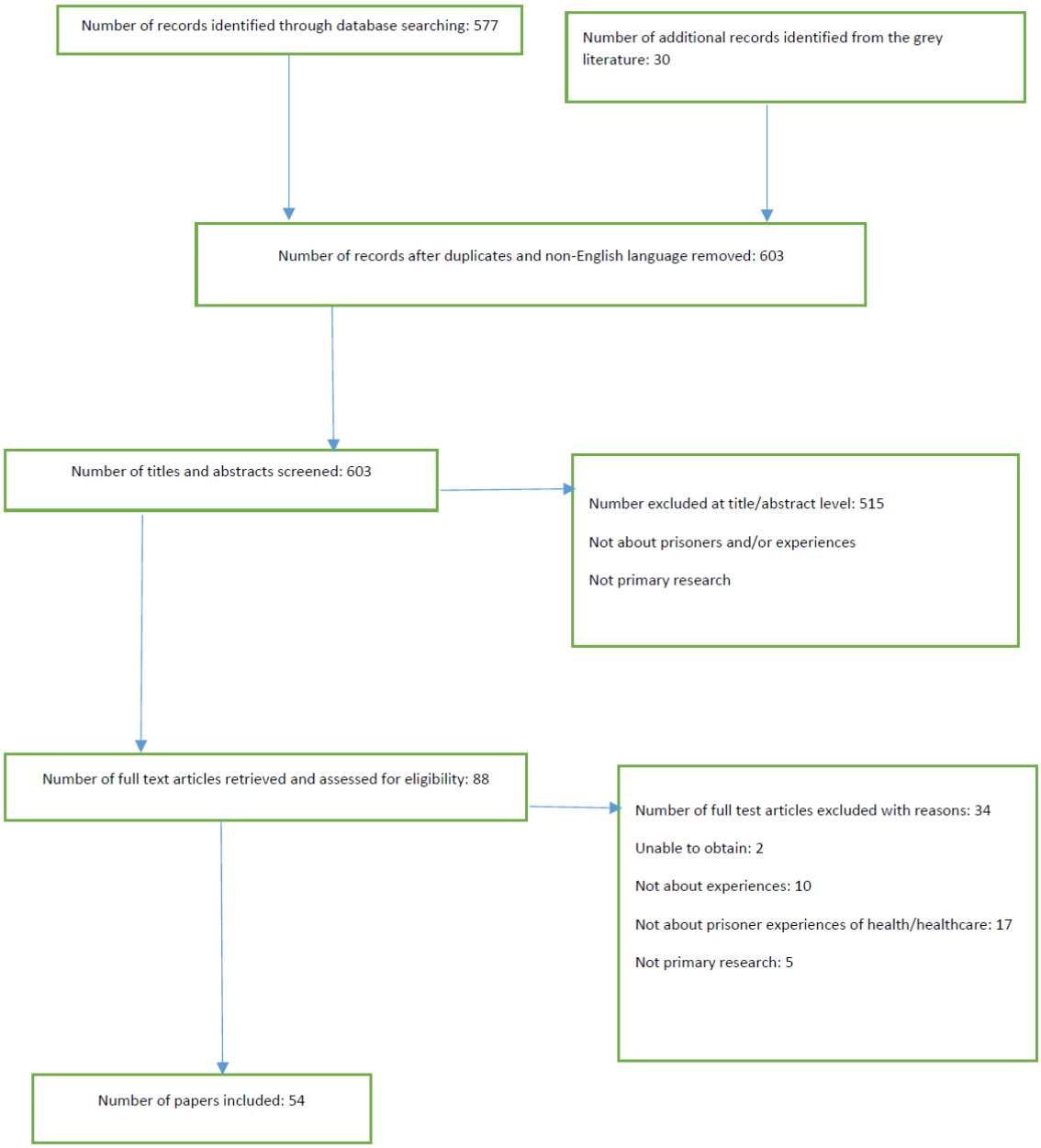

Figure 1. Flow diagram of literature search

1.2.3 Discussion

The literature review identified existing research that had explored prisoners' experiences of healthcare. Of the 54 papers identified from the literature search, 24 research papers including 30 from the grey literature have been identified. Twenty-one papers described qualitative research that explored the healthcare experiences of prisoners while in the prison environment using semi-structured interviews. Two papers described quantitative surveys of prisoners' attitudes towards their healthcare and one paper described a mixed methodology. Sample sizes in the studies varied in size from one to 1454 participants depending upon the study design and aims.

Nineteen papers described research that had been performed within the prison environment, two wholly within the community and three in prison with follow up on liberation. Three papers described research that had looked at patient perspectives before and after their liberation from prison. The first considered HIV care after release from prison (Haley et al. 2014). The second paper looked closely at the mental health of male offenders and examined their behaviours when seeking help for their mental distress (Howerton et al. 2007) and the third, the resettlement needs of female prisoners (Samele and Keil 2009). Studies were conducted in Canada (n=2), Norway (n=2), UK (n=12), and the USA (n=7). There was one study from Spain. A table containing more attributes of the 24 research papers are contained within Table 4 (Appendix C).

The study by Plugge et al. (2008) produced two papers; one that focussed on women prisoners experiences of primary care and the other with their concepts of health and illness. Condon et al.(2007) produced two papers from their study dealing with users' views of prison health services and prisoners' views on making healthy choices in prison.

The studies by Howerton et al. (2007) and Burnett et al. (2009) were developed in partnership with a voluntary sector organization providing services to ex-offenders with mental health problems. The sample of participants and methods used for data collection were the same, however the analysis and focus of the results differed for each; Howerton et al.(2007) focussing on understanding help seeking behaviours among male offenders while Burnett et al. explored their prospects.

Similarly, the studies by Nesset et al.(2011) and Bjorngaard et al. (2009) appear to have been conducted concurrently using the same samples of participants and quantitative data collection tool. The focus and statistical analysis of data have differed according to the aims of each study.

The paper by Small (2006) was an analysis and commentary of a case study presented by Venters, Razvi, Tobia and Drucker (2006) that described the healthcare experiences and court case of a Scott Ortiz, who was convicted of burglary in 2005, taken from public trial and sentencing transcripts.

The findings of the studies tended to focus on specific diseases or service provision for specific groups, for example those with mental illness or blood borne viruses. Mental illness was the subject of a study by Jordan (2012), which focuses on prisoners' narratives discussing the mental healthcare provided by the NHS in one prison. This case study utilised qualitative semi-structured interviews conducted with male prisoners in a Category B prison. The participants were also users of the mental health services. The author argues that the prison environment is not beneficial to mental health and healthcare. The clinician–patient relationship and patients' opinions regarding the mental healthcare received are discussed along with the concepts of understanding, care, trust, flexibility, cooperation,

conversation, relaxation, enjoyment and patient power. The overall conclusion from this study was that the prison atmosphere and the routine mechanics of the daily routine have a negative impact upon mental health and the delivery of mental healthcare.

HIV was the focus of studies by Scheyett, Hailey et al. (2009) Lichtenstein (2000), Haley et al. (2014) and Small et al. (2009). The first of these studies by Scheyett et al (2009) explored the role of social support in HIV prisoners' expectations of release and liberation plans. Although this study was primarily concerned with social support, this still has an impact upon health as the participants were all seeking a healthier lifestyle that did not include drugs and which would help them deal with their HIV status. This was a qualitative sub-study of a larger National Institute on Drug Abuse (NIDA) funded study. Interview data from 23 participants were collected from August 2005 to January 2006 using semi-structured interviews based on grounded theory methodology. It was found that participants reported concerns about their ability to access needed formal and informal social support upon liberation with many finding it difficult to access any form of support.

A study by Lichtenstein (2000) explored the dynamics of HIV risk using focus group interviews of male and female adolescents at an Alabama juvenile facility and interviews with HIV positive and negative adults in Alabama institutions. The interviews reflected that unprotected sex with multiple partners was a common risk activity for male and female adolescents with a related high risk of sexually transmitted disease. The adolescents were averse to using condoms and lacked knowledge regarding the transmission of HIV. Bisexual males who engaged in same sex prostitution for money or drugs viewed female partners as the source of HIV infection. Illicit drug activity and high risk sexual behaviour were strongly linked to economic and status issues. Experiences of healthcare were often coercive or were

undermined by negative perceptions of healthcare professionals. These perceptions could lead to avoidance with lack of access to healthcare compounded by the existing high risk of sexually transmitted disease for this group of adolescents.

Small et al. (2009) explored helping and hindering factors of HIV treatment adherence in a Canadian prison. They sought to evaluate experiences with highly active antiretroviral therapy (HAART) among HIV positive intravenous drug users who had been recently imprisoned in British Columbia in order to identify factors influencing adherence to treatment. Twelve in depth interviews were conducted with males recruited from another study involving over 450 HIV positive intravenous drug users. All the participants had been imprisoned after commencing HAART. Participant accounts described situations where adherence to HIV treatment was compromised in custody. A small number of participants reported treatment interruptions that lasted over a week when they were unable to obtain HIV medications through institutional healthcare. Short term interruptions in treatment were stated to be common during intake into the prison system and at the point of release. High levels of HIV discrimination motivate prisoners to hide the fact that they are HIV positive by making efforts to take medications discreetly, which may result in missed dosages. The authors concluded that the study identified contextual factors within prison environments that hinder individuals' ability to adhere to HAART. Their findings indicated that improved health services and coordination with community care providers was needed to enhance the quality of HIV treatment within prison.

This was reiterated in the findings in the study by Haley et al. (2014). They conducted semi-structured interviews (24 in prison and 13 upon liberation) with HIV infected offenders who had enrolled in a randomised controlled trial of a case management intervention to

enhance post-release links to care. A grounded theory methodology was adopted and a thematic analysis performed on the data. Most of the participants were heterosexual with a history of drug abuse. The sub-study participants, who were in prison at the time of the study, were more likely to anticipate living with family/friends and needing income assistance post-release. Most were taking antiretroviral medication prior to release and anticipated needing help securing health benefits and medications post-release. Before release, most participants felt confident they would be able to manage their HIV. However, upon release, many experienced intermittent or prolonged periods of antiretroviral non-adherence, largely due to substance use relapse or delays in care initiation. Substance use was precipitated by stressful life experiences, including stigma, and contact with drug using social networks. Findings illustrated the reciprocal relationships among substance use, experiences of stigma, pre- and post-release environments and skills needed to engage in HIV care. The authors concluded that the findings of the study emphasised the need for comprehensive evidence based interventions to prepare prisoners for the transition from imprisonment to liberty, particularly those that strengthen links to HIV care and focus on the realities of re-entry, including stigma, meeting basic needs, preventing substance abuse and identifying community resources.

Binswanger et al. (2011) explored the healthcare experiences of those recently released from prison in the USA and concluded that there was poor preparation and continuity of healthcare services. The objective of their study was to understand the health-seeking experiences, perceptions of risk, and medical and mental health needs of former prisoners in the first two months after release from prison. Participants were 29 former inmates within the first two months after their release from prison to the Denver, Colorado area.

Using qualitative methods, trained interviewers conducted individual, in-person, semi-structured interviews exploring participants' experiences with health, mental health, and health care since release. Interview transcripts were coded and analysed utilising a team-based approach to inductive analysis. It was found that health-related behaviour occurred in the context of a complex life experience, with logistical problems exacerbated by emotional distress. Former inmates reported multiple challenges, poor transitional preparation preceding release, and inadequate or absent continuity of mental and physical health care in the context of significant emotional distress and anxiety. It was concluded that improved release planning, coordination between the medical, mental health and criminal justice systems may reduce the risk of poor health outcomes for this population.

Drug use in prison was the focus of studies by Small et al (2005), Small (2006) and Tompkins et al (2007). Small et al (2005) explored the experiences of prisoners injecting drugs in a Canadian prison. The goal of this research was to qualitatively examine HIV risk associated with injecting inside British Columbia prisons. A sample of 26 former male inmates who had recently used drugs within prison was recruited from an ongoing cohort study of injection drug users in Vancouver, Canada. Data for this study were collected through in-depth interviews conducted in 2001/2002. Analysis of these data involved the identification of emergent themes and an exploration of these central concepts in further interviews to confirm the accuracy of interpretation. The authors found that the harms normally associated with drug addiction, and injection drug use, are exacerbated in prison. Interpersonal relationships and the possession of exchangeable resources determine access to scarce syringes. The scarcity of syringes has resulted in patterns of sharing amongst large numbers of persons. Continual reuse of syringes poses serious health hazards and the

distribution of bleach to sterilise them is an inadequate solution. The results of this study emphasised the need for effective harm reduction programs that provide an appropriate response to the problem of injection drug use among inmates and the authors concluded that more harm reduction strategies were required in prison to prevent further health problems for the population.

Small (2006) reports on a case study originally presented by Venters, Razvi, Tobia and Drucker (2006), which describes an unfortunate set of events pertaining to an individual's experience as they were failed by several systems all at once and neglected for having had experience with an addiction. The case study describes how bias against the former injection drug user, masquerading as concern for public health, is used to justify a lengthier sentence. Mr. Ortiz's lack of awareness of his Hepatitis C infection despite long term incarceration, combined with the justification (protection of the public from a former drug user) for his dramatically increased sentence from 2-4 years to 15 years, provide examples of how persons within the criminal justice system may face particular challenges to their health. Small's commentary provides some remarks on the case study with respect to differing institutional narratives as they pertain to experience in the context of everyday life. It is suggested that, in the special case of addiction, the mistreatment of the subject of the case study, Mr. Ortiz, is not an exception to the norm, but the norm itself for people living with addictions and their families.

This was reiterated by a study by Tompkins et al (2007). In this study, interviews with 51 injecting drug users focused on the experiences of drug related care and treatment in prison. Accounts of prison drug treatment experiences provided insights into drug treatment in English prisons. The participants' accounts provided a historical perspective,

many of which reflected the different practices of different prisons, prison staff and the changes in policy and practice that have occurred in recent years. Several experiences were discussed including issues that affected levels of drug use inside prisons, their receipt of care, support and treatment in prison including prescribing policies, illicit drug availability and prison staff attitudes. While negative experiences of prison and drug treatment prevailed, users identified that policy and practice changes had positively influenced healthcare provision for drug users in prison. Drug users often viewed prison as an opportunity to detoxify and contemplate their drug use. The authors concluded that there were many opportunities for improvement of the healthcare of injecting drug users within the UK prison system, particularly the provision of opiate maintenance therapy and chance to detoxify and contemplate their drug use.

A quantitative study by Nesset et al (2011) aimed to investigate prisoners' use of health service by utilising a cross-sectional study of 29 prisons in central and southern parts of Norway. A questionnaire was distributed to 1454 prisoners. A 90% response rate was achieved. Multilevel analyses were employed to analyse help seeking behaviour among the prisoners. The results revealed that help seeking was substantially associated with sleep problems and drug problems. There was evidence that closed prisons as well as high staffing levels of healthcare professionals were associated with elevated health care use. The authors concluded that sleep problems and drug use are those most frequently associated with health service use and that the differences between prisons suggested that the implementation of prison health care standards should be addressed.

Jennings (2009) study explored four areas related to the health and healthcare services available for the older age prison population.

1. How changes in a prisoner's personal health and functional status influenced the healthcare process.

2. How family relationship awareness and involvement affected prisoner health and healthcare.

3. The influence of policy on prisoner health and healthcare and

4. The influence of societal discourse on prisoner health.

Face to face interviews were conducted with sixteen participants. Four were between the ages of 50 and 90 years of age and had served part of their sentence within Alabama's only prison designed for the older age prisoner. The other 12 participants were prison staff, medical personnel, family members' church and community volunteers. This study highlighted that the health and healthcare of the older age are rarely considered within prisons, and families did not have much involvement in their healthcare process. Prisoners found the time they had to wait for healthcare to be a major source of frustration and complained at the difficulty of having to live in the overcrowded prison conditions. They had expectations of healthcare quality and delivery and were disappointed when these were not met. This study contributes to the literature on older age offenders and the understanding of experiencing health changes within prison. The study recommended that prisons be better prepared for the growing older age population.

Resettlement was also explored by Samele and Keil (2009). A sample of 27 female prisoners due for release was interviewed about the care they had received in prison and their plans for release. The interviews focused on mental health problems and care received. Attempts were made to track these prisoners after release, but only eight interviews could be

conducted at this time. There was no information available for eight of the sample after release and for the remaining eleven; information was obtained from family, friends, and agencies who had engaged with them on release. They looked at the perceived and actual needs of released female prisoners and from the interviews found that mental health, accommodation and substance misuse were significant issues upon liberation. All prisoners reported a long history of mental health problems. The problems they talked about were bipolar disorder, depression, borderline personality disorder, and deliberate self-harm. Due to the nature of the prisoners' mental health problems, most were under the care of the prison GPs. Most prisoners reported being unhappy with the length of time they had to wait for an appointment with a GP with most reporting a wait of two weeks.

Temporary accommodation was the main option for most of the prisoners being released. Twelve prisoners were staying with friends or family upon release, two had a hostel arranged, three expected to be homeless, and six were returning to their own home.

Five prisoners talked about alcohol abuse, and a further 14 about drug abuse. Continuity of substance treatment was well established for some prisoners. They had received letters from drug workers in the community, or knew their worker had been in contact with the prison counselling, assessment, referral, advice and throughcare (CARAT) team. However, even if arrangements are made for prisoners, there is no guarantee that they will engage with services on release.

Rae (2015) performed a study in order to gain a greater understanding of the perspective of the homeless about their healthcare encounters and how their experiences of receiving healthcare influenced their health-seeking behaviour. Although this study was not performed directly with offenders, it is highly relevant as many prisoners endure

homelessness before committing their crime and being imprisoned. Upon liberation, prisoners often have difficulty finding accommodation and return to a state of homelessness. The study was an interpretive phenomenological inquiry in which fourteen single homeless adults were interviewed. The interviews were semi-structured and recorded. Data analysis identified three major themes; expressed health need, healthcare experiences and attitudes to healthcare. Findings revealed that health problems are recognised by those homeless but the need for intervention was not always prioritised. Obstacles in access to health care in the UK are perceived, for example, attitudes towards the homeless. The problems can be also genuine, for example, difficulty in registering with a general practitioner, difficulty travelling to services and being forced to a new area. Some homeless people felt that they were treated with prejudice and received substandard care. However, positive experiences were also reported. The author concluded that positive and negative healthcare encounters could profoundly affect the homeless. It was recommended that there is a need to address the inconsistency of care and promote greater interdisciplinary communication between the prisons and homeless services. There is a need to increase the availability of intermediate services and a reduction of the obligation of homeless people to move from their own local area.

Two studies explored the perceptions of healthcare amongst prisoners and found that they held positive attitudes towards their imprisonment and perceived that their health improved while inside prison. The study by Yu et al. (2015) investigates inmates' perception of health status while incarcerated using a sample of 136 soon-to-be released prisoners. Structured interviews were used to explore participants living situation, medical conditions, health care coverage, and substance use prior to their incarceration. Interview questions

considered current medical conditions, self-perceived changes in health status upon incarceration, and self-rated current and previous health status. Conclusions found that prisoners with poor health perception prior to their incarceration were most likely to perceive health improvement. Sociodemographic characteristics were generally not associated with the perceived health improvement during incarceration. Analysis results suggest prisons may play a vital role in delivering vital medical care to a segment of the prisoner population, including determining how they feel about their health. It is important to explore the policies and practices to increase continuity of health care following release to maintain perceived health improvement. Burnett et al (2009) also found that prisoners held a deep distrust of healthcare staff. In their study, they performed thirty-five in-depth, face-to-face interviews with sentenced male prisoners shortly before their release from prison. All but two of them had been incarcerated on at least one prior occasion, and had served an average of five previous prison sentences. A quarter of them had been flagged by the prison staff as being at risk for suicide or self-harm. Although the principal objective in setting up the study was to explore the factors that influence help-seeking for mental distress, the participants answered more generally about their problems, concerns, and expectations on leaving prison. Fifty-four percent of them were re-interviewed four to six weeks following their discharge date. While most faced multiple social problems, a dominant theme in their accounts was positive thinking about imprisonment combined with fatalism about coping with obstacles such as homelessness or substance addictions, and distrust of ‘‘helping’’ professionals.

This distrust was also found in the study by Howerton et al (2007) while exploring the help seeking behaviours for mental distress amongst male offenders. The study was based on in

depth interviews with prisoners before and after release from a category B prison in southern England. Most participants reported that they would not seek help form a general practitioner or other healthcare professional if experiencing mental distress. When followed up after release, none had sought medical help despite the fact that many had considerable emotional problems. Many participants were hesitant to seek help because they feared being given a formal diagnosis of mental illness. Some of the men feared the stigma that such a diagnosis would bring, whereas others feared that a diagnosis would mean having to confront the problem. Lack of trust emerged as the most prominent theme in prisoners' accounts about not seeking help from health professionals. Distrust towards the "system" and authority figures in general was linked to adverse childhood experiences. Distrust directed at healthcare professionals was often expressed as specific negative beliefs. Many perceived that health professionals "just don't care", "just want to medicate" and treat patients' superficially. Those men who would consider going to a general practitioner reported positive previous experiences of being respected and listened to. The authors concluded that distrust is a major barrier to accessing health care among offenders.

The aim of a study by Bjorngaard et al (2009) was to investigate patient satisfaction with prison health services in Norway and to analyse possible patient and service effects. A quantitative prisoner health satisfaction survey took part in 29 prisons in the southern and central part of Norway, representing 62% of the total prison capacity. A total of 1,150 prison inmates with prison health services experiences completed a satisfaction questionnaire. The patients' satisfaction was measured on a 12-item index. Results revealed high levels of dissatisfaction with prison health services dealing with mental health and sleeping difficulties. Dissatisfaction with services appeared to centre on the lack of specialist

provision for those with mental health issues. It was suggested that dissatisfaction with sleeping difficulties might be connected with the services' reluctance to prescribe sleep inducing medication. Satisfaction was significantly associated with a senior staff member's evaluation of the health services possessing adequate resources and the quality of drug abuse treatment. At the patient level, satisfaction was significantly associated with older age, frequent consultations and better self-perceived health. The authors concluded that the prison inmates' satisfaction with health services provided are low compared with patient satisfaction measured in other health areas and that the differences observed between services indicated a potential for quality improvement. However, the usefulness of these findings is limited as findings from another country are only valuable in the context of gaining a stronger understanding of their health system. Given that my study is exploring the experiences of men in the Scottish healthcare system, then findings from Norway, although interesting, are of limited value.

Plugge et al. (2008), in their qualitative study, explored women prisoners' experiences of primary healthcare provision in prison using focus groups and interviews in two women's prisons in southern England. Six focus groups involving 37 women were conducted as well as 12 semi-structured individual interviews. The groups and interviews were recorded, transcribed and thematically analysed. The results showed that women prisoners' perceptions of the quality of prison health care were mixed. There were accounts of good care where practitioners were regarded as knowledgeable and respectful but many perceived that the quality of care was poor. They complained about difficulties with the application process and gatekeeping, by nurses, in accessing care and medication. The disrespectful treatment due to the uncaring attitudes of primary care staff were also

reported. Breaches of confidentiality by care staff were also a source of concern and complaint. They voiced the belief that staff-were less qualified and competent than their counterparts in the community. The authors concluded that the prison environment presents unique challenges to those providing healthcare and that a lot has been done to modernise and improve professional standards of practice in prison. However, the accounts of women prisoners in this study suggested that there is a gap between patient experience and policy aspirations.

While performing the above study the authors (Plugge, Douglas and Fitzpatrick 2008) also explored women prisoners' perceptions of health and illness to consider the extent to which they differed from those of lay people. Data was obtained from the same sample of participants. They spoke about their views of health and what it was to be healthy. Women prisoners' concepts of health and well-being were similar to those of lay people in that participants viewed health as being related to an individual's actions such as what they ate and whether or not they exercised or took drugs. Participants also demonstrated a good understanding of the key health issues faced by women prisoners, for example, taking illicit drugs and the associated treatment, mental health, self-harm and the difficulties with sleeping in the prison environment. The authors concluded that this group had much to contribute to the research process and researchers should attempt to overcome the existing barriers in order to involve prisoners more fully in line with UK Government policy.

Condon et al. (2007) conducted a study exploring users' views of prison health services. Semi-structured interviews were performed with 111 prisoners selected from 12 English prisons in 2005. The interviews covered the prisoners' views of health services and their own ways of caring for their health in prison. Prisoners considered health services part of a

personal prison journey, which began at imprisonment and ended upon liberation. For those that did not access health services outside prison, imprisonment improved access to both mental and physical health services. Prisoners' identified that accessing services, confidentiality and being seen as a legitimate patient and living with a chronic condition were problems within the prison healthcare system. The authors concluded that a lack of autonomy is a major obstacle to ensuring that prisoners' health needs are fully met. Prisoners' views should be considered and taken into account when planning, organising and delivering prison health services. They also recommended that further research be conducted to examine how nurses can provide joined-up health care for prisoners.

Condon et al. (2008), while conducting the previous study, also conducted a study that explored the views of prisoners on making healthy choices in prison. In their results, they found that all the priority areas of *Choosing Health* were relevant to the self-identified health needs of prisoners. These priorities were:

1. Reducing smoking
2. Reducing obesity and improving diet and nutrition
3. Increasing exercise
4. Encouraging sensible drinking of alcohol
5. Improving sexual health
6. Improving mental health

Opportunities to make healthy choices varied between prisons, particularly in relation to diet, exercise and access to smoking cessation support. This appeared to be in keeping with the degree to which individual prisons prioritized promoting prisoners' health while serving their sentence. Similar to the wider community, prisons appear to be dedicated to impose

measures to reduce smoking, while reluctant to taking proactive strategies to promote healthier eating. Condon et al. found that with regard to diet and exercise there appeared to be inequalities between prisons, in terms of the opportunities provided for prisons to maintain and improve health between different categories of prisoners. Older age prisoners appeared to be particularly disadvantaged in terms of access to exercise, unless specific measures were taken to include them. Alcohol misuse was considered insufficiently addressed in prison. In conclusion, while imprisonment offers prisoners an opportunity to access health promotion services, in the priority areas identified in *Choosing Health* prisoners are often prevented from making healthy choices within the prison setting. Barriers exist which limit the ability of prisoners to maintain and improve their health.

De Viggiani (2007) explored the structural determinants of prison health in an English Prison. He argues that prisoner health is influenced as much by structural determinants (institutional, environmental, political, economic and social) as it is by physical and mental constitutions of prisoners themselves. Sykes (1958) argued that prison deprives people of key rights and possessions, such as liberty, goods and services, relationships, security and autonomy. These losses bring pain and hardship and compromise their identity, self-worth and esteem. Sykes (1958) wrote that prisoners' response to imprisonment was that their self-worth and image of themselves as a person of value wavers and diminishes. However, Jewkes (2002) added that prisoners engage in many behaviours to put on a front to others to prevent themselves from being exploited while simultaneously maintaining a private "pre-prison" sense of self and a public persona that is presented to others.

De Viggiani argues that prison health may be better understood with a greater insight into how people respond to imprisonment – the psychological pressures of incarceration, the

social world of prison, being dislocated from society, and the impact of the institution itself with its regime and architecture. His ethnographic study was conducted in an adult male training prison in England, using participant observation, group interviewing, and one-to-one semi-structured interviews with prisoners and prison officers. The paper explores how different layers of prison life impact on the health of prisoners. Prisoners commented on the differences in prison regime and that the actual rules of a prison may differ from the official rules. They observed that the initial reception into the prison and induction period thereafter were bureaucratic and disempowering. This was seen to represent an authoritarian system of control that stifled prisoners' potential for rehabilitation. Prisoners were locked up for long periods and study participants felt that there was little opportunity for any useful activity in prison such as a job or education. This resulted in them describing their experiences of imprisonment as "jail mode" or living in a "dream world." Participants also commented that there was no collaboration between prisoners and prison officers or healthcare staff. Prisoners also perceived that the attitudes displayed by prison officers and healthcare staff showed that they had no interest in the health and welfare of prisoners.

Having presented his findings, De Viggiani concludes by arguing that health inequalities are enmeshed within the workings of the prison system itself. Interestingly, this was an ethnographic study performed in a category C prison in England, which had a capacity of approximately 500 prisoners serving sentences ranging from a few weeks up to a year. It would be impossible to replicate this ethnographic study in Scotland, as there are not different categories of prison, category A, B, C, etc. according to security risk. Instead, the security level of each prisoner is assessed as high medium or low. Prisoners can then be placed in any of the SPS estates, which are all closed conditions except the one open prison

at HMP Castle Huntly. The result of this is that each of the prison populations within Scotland can vary, comprising of those on remand to those convicted and serving life sentences.

A study by Hassan et al (2012) explored prisoners' views of holding their own medication in prison and concluded that risk management needs development within the prison. Traditionally, medication in prison has been administered in single, supervised doses. However, prisons in England and Wales have now been encouraged to allow prisoners to hold and manage their own medication themselves as 'in-possession' medication, in line with community practices. The authors aimed to examine the range of policies and practices used to manage in-possession medication in prisons, and to explore staff and patient perspectives. A mixed methods design was selected with questionnaires sent to all prisons throughout England and Wales in 2008, and follow-up interviews completed with 68 staff and 24 patients at 12 prisons. The results showed that in-possession medication was permitted to some degree within all prisons. Interviewees identified its principal benefit in terms of empowerment. Empowerment was viewed as the benefit of increasing the availability of medication. Giving patients the responsibility for when and how to take their medication was portrayed as a way of encouraging greater independence, personal responsibility and control over their use, ultimately leading to improved health. However, participants acknowledged the need to minimise health and security risks associated with prisoners possessing their medication in prison. Structured methods of risk assessment were used in prisons, although the content and structure varied widely between them. The conclusion was that there is still some way to go before in-possession medication policies are fully embraced in prisons. Staff and patients recognise its benefits, but some remain

uneasy around the perceived risks. Risk management processes in some establishments may still require development.

The studies by Condon et al. (2007), Plugge, Douglas et al. (2008) and Jordan (2012), 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.

As a result, of this literature review, it has been identified that there are few studies in the literature about male prisoners' own views about their involvement in health services. It would appear from the literature review that prisoners 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.

The majority of work is specific to the medical discipline (Plugge, Douglas and Fitzpatrick 2008, Condon et al. 2007, Nesset et al. 2011, Bjørngaard, Rustad and Kjelsberg 2009) or disease specific (Haley et al. 2014, Lichtenstein 2000, Scheyett et al. 2009, Small et al. 2009). However, studies such as those by Condon et al. (2007) and De Viggiani (2007) have looked at patient experiences of healthcare overall.

Prison health research can focus on different areas and perspectives. For example, studies can focus on aetiology versus treatment outcomes or prisoners' experiences of physical and mental health problems in prison. However, healthcare is a common theme throughout. The studies found in the literature review have shown that men who have been in prison

encounter many problems in accessing and using healthcare services in prison and the community.

Prisoner health has been studied by a number of researchers and has been diverse in nature. The literature has focussed on health issues such as offenders' attitudes towards health/illness and wellbeing, mental health, maintaining and improving health, family and supportive relationships, drug use/treatments and sexual behaviour whilst in the prison environment. Yu (2015) explored prisoners perceptions of health as a result of imprisonment and the structures of prison health care were explored by De Viggiani (2007) and Hassan (2012). However, a number of health issues such as dental health, vaccinations, suicide and self-harm, alcohol, gambling, smoking, tattooing or body piercing do not appear to have been researched from the offenders' perspective.

The vast majority of studies were performed within the prison environment and have looked at primary care provided by doctors and nurses, mental health or addiction services. However, three studies interviewed offenders about their experiences inside and outside of the prison; Samele and Keil (2009) looked at the resettlement needs of women offenders in the UK, Howerton et al. (2007) explored the help seeking behaviour in men in UK and Haley et al. (2014) studied the care given to those with HIV after liberation in the USA. Two studies focused upon the liberation period within the community; Binswanger et al. (2011) looked at the health experiences of those men recently liberated in the USA and Rae (2015) explored the perceptions and experiences of healthcare of the homeless in the UK. No studies exploring offender experiences of healthcare have been performed in the UK since 2012. None of the studies outlined in the review explored the offenders' use and experience

of other health services such as dentist, optician, chiropody and physiotherapy in the prison or community. These have been explored in this study.

A strength of this study is that the literature review has not just examined empirical literature but has also included sources from the grey literature which are utilised in the next section that deals with the policy literature review, which examines and discusses the healthcare provision that should be provided for prisoners and ex-prisoners in Scotland.

This study makes a contribution to the general debate of healthcare provision for offenders within not only the prison environment but also regarding the continuity of their care upon liberation. There have been few non-institution based studies within the UK that have explored healthcare services for male offenders using their first-hand experiences. As a result, given the lack of first-hand NHS, imprisoned or liberated patient literature helps justify the present study being conducted.

1.3 Theoretical Framework for Policy Literature Review

The approach to public health within prisons is published in *Health Promoting Prisons: a shared approach* (Department of Health 2002). Together with the documents, Prison Service Order 3200 - Health Promotion (HMP Prison Service 2004) and *Better health, better lives for prisoners* - the framework for improving the health of Scotland's prisoners (Brutus et al. 2012), a Public Health Policy framework for prisoners is evident. This framework is based upon the key issues of the public health agenda, health promotion and education, the prevention of disease, healthy settings and the impact on prisoner health. These issues have been chosen to form the framework for organising the literature.

1.3.1 Public Health Agenda

Public Health is conceptualised as a pursuit that addresses health inequalities and targets resources appropriately (Department of Health 2002). It also reflects the Governments approach to ensuring the health of the country. As a result, public health incorporates political, ethical and practical aspects.

For patients in prison, the political focus on improving their health has been relevant. For Scotland's prisoners, the transfer of responsibility for primary healthcare in prison from the SPS to NHS in November 2011 represents a crucial point. From this time, services should have been commissioned on an equitable basis (Scottish Government 2007a). This means providing care that does not vary in quality because of personal characteristics such as gender, ethnicity, geographic location or socio-economic status. Scottish Government policies, recommendations and action plans will be referred to in this chapter, which aim to

provide prisoners with access to health services broadly equitable with those of the general public as well as improving the health of Scotland's prisoners.

It is difficult to define how health equity is quantified. For Braveman and Gruskin (2003) it is the decrease of social disadvantages in the population. Whitehead's (1991) call for scrutiny of the rates of use by different groups in order to draw attention to social injustice could be valuable. It was argued that a person's opportunities were enabled by way of a process based on need rather than social influence (Whitehead 1991). However, the Department of Public Health and Epidemiology (2000) found confusion between the services people needed and wanted, which suggested an error in Whitehead's (1991) proposition.

When the NHS Primary Care Trusts (PCTs) took on the responsibility for prisoner healthcare, they had a considerable challenge due to lack of specific service user data. Some useful information was available, as Lesley Graham (2007) had performed a health care needs assessment for the SPS. She looked at the epidemiology of prisoner health within the SPS, health services and interventions delivered and the human and physical resources provided to achieve these interventions. This report finished by making a number of recommendations for future service planning and provision. These concerned alcohol, tobacco and drug use, blood borne viruses testing and treatment, asthma, diabetes and epilepsy care, coronary heart disease, accidents and injuries, sexual health, dental health and mental health. Although this information was already four years old when the NHS took over responsibility for primary prison healthcare it will have been useful to NHS Scotland in service planning as it highlighted the main areas of healthcare need within the prison environment. However, Graham also stated that there was limited communication with

prisoners on health service provision and of prisoner involvement in health promotion and self-care. As a result, it was recommended that service planners should seek patient views by the use of patient groups, surveys, etc. and that these should be linked to health promotion initiatives.

In "*Understanding help seeking behaviours among male offenders: a qualitative study*," (Howerton et al. 2007) conducted interviews with male prisoners in a male Category B prison in England. Distrust towards the healthcare system appeared as the most visible theme. As a result, many prisoners had not accessed healthcare before imprisonment (Howerton et al. 2007). This study was one of the few identified, in which participant interviews were performed before and after liberation in order to explore their experience of transition from prison into the community, experiences of mental distress, and specific barriers to use of health services. This also allowed participants to speak, free of the restraints of the prison system. Participants' perceptions and negative experiences with healthcare professionals led to a distrust in healthcare services and a deep belief that health professionals did not care about them continued beyond the prison walls.

Prison healthcare services were accepted as being poor in relation to the general population (Lord Ramsbotham HM Chief Inspector of Prisons for England and Wales 1996). However, although prison created considerable challenges to health promotion and treatment, it presented a unique chance to treat this group (Department of Health 2002) as prison provides a suitable site for health interventions. Macdonald (2006) highlighted that prisoners' did not use healthcare before imprisonment and that prison could be valuable in improving the health of young offenders. MacDonald's (2006) work consisted of a literature review of epidemiological and cross-sectional studies related to the health needs of young

offenders. Although this presented an appraisal of a wide body of prison health related literature, an exploration of the young peoples' own perceptions of how they viewed their health experiences was essentially missing.

Condon et al. (2007) analysed 111 semi-structured interviews with prisoners in 12 English prisons in order to develop a conceptual framework. Prisoners considered that health services were part of a personal journey within prison. This began when sentenced and imprisoned and ended upon liberation. For those that did not access services in the community, prison improved their access to health services. However, the organisation of the prison could clash with ideal health care. From the findings, it appeared that the group who suffered most in prison were those with chronic conditions. This was most visible when there was a need for specific care needs such as a special diet, equipment or better access to showers and this differed from the general prison regime. The prison setting has been found to directly affect prisoners' health. Massoglia (2008) used data from the National Longitudinal Survey of Youth to establish that exposure to stresses and/or infectious diseases are needed in understanding the long-term effect of prison on health. It was argued that by tackling the high rates of underlying disease, prison presented an opportunity to generate health benefits in the long term.

Prison healthcare should also be considered from a different perspective, that of public health and the use of health promotion. Although health promotion is essential to prison healthcare policy, this approach to health in prison is not without criticism. Smith (2000) argued the Public Health agenda conflicted with the prison regime and the prison environment added to the ill health that many already had before prison and found that behaviour that damaged their health was used as a coping strategy. Furthermore, Smith

suggested that interest in health promotion could lead to victim blaming and marginalised groups being excluded. As a result, it could be unhealthy if they were excluded from services.

The evidence indicates prisons contain a patient population with a wide range of health and social needs. Health problems include alcohol, tobacco and drug use, blood borne viruses, asthma, diabetes and epilepsy, coronary heart disease, accidents and injuries, sexual health, dental health and mental health. These were found in the health needs assessment of the prison population in Scotland, which was performed for the SPS, by Graham (2007). The level of security people experience in prison depends upon the severity and nature of the crime they have committed. Literature relating to the impact different prisons have on prisoners' NHS healthcare experiences is rare.

The prisoners' lives before prison are important as these have an impact upon this group's health and its awareness of the requirements for healthcare services in prison. The journal literature describes the chaotic lifestyles leading up to their imprisonment, creating a situation in which it becomes difficult to access healthcare and other forms of support (Condon, Hek and Harris 2008). There are numerous accounts of poor life experiences in the literature that highlight a wide variety of health-related issues and so this would suggest that pre-existing levels of ill health are widespread in the prison population. For example, sexual and physical abuse (Moran and Peterman 1989), mental illness (Hayward, McMurran and Sellen 2008), poverty (Braveman and Gruskin 2003), learning disability (Lord Bradley 2009) homelessness and substance misuse (Fazel, Bains and Doll 2006).

The WHO highlighted inequity for different groups in society (Whitehead 2000). The author posed the question: "which health differences are inevitable – unavoidable – and

which are unnecessary and unfair?" Seven main determinants of health differentials were identified (Whitehead 2000, p.5) in an analysis of the international literature:

1. Natural, biological variation,

2. Health-damaging behaviour if freely chosen, such as participation in certain sports and pastimes,

3. The transient health advantage of one group over another when that group is first to adopt a health-promoting behaviour,

4. Health-damaging behaviour where the degree of choice of lifestyle is severely restricted,

5. Exposure to unhealthy, stressful living and working conditions,

6. Inadequate access to essential health and other public services,

7. Natural selection or health-related social mobility involving the tendency for sick people to move down the social scale.

The author argued that health differences caused by factors 1, 2, and 3 above would not normally be known as inequalities in health. However, it could be argued that prisoners are excessively included in 4, 5, 6 and 7, while inequality in their health, resulting from social injustice, is likely to be widespread.

In summary, people often enter prison with multiple mental and physical health needs as highlighted by Graham (2007). The prison can raise difficulties for prisoners to maintain their health as well as service delivery. Academic work suggests that prisoners could benefit from application of the principles of equitable healthcare in prison, meaning care that does

not vary in quality because of personal characteristics such as gender, ethnicity, geographic location or socio-economic status.

1.4 Health Promotion

The Ottawa Charter for Health Promotion was produced as a result of the first international conference on health promotion, which took place in Ottawa on 21 November 1986. Its main objective was for action to achieve good health for all by the year 2000 and beyond.

This conference was primarily a response to growing expectations for a new public health movement around the world. Discussions focused on the needs in industrialised countries, but took into account similar concerns in all other regions. The Ottawa Charter for Health Promotion highlights five priority areas for health promotion (World Health Organisation 1986). These are:

1. Build healthy public policy,

2. Create supportive environments for health,

3. Strengthen community action for health,

4. Develop personal skills,

5. Re-orient health services.

Literature has been grouped using these themes in order to examine the policy and research that has been performed in the field of prison healthcare in relation to each of the five areas above.

1.4.1 Build healthy public policy

Better Health Better Care (Scottish Government 2007a) set out the Government's plan to bring about a better public health policy. Along with the specific prison healthcare reform a clear framework was created that made the delivery of equitable healthcare to Scottish prisoners achievable. The plan stressed the mutual status of the NHS in Scotland and proposed a shift in ownership and accountability to the people of Scotland offering them an opportunity to take more control of their health. As regards prisoner health, it eventually led to the launch of 'Better Health, Better Lives for Prisoners: A framework for improving the health of Scotland's prisoners' (Brutus et al. 2012). This framework is designed to assist with the planning, commissioning and delivery of health improvement services in Scotland's prisons. With regard to planning this refers to personal health planning and offering every prisoner a simple health and wellbeing assessment and action plan during induction, on change of prison and upon liberation. These services will be commissioned by the SPS and local health boards in Scotland and delivered by prisoner health trainer, prison staff (for example, personal officer) and healthcare staff within the prison environment. Community health staff will be responsible for delivery of the services once a prisoner is liberated.

Figure 2 is a diagram showing the key elements of Scotland's prisoners' health promotion framework. This framework seeks to support the development of the 'healthy prison', and is built around 11 health promotion pillars (relating to tobacco, alcohol, illicit drugs, mental wellbeing, healthy eating/ obesity, oral health, sex and relationships, blood borne viruses, physical activity, parenting and long-term conditions). There are four unifying themes in the framework that cut across these pillars – relating to prisoner involvement, policies and environment, community and public sector links and measurable outputs and outcomes. Finally, the whole framework is supported by three foundations – including "Hope, which

underpins changes required to help prisoners and their families and their communities have a better and healthier life" (Brutus et al. 2012, p.5). The hope referred to in this quote, is that of all the stakeholders in prisoner health, including that of prisoners, their families and the community.

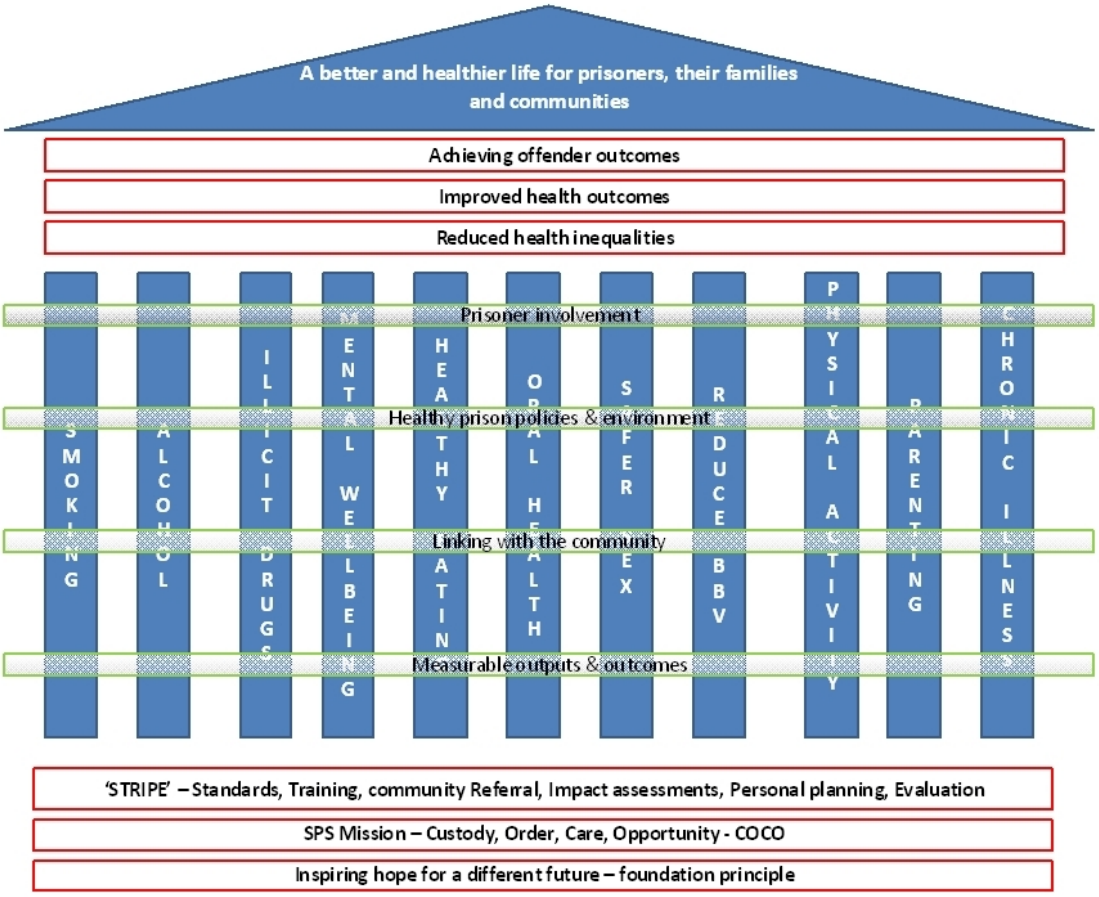

Figure 2. Diagram showing the key elements of Scotland's prisoners' health promotion framework

However, benefits in health are not created by frameworks alone. The implementation of policy is equally important (Easton 1953). This is performed through the formulation of action plans, which are enacted and finally evaluated. In addition, it is argued that plans to

reduce health inequality cannot simply be forced on people (World Health Organisation 1986). They must feel that solutions have been based upon their needs. In relation to prisoner healthcare, the Scottish Government, despite its aim for people to take more control of their health, has offered little in the way of consultation with the patient group in order to devise strategies that would enable this worthy goal. Evaluation of the SPS/NHS partnership by the National Prisoner Healthcare Network set up in 2011 has been slow with little or no feedback to service users.

Fundamental factors of ill health are described in the document *Better Health, Better Care* (Scottish Government 2007a). This summarised conditions that were to be targeted along with interventions to improve the health of Scotland's population. It also declared the goal of Government to change the medical model of healthcare delivery in Public Health. Instead, the emphasis would be on the choices made by people in relation to their health and the underlying social and structural causes of ill health. This was a significant change as the responsibility for Public Health improvement could remain with individuals in Scotland for the first time (Scottish Government 2007a). Although this was an official view expressed in the document, an alternative view could claim a government aim to change behaviour through social policy may have been an operating goal, for example smoking bans, minimum pricing on alcohol, etc.

1.4.2 Create Supportive Environments

The action plan contained within Better Health, Better Care (Scottish Government 2007a) highlighted that prisoner and offender care required improvement. This along with the recommendations made in Equally Well (Scottish Government 2008) provided the impetus

for the document Better health, better lives for prisoners (Brutus et al 2012). This presented a framework for improving the health of Scotland's prisoners and states:

Within Scotland's prisons, we should adapt this 'healthy settings' approach to our context. We can build on the experience of prisons in England and Wales where they have found it helpful to tailor the three 'healthy settings' elements to

- policies in prisons which promote health (e.g. a no smoking policy)

- an environment in each prison which is actively supportive of health

- prevention, health education and other health promotion initiatives which address health needs within each prison.

(Brutus et al. 2012. p.13)

There are numerous references to the importance of supportive environments and the contribution to health throughout all of the documents; Better Health, Better Care (Scottish Government 2007a), Equally Well (Scottish Government 2008) and Better health, better lives for prisoners (Brutus et al 2012). These mention the role that prison officers and healthcare staff can play in creating a healthy environment by ensuring that it is safe, structured and orderly for working, living and learning. This can be done by ensuring that health-promoting policies such as those pertaining to smoking cessation, drug and alcohol awareness are encouraged BY prison officers and healthcare staff.

In Better health, better lives for prisoners (Brutus et al 2012) the following issues are referred to with regard to improving the environment within the Scottish Prison Service estates.

- Role of Integrated Case Management (ICM) Practice Guidance Manual – following

Core Screen, there is currently only a requirement to offer smoking cessation where the sentence is longer than 1 year. This equates to a minimum of 6 months in custody).

- Cell sharing policy.
- Role of purposeful activity.
- Role of recreational and leisure activity, especially physical activity.
- Policy regarding cell sharing with smokers.

(Brutus et al 2012 pp. 27-28)

The action plan demonstrates a commitment to the principle of creating supportive environments within the prison and general population. However, the ways in which supportive environments are implemented and achieved, for prisoners and ex-prisoners, can vary at a local level. This is due to the influences of the prison governors and NHS primary care trusts, in which the prisons are located, because healthcare priorities and service provision can vary across Scotland. Examples of this are the provision of services for the testing and treatment of blood borne viruses and those dealing with the treatment of drink and drug misuse.

Supportive environments refer to the setting in which healthcare is delivered in prison. It was established that taking away an individual's liberty could be as harmful to them as

physical punishment (Sykes 1958). More recently, prison has been identified as the primary stressor (Massoglia 2008).

Prison culture has mostly been investigated in the United States of America. This focus is understandable when one considers that while it accounts for approximately 5% of the world's population, the US contains almost 25% of the total number of imprisoned people worldwide. Spelman (2009) performed an analysis of studies undertaken in the US during the period between 1977 and 2005. He advised that the situation should be considered a warning to other countries regarding the effects of poor prison policy in the United States. One of the ways he demonstrated this was by referring to the 1994 Crime Bill, which provided ten billion dollars to states for the construction of new prisons between 1995 and 2000. However, this money was only available to those states that had passed sentencing laws that ensured that prisoners served a minimum of eighty-five percent of their sentence and which eliminated the provisions for prisoners getting time taken off for good behaviour while serving it. The effect of this policy was that the number of states that had these statutes in place increased from 4 in 1992 to 27 in 1998. Thus, the passing of the Crime Bill caused an increase in the prison population in the USA in two ways: by making it cheaper for states to build new prisons and by making it more difficult to control populations as prisoners were serving longer sentences. The result was, that due to a lack of alternatives to imprisonment, along with financial incentives from the federal government for states to build prisons, American policy reflected a boom in the prison population.

Condon et al (2008), in an English study, explored the nature of primary care practice in prison. Opportunities to make healthy choices varied between prisons, particularly in relation to diet, exercise and access to smoking cessation support. Alcohol misuse was

considered insufficiently addressed in prison. They found that while imprisonment offers prisoners an opportunity to access health promotion services, prisoners are often prevented from making healthy choices by the prison setting. Barriers exist within the prison setting which limit the ability of prisoners to maintain and improve their health. The conclusion was that prison significantly lessened any positive effect of treatment and that prison is not an easy place to provide effective healthcare.

One in seven people in prison in the UK are serving sentences of life or indeterminate periods as a result of changes to the penal policy (HM Inspectorate of Prisons and Youth Justice Board 2009). There is limited data regarding the effect on prisoners of these types of sentences despite the figure being larger than that of the combined total for the entire Western world (Nagel 1984).

There is limited evidence to suggest that health authorities have undertaken work to provide more caring and supportive settings for prisoners. For example, Flynn (1992) highlighted the situation of the older age in prison and the position of older prisoners continues to be a concern. Currently, there is no nationwide strategy for developing older age care facilities within the Criminal Justice System. This lack of patient choice is in opposition to the Government's objectives to reduce inequalities in health (Scottish Government 2007a). In relation to the notion of equity, these are relevant issues. It could be argued that this situation is suboptimal in comparison to that care available for older people in the community. However, people in the general population also experience a range of services that impact on their health and wellbeing, which in turn affects their life expectancy. When comparing demographic data from the Human Mortality Database, Vaupel et al (2010) found the lowest male and female life disparity was in those countries

that were also the most successful in preventing premature deaths. This would support the argument for a greater focus on health promotion.

1.4.3 Community Health

The action plan contained within Better Health, Better Care (Scottish Government 2007a) states:

Offenders and ex-offenders tend to have poorer physical and mental health, lower standards of dental health, greater prevalence of substance misuse and higher rates of conditions such as Hepatitis C. Within a wide ranging strategy to tackle health inequalities, it therefore makes sense for NHS Scotland to review its approach to the health and health care of offenders and ex-offenders and to consider what more can be done in prisons and custody settings to ensure continuity of care during the transition between prison and the community. Subject to the normal controls around patient confidentiality and consent, this requires us to improve the exchange of information between healthcare professionals working inside and outside of Scotland's prisons.

(Scottish Government 2007a p.36)

This statement confirmed The Scottish Governments view that the health of those currently and formerly in Scotland's prisons tended to be poorer than that of the general population. However, the only commitment that was made in the action plan to address this problem was that The Scottish Government would:

Review NHS Scotland's approach to the health and healthcare of offenders and ex-offenders

(Scottish Government 2007a p.39)

In 2OO8, the Scottish Government published "Equally Well", a report of the ministerial task force on health inequalities. In this report, it states:

Offenders and ex-offenders should have access to the health and other public services they need and benefit from the same quality of service as the rest of the population. Women offenders' health needs should have priority. This will require joint action by community health partnerships and community justice authorities.

(Scottish Government 2008 p.40)

However, there are no firm commitments or action plans as to how this will be implemented by the SPS or NHS, community health partnerships or community justice authorities. Nevertheless, "Better health, better lives for prisoners" (Brutus et al 2012) acknowledged that it was not just the role of Community health partnerships to achieve this goal.

Equally Well also identifies the key role that Community Health Partnerships (CHPs) have in addressing both causes and consequences of health inequalities and that no agency on its

own can reduce these inequalities. Local NHS Boards and other key stakeholder organisations are actively involved in the delivery of local community plans and single outcome agreements through CHPs and Community Planning Partnerships. It is hoped that prisoners' health will be a feature of these partnerships, bringing key agencies, including local authorities, together with a common purpose.

(Brutus et al 2012 p.8.)

Not only did Brutus et al. (2012) acknowledge the difficulty in delivering healthcare for the prison population and those that had been liberated, they also attempted to give some guidance in the planning and delivery of care by presenting a set of general principles in the new framework for improving the health of Scotland's prisoners. These principles were to:

- aim to empower and inspire prisoners to make positive informed choices that can improve their lives, good health is a part of that

- recognise that 'health services' are only one part of a wider team working in partnership with a prisoner, to help improve health. (This team includes within prison, prison officers, chaplains, social workers, teachers, voluntary/third sector staff and outside of prison, Community Justice Authorities, local authorities and representatives from the wider community.)

- build on a prisoner's 'assets' rather than just their 'deficits'

- inspire the vision but provide a practical toolbox for key stakeholders

- build on the evidence but also value stakeholders', including prisoners', assessment of what works and what should be priorities

- view each prisoner potentially as one of the parents or grandparents of

Scotland's future.

(Brutus et al 2012 p.8.)

However, the ways in which these principles were to be utilised and put into practice within the SPS estates and communities throughout Scotland was left open to interpretation by the SPS, NHS, Community Health Partnerships and Community Justice Authorities at a local level.

Prisoners' health status has been found to display inequalities to that of the community. One example of this is that they are estimated to age 10 years prematurely (Oliviere, Monroe and Oayne 2004). To impact upon health, community intervention and prevention is required before imprisonment.

Another challenge to public health is the effect of early traumatic life experience. Easteal (2001) found that abuse in childhood led to a distrust of authority figures. This finding was supported by Howerton et al.(2007). While Easteal's (2001) research involved female offenders in Australia, the experience of women in English prisons was similar. It was argued that shame might lead female prisoners into abusive relationships or addiction behaviours. Shame may be so painful to the psyche that avoidance is a natural human reaction. It is a physiologic response of the autonomic nervous system, which may cause a number of

responses such as blushing, rapid heartbeat, sweating, dizziness or nausea. For many people, the feeling of shame can be overcome, however for addicts and their co-dependents, it remains and can lead to other behaviours and painful feelings. People become ashamed of who they are and do not believe that they matter or are worthy of love, respect, success, or happiness. When shame becomes all-pervasive, it paralyses spontaneity. A chronic sense of unworthiness and inferiority can result in depression, hopelessness, and despair, until they become numb and, feel disconnected from life and relationships. Relationships can be difficult due to the anxieties and fears created by shame and, because of these, many sabotage themselves in their relationships and work (Lancer 2013). However, shame can lead to positive things and be a motivator for change as well, leading to self-development and increased performance at work (Henriques 2012).

1.4.4 Personal Skills Development

It was recognised that personal skills development had a part to play in the health improvements and positive changes to prisoners' lives in Scotland in the future. The new health framework presented in *Better health, better lives for prisoners* (Brutus et al 2012) contains a statement by the Chief Medical Officer for Scotland in the foreword that supports this:

Ultimately, Better health, better lives for prisoners is about helping people to develop the skills and opportunities to sustain the social and familial "connectedness" which improves health and changes lives for the better.

(Brutus et al 2012 p.2)

However, there are no details of the strategies that were to be employed to develop the personal skills of prisoners within Scotland's prisons or communities. It is assumed that this would be left to the SPS, NHS and local authorities to develop their own skills programmes in response to local needs and utilise what resources they had at their disposal.

The development of personal skills to affect one's own health positively is reliant upon the cognitive ability to integrate knowledge. This relates to specific skills involving problem solving, such as identifying negative feelings, defining problems, selecting desired goals, generating options for goal attainment, analysing the potential outcomes of these options, choosing those options likely to be effective, and formulating an action plan. The imprisonment of the vulnerable can negatively alter the learning and utilisation of these personal skills (Lord Bradley 2009, Hayward, McMurran and Sellen 2008, Yorston 2004). These studies suggest that many people in prisons are ill equipped to cope with prison, and should be cared for in environments that are more therapeutic, in which personal development skills training is provided on an individual basis. However, to implement this would be costly and time consuming and impractical, because the prison service operates a system that manages the prisoners as social groups.

Prison is challenging for those with learning difficulties (Lord Bradley 2009). Lord Bradley (2009), in a review over a six-month period, explored some of the difficulties encountered by those with learning difficulties and mental health problems to court liaison and diversion schemes. Mental health diversion schemes operate at the interface between criminal justice and mental health. They seek to ensure that people with mental health problems who encounter the police and courts are identified and directed towards appropriate mental health care, particularly as an alternative to imprisonment. However, the review found that

there was confusion around the terminology used and a difference of opinion regarding when diversion schemes should be utilised and implemented. Diversion was acknowledged to increase the risk of inappropriate or dangerous behaviour at community level, bringing it into conflict with the NHS "*Zero Tolerance"* agenda (Department of Health 1999).

A number of peer support initiatives for prisoners have been introduced to the SPS in recent years (Gauld 2014). These include listeners trained by the Samaritans, befrienders and health advisors. These schemes provide useful skills, experience and employment opportunities, which can be used after liberation. One example of this can be found in HMP Perth. Here, prisoners have achieved a health coaching qualification, which supports the development of motivational interviewing type skills alongside the development of appreciative inquiry to support others with health behaviour change.

1.4.5 Health Services Re-orientation

As has been previously mentioned, it was recognised that the healthcare for offenders in Scotland's prisons and communities was in need of improvement. After a consultation with stakeholders, Better health, better lives for prisoners (Brutus et al 2012) was published that presented a new framework to improve the health of prisoners. This involved a re-orientation of the healthcare services to focus more on health promotion. The framework was built around a number of pillars that focussed on health promotion initiatives. These pillars are shown in Figure 2 (page 59) were:

- *Reduce use of tobacco*

- *Reduce harmful use of alcohol*

- *Reduce harmful use of illicit drugs*

- *Improve mental wellbeing*

- *Increase uptake of healthy eating and reduce obesity*

- *Encourage better oral health*

- *Increase safer sex and better personal relationships*

- *Reduce transmission of blood-borne viruses*

- *Increase physical activity*

- *Improve parenting*

- *Management and prevention of long-term conditions*

(Brutus et al 2012 pp. 4-5.)

It was recognised that there was a risk of the SPS, NHS and local authorities working in isolation and not sharing information with each other. In order to reduce the risk of this happening the framework contained four "unifiers" which are shown in Figure 2. As stated in the document:

These attempt to highlight where there is the opportunity for prisoners, prisons and stakeholder partners to be involved and specifically address the prison context for that individual topic area. Prisons have always aimed to provide a safe and structured

environment, the opportunity for stability and the opportunity to build on the assets and the positive personal qualities that prisoners possess. The relevant unifying themes are:

1. prisoner involvement

2. healthy prison policies and environment

3. links with community and public sector services including NHS health promotion services

4. measurable outputs and outcomes

(Brutus et al 2012 p. 5.)

This statement this gives licence for the SPS, NHS and local authorities to redesign their health services using local policies that are developed taking available resources and patient needs into account. However, it does stipulate that there should be measurable outcomes, which would suggest that local policies might be scrutinised by the Government to ensure that the recommendations put forward in the framework are being delivered and having a positive effect on the health of prisoners in Scotland.

The re-orientation of prison health care has numerous challenges. Additionally, prisoners may reject the support offered. This is mainly seen in those experiencing mental ill health (Gray et al. 2008). In this study, the authors examined adherence to prescribed antipsychotic medication in 44 participants. Evidence indicated that the options for treatment available to people with mental illness were constrained by the prison environment. Restrictions placed on movement and involvement in decisions regarding their treatment brought about feelings of coercion amongst patients and a refusal to comply

with regimes. This was evidenced in this sample of prisoners by the adherence to treatment scores, which suggested a passive acceptance of treatment with antipsychotic medication. Only 20% were actively participating in treatment decisions and taking some responsibility for treatment. It was argued that this could make individuals a risk to themselves and others.

This supports the previously mentioned point that patients are likely to reject plans to improve their health if they consider these have been imposed on them (World Health Organisation 1986). It could also be argued that this underlying opposition creates a challenge to health service redesign. Service re-design may inadvertently create inequalities among vulnerable groups. For example, those with learning disability/mental health issues may not be in a position to feel the full benefits from any initiatives due to their underlying pathology.

1.5 Health Education

In the document "Health Promoting Prisons" (Department of Health 2002), the following components are important in Public Health strategy and delivery:

- Interventions/programmes for health education,
- Healthy living choices,
- Provision of information,
- Self-esteem and skills development.

These components will now be presented individually in the following four subsections in order that they can be more fully discussed.

1.5.1 Educational Interventions/programmes

Health Promoting Prisons (Department of Health 2002) stated the Prison Service's Health Care Standards policy that had been in force since 1994 regarding the teaching of health education programmes. This referred to Health Care Standard 6, which stated the minimum that prison establishments should be delivering to the prison population. Additionally, the Health Services for Prisoners Standard was introduced in 1999, which incorporated and reinforced the requirements set out in Standard 6. The policy stated:

Both Health Care Standard 6 and the Health Services for Prisoners Standard require all prisons to provide health education around the following subjects:

- *Coronary heart disease and stroke*

- *Cancer*

- *Mental health*

- *HIV/AIDS*

- *Substance misuse*

- *Sexual health.*

However, it was stated in the Health Promoting Prison (Department of Health 2002 p.11) that, although there was a policy regarding the teaching of health promotion within prisons,

- *there was a significant amount of health promotion activity, though it was often poorly prioritised;*
- *the concepts and practice of promoting health were sometimes poorly understood, and evaluation was largely absent;*
- *most prisons did not have a written strategy in this area;*
- *Just a handful of prisons were adopting the 'Whole Prison Approach' to health promotion suggested in this strategy.*

This would suggest that a gap existed between the policy makers and those charged with executing the policy.

Programmes and interventions that develop patients' knowledge of health have been implemented throughout the prison service. However, prisoners can be suspicious of professional involvement and authority figures. The phrase "don't talk, don't trust and don't feel" exemplifies the culture and code in prison by which many prisoners live (Easteal 2001). Easteal's (2001) study also showed that prisoners' attitudes in prison remained unchanged despite implementing steps to provide a better knowledge of health to them. Condon et al (2008) also found that many prisoners talked of barriers to making healthy choices in prisons. These were associated with the lack of autonomy that prisoners experience in prison and being separated from family and friends. Condon et al (2008) found that few participants in their study talked of the healthy behaviours that they had developed in prison that they intended to maintain when liberated back into the community. The success of programmes for people to learn about health in prison can be challenged and there appears to be scope for future development in this aspect of prison healthcare.

1.5.2 Behaviour change opportunities

The behaviour of prisoners has been of interest to academics for decades. However, whether prisoners are willing to change voluntarily remains hard to establish. There is some relevant work where the application of a behaviourist model helps to examine prisoners' behavioural patterns. Glaser (1967) suggested that prisoners' behaviour is shaped through the process of stimulus and response.

Behavioural responses to life experiences are unique to the individual and situation. Childhood learned behaviour is considered a predictor of behaviour in adulthood. If we accept this model of human socialisation, then people entering the prison already have a set of established behavioural patterns, which may influence their reaction to events in prison and may also affect their ability to derive help from health services.

People enter prison with established behaviours, attitudes and beliefs (Huggins, Capeheart and Newman 2006) to be met with a strict prison regime. This operates under a rigorous bureaucracy with numerous rules and regulation. To ensure that the Prison Service maintains security and protects the public from harm. Prisoners have behaviours and a culture, which they have to respond and adapt to (Rosen 1990). Those that do not possess the knowledge or ability to do this are disadvantaged in the prisoners' social system (Lord Bradley 2009, Yorston and Taylor 2009).

For women prisoners and those with a learning disability (Lord Bradley 2009), prison can be challenging, leaving them open to criticism from other prisoners. This can also be said for male prisoners. Claes et al. (2004) found behaviour in prison to be ideographic as prisoners construct their own version of reality. In comparison, prisoners perceived as strong find endless opportunities "for personal victimisation" (Bowker 1980, p.19). In conclusion,

behavioural modification programmes based on health must be suitable for prisoners and the prison setting if any improvement in health is to be achieved.

1.5.3 Provision of Information

Health Promoting Prisons (Department of Health 2002) refers to the most effective interventions in a health promoting prison. It states:

Providing information perceived as relevant to the needs and concerns of the target group (although giving information alone is rarely sufficient to change behaviour)

(Department of Health 2002 p. 59)

However, the report also mentions that although interventions like providing information are likely to increase the effectiveness of health promotion initiatives their transferability to use in prisons has not been demonstrated through research.

De Viggiani (2007) documented a disproportionate number of prisoners who have previously lived on the margins of society before committing their crime. This group includes those who have been socially excluded for reasons such as poor education, lack of money and support to participate effectively in daily living. Social exclusion issues often persist for this group before they commit their offences and are relevant to the argument that social injustice drives health inequality. Poverty may also lead to a fragile housing situation and homelessness (Braveman and Gruskin 2003). As a result, the ability to belong

to a stable community and use its information resources will be poor. This represents the lives of many before they are imprisoned.

The education that most people access in the UK may not be attainable for those in prison, as poor attendance may lead to expulsion at a young age (Prison Reform Trust 2003). In addition to this poor connection with the education system during childhood, it is reported that 60% of offenders have literacy and numeracy levels at SCQF level 4 or below, compared to 15% of adults across Scotland (HM Chief Inspector of Prisons for Scotland 2010). Therefore, those with poor literacy will be unable to easily access any information related to public health and as a result will unlikely to have been affected. Interestingly, the deaths of prisoners tend to occur as a result of conditions that *Better Health Better Care* was intended to correct (Scottish Government 2007a), that is, those with mental health, alcohol and drug problems.

1.5.4 Development of Skills and Self Esteem

As Regards the development of skills and self-esteem, In England and Wales the Prisoner learning and Skills Unit provides a lot of health education. This is performed in the prisons by local educational institutions that are contracted to the Prison Service. As stated in *Health Promoting Prisons* (Department of Health 2002):

All Prisons must currently offer at least 3 out of a possible 13 Social and Lifeskills Units. Of the 13 Units:

2 are health education Units: Sex and Relationships Education and Healthy Living;

3 have elements of health education: Drug and Alcohol Awareness, Family Relationships and Parent Craft;

2 are related to mental health promotion: Personal Development and Improving Assertiveness/Decision making.

(Department of Health 2002 p.42)

The situation in Scotland is similar in that the provision of prison based learning and skills in the SPS prisons is contracted out to sub-contractors to deliver parts of the curriculum and respond to the changing prisoner needs or work to support vocational skills or employability.

Programmes to increase social and work skills are an enduring priority for the SPS. Coping strategies, such as self-harm and suicide, are widely recognised (De Hart, Smith and Kaminski 2009). In an analysis of suicide and self-injury data from prisons, Brooker et al. (2010) found that suicide in England had fallen as a result of prison-based initiatives such as new suicide screening and care planning systems, better integration with health care, more peer support structures and revised standards for suicide and self-harm including environmental risk assessments. Together with these improvements, prison healthcare in England and Wales had been moved to the Department of Health, which was dealing with mental health in the criminal justice system. Prison mental health in-reach teams were introduced in 2002 and the National Institute for Mental Health commenced mental health awareness training for prison officers. A screening tool was also introduced for healthcare staff to use in prison receptions, which included mental health. All prison mental health

programmes were seen as part of The National Service Framework for Mental Health (Department of Health, 1999), which was designed for the general population, but included targets for suicide reduction.

The study by Brooker et al (2010) was also in keeping with the study by Bird (2008) that researched suicide rates within the SPS from 1994 to 2003 and found that Scotland has redressed an excess of male suicides, especially by its youngest prisoners. This has been achieved by the SPS acting upon recommendations of HMP Inspectorate of Prisons. For example, mental health nurses now conduct a suicide risk assessment on reception into prison, prisoners can now have a television in their cell and there is improved induction for remand prisoners. These strategies have all helped to reduce the number of suicides in the SPS. However, they are also concerned with helping to develop prisoners' skills and self-esteem, which is a continuous challenge.

1.6 Disease Prevention

1.6.1 Strategies to prevent disease occurring

The health risks associated with prison do not mirror those found in the community. There has been little support found of the prisons ability to meet the health needs of prisoners. Cropsey et al. (2007) argue that large prisons result in healthcare being delivered ad hoc.

In their findings, most prisons reported a number and types of services (including assessment and treatment services) offered. The services provided ranged from medical to spiritual services. All types of prisons reported offering medical services because they were legally bound to provide them. Most prisons provided faith or spiritual services, often due to

volunteers. However, the study found inconsistencies in the number of services that were offered with regard to specialist services, such as substance abuse treatment services and mental health. This led the authors to argue that the number and quality of healthcare services provided for prisoners was not consistent. However, it must be noted that this study looked at the prison system in the United States of America (USA) that has different health, penal and legal systems to that in Scotland, with prisons in the USA being much larger and sentencing terms served by prisoners longer. As a result, it is difficult to make direct comparisons with the healthcare services available for prisoners in the USA with those in Scotland. It may also be argued that prisons in the UK cannot provide for the health needs of older age prisoners (Yorston 2004).

Older prisoners are considered to be at risk in the prison population and it is argued that resources need to be made available to this group (Yorston and Taylor 2009). A reluctance to exercise is due to a fear of mixing with others (Docherty 2009). Furthermore, the high prevalence of sexual offences in the older age group has led to a supposition that all older age prisoners are guilty which often leads to violence against them. This situation is compounded when medication is stolen in the prison (Docherty 2009).

Research into bullying within the prison has focused on developing methods of measurement and exploring the environmental factors known to promote aggression (Ireland et al. 2009). O'Donnell and Edgar (1999) surveyed 1,182 prisoners about their exposure to fear in prison. In the previous month, they found that the majority of prisoners had witnessed an assault. Despite most prisoners, feeling safe, participant accounts revealed that there were those who deserved to be attacked. Approximately 72% agreed that sex offenders deserved it and it was acceptable to intimidate or assault "grasses".

A number of health improvement priorities are outlined in *Better Health, Better Care* (Scottish Government 2007a) under the disease prevention heading are relevant. These include reducing smoking rates, reducing obesity and improving diet and nutrition, increasing exercise, supporting sensible drinking, reducing the use of illicit drugs and improving sexual health.

1. Reducing smoking rates

Better Health Better Care (Scottish Government 2007a) stated that the Scottish Government would:

Publish a new smoking prevention Action Plan in 2008 supported by additional funding of £3 million per annum and continued investment in a network of cessation services.

(Scottish Government 2007a p. 25)

However, this was for the whole of Scotland and did not ring fence money specifically for use within the prisons.

Smoking is a behaviour, which damages health (Whitehead 2000). Despite this smoking is very popular in Scotland's prisons with approximately 75% of all prisoners reporting that they smoke (Fraser 2012). It is estimated that half of smokers will die of a smoking-related disease (Doll, Petro and Wheatley 1994). Reducing the smoking rates within the SPS is a laudable aim. However, it is difficult to bring about reduction because of factors associated with the prison environment whereby tobacco is used as a currency and smoking is an

activity performed by the majority of the population due to its perceived stress reduction (Twyman 2014).

2. Improving diet and nutrition

A healthy diet can help in the reduction of conditions like cardiovascular disease and cancer. Along with physical activity, it can help to maintain a healthy weight, which can help reduce the risk of musculoskeletal problems and diabetes. In order to improve diet and nutrition in Scotland, the Government stated in *Better Health Better Care* (Scottish Government 2007a) that it would:

Improve Scotland's diet through a Food and Health Delivery Plan and the development of a national food policy for Scotland.

(Scottish Government 2007a p. 25)

However, in Scottish prisons, prisoners are heavily dependent on catered meals as there is no routine provision of prisoner cooking facilities. For many prisoners, prisons provide a stable routine of meals that they lacked on the outside. However, canteen choice can be problematic with a 'catch 22' situation where canteen managers do not order healthy items if there is going to be limited uptake, but if it is not provided, then prisoners cannot make a healthy choice. Prisoners may buy snacks and confectionery from prison-provided 'canteen sheets'. It is important to appreciate that especially within the prison setting, for many, food

represents more than nutrition and sustenance, but also opportunities for interaction with others and something to look forward to during what can be a mundane and difficult day (Her Majesties Inspectorate of Prisons 2016).

Assistance with weight management is an area of need in the prison population. While the recording of BMI for prisoners in not complete, data from 2011 suggests that across the whole SPS estate indicated that some 25% or prisoners are overweight, obese or severely obese (Scottish Prison Service 2011). It was also noted that nearly 13% were underweight. While seeking to manage overweight prisoners and reduce overall obesity is an important area for health promotion in prisons, it must be set within a context of individual prisoners for whom eating may be poor or subject to an eating disorder.

Prisoners may enter the prison with unhealthy eating habits and the provision of healthy food options by the SPS is questionable. A number of factors such as chaotic lifestyles, poverty and poor housing often make it difficult to eat a healthy, nutritious diet to prevent disease in this vulnerable group with a lot of peoples' health having been damaged before their imprisonment (Cross and Macdonald 2009).

3. Increasing exercise

Obesity is recognised to be an increasing problem within Scotland. Factors that influence this are diet and the lack of physical activity. The rising levels of obesity bring increased risks of chronic diseases such as diabetes, stroke, cardiovascular disease and cancer. In order to tackle obesity, *Better Health Better Care* (Scottish Government 2007a) stated that the Scottish Government would:

Tackle obesity by delivering consistent weight management strategies across Scotland

Work with partners to address the environmental influences on obesity including the greater provision of opportunities for safe walking and cycling

(Scottish Government 2007a p. 25)

Facilities for exercise in prison are limited and this situation is compounded by the pressures on staff time to supervise exercise programmes. This can result in many prisoners being locked in their cells for up to 23 hours per day. For the sick and disabled in older prisons a lack of ramped access can produce physical barriers for those prisoners with disabilities. Additionally, the negative effect upon the health of prisoners from a lack of exercise contradicts the WHO's (1986) demand that nobody should be disadvantaged from achieving their full health potential.

4. Sensible drinking

There is a current debate in Scotland regarding the negative effects of excessive alcohol consumption on health improvement. Although it is recognised by the Scottish Government that many people drink sensibly, alcohol appears to be responsible for significant levels of ill health for individuals, their families and the wider community. In an effort to tackle this issue, the Scottish Government has stated that it would:

Expand significantly access to treatment and support for those with alcohol problems as part of a new strategy for tackling alcohol misuse to be published in Spring 2008 and supported by additional investment of £85.3 million over three years

(Scottish Government 2007a p. 25)

There is a strong correlation between alcohol and an offence resulting in imprisonment. In the 2011 Scottish Prisoner Survey, 50% reported being drunk at the time of their offence. Forty-one percent of male and 36% of female prisoners had an alcohol problem in 2006 (Graham 2007) compared to 14% of men and 9% of women in the Scottish population. This is a particular problem in young offenders. In terms of resources allocated within prisons, alcohol is perceived as a much lower priority in comparison to drugs. However, there is insufficient identification of alcohol as a problem. The use of screening tools such as Alcohol Use Disorders Identification Test (AUDIT) and the widespread perception that, since alcohol is not available in prison, it is no longer a problem. Alcohol problems for prisoners need to be understood in connection to their current circumstances, offending behaviours, employment and mental health, and that requires a whole prison approach. This is particularly important as alcohol problems appear from the literature to be getting worse. Plugge et al. (2006) found that alcohol consumption in prison decreased for some prisoners. However, many prisoners continue to use alcohol during their sentence casting some doubt on the authors' findings.

5. Reduce harmful use of illicit drugs

Better Health Better Care (Scottish Government 2007a) stated that the Scottish Government would:

Support drug treatment services and work with partners to introduce a new drugs strategy and delivery framework in 2008

(Scottish Government 2007a p. 25)

This resulted in the publication of the document *The Road to Recovery. A new approach to tackling Scotland's drug problem* (Scottish Government 2008) and described the Scottish Government's new national drugs strategy that focused on recovery but also looked at prevention, treatment and rehabilitation, education and enforcement. With regard to prison, the action plan presented in *The Road to Recovery* stated that the Scottish Prison Service should:

Develop and implement an information sharing protocol between Throughcare Addiction Services (TAS) and Enhanced Addiction Casework Service (EACS).

(Scottish Government 2008 p.76)

The anticipated outcome of this was that there would be improved continuity of care for prisoners upon their admission to prison, while serving their sentence and upon their liberation back to the community.

Illicit drugs are used widely within the SPS population and pose considerable risks to the health of those using them. In the 12 months prior to imprisonment, 82% of the prisoner population self-reported that they had used an illegal drug (Shewan et al. 2006) and 44% of prisoners reported that they were under the influence of drugs at the time of their offence. Thirty-nine percent stated that their drug use was problematic for them in the community while 20% of prisoners reported that their drug use had continued in prison. (Scottish Prison Service 2011).

Interventions to reduce drug use in prison must address the social factors that exacerbate the consequences of drug use, e.g. homelessness and mental health problems. This is particularly important on release from prison. Similarly, drug interventions need to provide support for short-term prisoners beyond maintenance of a current intervention or detoxification.

Prisons contain a disproportionate number of people who use illegal substances and/or alcohol (Easteal 2001, Samele and Keil 2009). Substance misuse literature explains the two main reasons why people use drugs in prison. Firstly, people misuse drugs because either they are attempting to reduce anxiety or conversely they are using the substance for stimulation (Hussein Rassool 2006, Hussein Rassool 2009). Secondly, they suffer from a condition rooted in their biology or genetics (Jellinek 1960, Valliant 1983). Jellinek (1960) and Valliant's (1983) work puts the misuse of alcohol and/or drugs within the sphere of

healthcare and they suggest a need for treatments to improve individuals' health and health education/promotion programmes.

6. Improving sexual health

With regard to improving sexual health within Scotland, the document *Better Health Better Care* (Scottish Government 2007a) stated that the Scottish Government would:

Implement Scotland's sexual health strategy and increase the availability of independent sexual health information

(Scottish Government 2007a p. 25)

However, it was not until 2012 that the publication of *Better Health, Better Lives for Prisoners* (Brutus et al. 2012) recommended that, in order to help improve the sexual health of Scotland's prisoners, there was a need to:

Increase involvement of local NHS specialist sexual health services in both adult prisons and young offender establishments.

(Brutus et al. 2012 p.46)

As there is no mention in *Better Health, Better Lives for prisoners* (Brutus et al. 2012) of how this would be implemented at a local level, it is assumed that responsibility lay with each

NHS primary care trust, in partnership with the SPS, as to how sexual health services would be delivered within the prisons in their catchment areas.

There are strong associations between risky sexual behaviour and other higher risk behaviours such as drug use and harmful alcohol use. Younger prisoners in particular are at risk of poor sexual health. A large proportion of male prisoners aged 21 to 39 years are more likely than the general population to have injected drugs, had multiple female sexual partners, and sex with men. It is also reasonable that they might want to celebrate their liberation from prison with a potentially risky combination of sex, drugs and alcohol (Ward 1996, Burrows 1995). Delivery of health promotion interventions in sexual health to prisoners has to be gradual and in proper context; health promotion interventions in sexual health should be tailored to the needs of the individual prisoner and prioritised according to those most in need – e.g. young offenders and their partners, and women who may be vulnerable to harmful sexual relationships (Eaton 1994).

Along with risky sexual behaviours, sexual lifestyles and rape, the prison population has a high incidence of sexually transmitted infections (STIs), and blood-borne viruses (Abiona et al. 2010, Stewart 2007). In male prisons, a particular concern are the high rates of HIV, hepatitis B and C (Stewart 2007) who argues that this situation could be improved by making condoms more widely available.

Krebs (2002) looked at HIV transmission in prison. He found that prisoners indulged in high-risk transmission activities that they would not have previously done. Of 121 participants in the study, 44 percent reported having consensual sex in prison and 16 percent that they had been raped. The study highlighted how, for many, sexual and other diseases are transmitted.

Sexual assault is another aspect of prisoner behaviour, which may damage health, and one which individuals have little control. In 2013/14, five male and five female prisoners alleged sexual assault within the SPS (Scottish Prison Service 2014). The information is unavailable as to how many of these were given medical treatment/hospitalised because of their sexual assault in prison. Tewksbury and West (2000) asserted that the fear of sexual assault amongst male prisoners might have a greater impact and be more common than the actual frequency rates of sexual assault.

If damage to prisoners' health is going to be prevented, the literature suggests that, it is essential that there are facilities in prison to treat these conditions. However, not all blood-borne viruses, such as HIV are curable, but if detected early can be controlled using the appropriate therapeutic regime. Unless challenged at institutional level, the sexual abuse and exploitation of some will continue during their prison sentence.

1.6.2 Medical intervention

Prior to imprisonment, prisoners are known to be poor users of health services. It is questionable they may not have accepted the offer of Public Health programmes such as vaccination, health screening and dentistry (Harvey et al. 2005, Tickle et al. 2007).

Effective medical intervention is further prevented by an avoidance and lack of belief that those in authority had prisoners' interests at heart (Howerton et al. 2007). Howerton et al's qualitative study recognised the most common feeling expressed against healthcare staff was that they "just don't care" (Howerton et al. 2007, p.3).

1.7 Healthy Settings

The World Health Organisation has defined a setting for health as:

"The place or social context in which people engage in daily activities in which environmental, organisational and personal factors interact to affect health and wellbeing . . .where people actively use and shape the environment and thus create or solve problems relating to health . . .normally . . . having physical boundaries, a range of people with defined roles, and an organisational structure"

(World Health Organisation 1998a p.19)

The settings approach to promoting public health has been given a high profile since the mid-1980s. It provides a framework, encourages multi stakeholder ownership of health and allows influences between people, environments and behaviours to be explored.

To aid the development and implementation of a settings approach a number of models have been developed. Paton et al (2005) proposed the Healthy Living and Working Model, which emphasises the use of organisational development and systems theory in creating change. Dooris (2004) stressed the need for a values-based approach that balances organisation development with high visibility projects, top-down commitment with bottom-up engagement, and the health promotion agenda with core business concerns (see Figure 3).

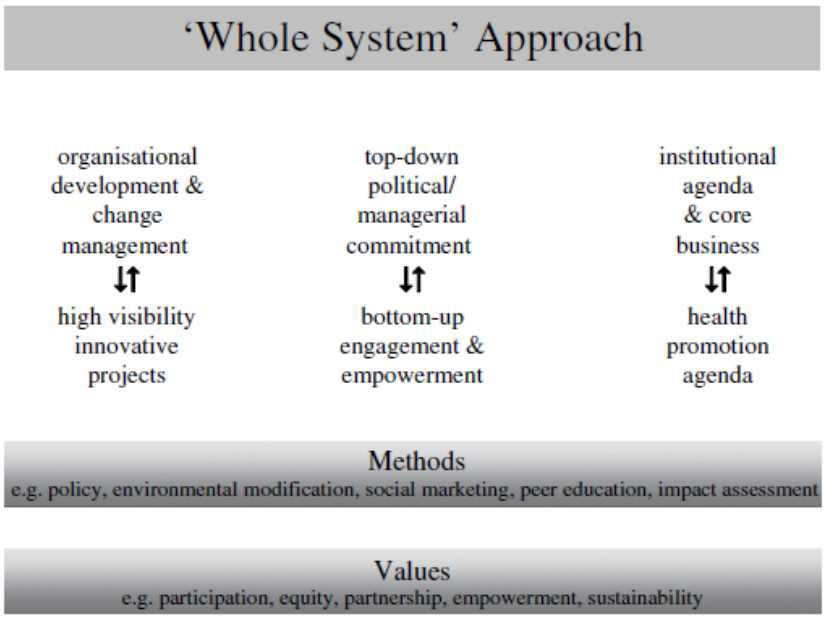

Figure 3. A model for conceptualising and operationalising the healthy settings approach

With regard to the approach that was implemented for the new prisoner health framework (Figure 2) in *Better Health, Better Lives for Prisoners* (Brutus et al. 2012), this whole systems approach utilises organisation development to introduce and manage change within the setting, in this case the prison (Grossman and Scala 1993; Paton et al. 2005). As demonstrated in Figure 2, the framework proposed for improving the health of prisoners' lives in Scotland uses a number of interrelated interventions and programmes to drive health within the prison culture and routine; encourages living and working environments that promote greater health and productivity and engage with and promotes health within the wider community.

Prisons can make an impact in improving the health of the most excluded people in society (Greenwood 1999). The idea of prison as a location for health promotion has been accepted internationally. It follows the 'settings' approach to promoting and improving health, which

concentrates on “taking health promotion to people where they live, learn, work, spend their leisure time or seek help” (World Health Organisation 1986). The goal of health promotion is to improve health while preventing ill health. This recognises that health has physical, mental and social components (World Health Organisation 1946). Involving people in appropriate, targeted health promotion activities is seen as an important means of reducing the incidence of serious, and in many cases preventable, diseases.

The concept of a health promoting prison is one that has been located in public health and health promotion discourse for almost the past two decades. It is an idea which has germinated from the ‘healthy settings’ philosophy which originated from the Ottawa Charter (World Health Organisation 1986). Prisons were recognised as a setting that afforded an opportunity to promote health to groups who could be termed as marginalised in the community and thus contribute to tackling health inequalities.

Prisoners face a period detached from community life due to a loss of liberty. As a result, prisoners undergo psychological adjustments to their environment until liberated (De Viggiani 2007). They return to the community with the impacts of their prison experiences, which are largely regarded as negative (Lord Ramsbotham HM Chief Inspector of Prisons for England and Wales 1996).

De Viggiani (2007) argued that a prisoner’s ability to survive imprisonment would depend on their capability to withstand the deprivations of that environment. As a result, prisoners’ health is as much influenced by structural determinants of the prison, as it is by the physical and mental health of the individual. De Viggiani (2007, p.115) stated that prisons “epitomise the antithesis of a health setting”. A healthy prison was, therefore, “an oxymoron”. His study is one of a limited number of first hand research studies with imprisoned patients and

highlights the apparent contradiction of trying to achieve equitable healthcare provision within a highly variable and inequitable landscape when compared to patient experience. This work only involved male adults between 1998 and 2001, which pre-dated the transfer of prison healthcare to NHS responsibility in England. Consequently, the assertions made by De Viggiani (2007) may now require revaluation.

It is difficult to quantify how the mental health of prisoners can be improved during a period of imprisonment. However, a report by Her Majesties Inspectorate of Prisons in 2008 found that the number of prisoners within the Scottish Prison Service with severe and enduring mental health problems represented 4.5 percent of the prison population, which was noted to be a higher proportion than that found in the general population (HM Chief Inspector of Prisons for Scotland 2008). The report also noted that the numbers appeared to be rising steadily and that the SPS needed to respond to this, as it stated that prison was not the appropriate setting for treating those with mental illness and that it should be performed in hospital.

1.8 Impact on Prisoner Health

The promise of equitable healthcare is a worthy pursuit. However, whether this is a realistic goal for the prison population is highly debateable.

The Scottish Government policies that have been referred to throughout this chapter aim to provide prisoners with access to health services broadly equitable with those of the general public. The aims of the policies were to give equitable service provision; however, from the limited literature or Government evaluations on the subject, it would appear that little

research has been performed into whether or not the outcomes of the service are equitable.

It is also noticeable, from the lack of evidence, that these major changes to healthcare provision took place with little or no consultation with those that would be affected most by them. In this case, the prisoner group was not asked for their thoughts, views or opinions despite the rhetoric stated in the document, *Better Health Better Care* (Scottish Government 2007a) to "Help people to sustain and improve their health, especially in disadvantaged communities, ensuring better, local and faster access to health care." (Scottish Government 2007a, p.1) and "contains a number of proposals that shift ownership and accountability to the people of Scotland and offer them the opportunity to take more control of their health" (Scottish Government 2007a, p. v). While it is acknowledged that this does not directly imply the need for the prisoner voice to be included, it would be a reasonable assumption to make given the Scottish Government and SPS wishing to consult with all the stakeholders in prisoner healthcare when devising the new framework for improving the health of Scotland's prisoners (Brutus et al, 2012).

Government policy to provide equivalent care is further challenged by the informal rules existing within the prison population. Prisoners need to adapt within prison but some do not have the abilities (Lord Bradley 2009). Prisons are characterised as closed institutions (Goffman 1958) and where power is demonstrated and exerted (Foucault 1995). Prison is represented in literature as a world where people live in a network of different cultures (Rivera, Edgar and Dorman 2003). They also have their own values, customs (Ireland et al. 2009), languages and beliefs (Hensley et al. 2003) and prisoners do not trust many people. This is not a helpful environment to the delivery of healthcare delivery or establishing

therapeutic relationships with healthcare workers (Howerton et al. 2007). The continuing task for prison healthcare is to deal with these biases.

The NHS in Scotland was charged with the responsibility for providing care to prisoners. Many of this population neglect their health before prison and do not trust the prison system. Healthcare services for prisoners' equivalent to those in the community or their first-hand experiences of healthcare service delivery are not evident in the literature.

1.9 Summary

The literature review has considered literature regarding the health of prisoners and their experiences of healthcare. This chapter has presented reviews of the empirical and policy literature. The search strategy employed to identify the relevant empirical literature has been presented along with a discussion of the results. A Public Health Policy framework has been utilised in order to present and discuss the healthcare policy for prisoners.

From the literature review, it can be seen that prisoner experiences and satisfaction of healthcare services is scarcely investigated. This point is supported by Bjorngaard (2009) in his discussion of a Norwegian prisoner health services satisfaction survey. It must be noted that none of the studies in the literature were performed in Scotland. This is a critical point as the context, laws and Criminal Justice System, healthcare systems and policies related to prisoners in Scotland are different from those in the rest of the UK and other countries outwith. These are important differences that are not reflected in the existing literature

De Viggiani (2007) supports the point that as agencies of disempowerment and deprivation, prisons fail to provide a healthy setting. He also argues that the World Health Organisation's notion of a 'healthy prison' is an oxymoron. However, the UK government is committed to the WHO's principles of health promotion as a strategy to reducing inequalities in health.

Binswanger (2011) makes the point that, in many states in the USA, budget constraints are prompting earlier release of prison inmates. They discuss that elevated mortality rates have been demonstrated in the post-release period but little is known about the health experiences of former inmates in the transition from prison to the community.

Stigma and labelling can have serious effects upon the healthcare experiences of offenders. This was illustrated in the case study analysed and discussed by Small (2006) which describes an unfortunate set of events pertaining to an individual's experience as they were failed by several systems all at once and neglected for having had experience with an addiction.

The development of a partnership between the SPS and NHS in 2011 formed the basis upon which equitable healthcare should be delivered to the Scottish prison population in the future. This was driven by International legislation and standards for prisoner healthcare and had already been implemented six years previously within the prison healthcare system in England and Wales.

The lack of first-hand, imprisoned or liberated patient accounts is identified as a gap in the literature. Prisoner health has been studied by a number of researchers and has been diverse in nature. The majority of work is specific to the medical discipline (Plugge, Douglas and Fitzpatrick 2008, Condon et al. 2007, Nesset et al. 2011, Bjørngaard, Rustad and Kjelsberg 2009) or disease specific (Haley et al. 2014, Lichtenstein 2000, Scheyett et al. 2009, Small et al. 2009). However, studies as those by Condon et al. (2007) and De Viggiani (2007) have looked at patient overall experiences of healthcare but only in the prison environment.

There is a variety of research topics in prison health. Studies can focus on aetiology versus treatment outcomes or prisoners' experiences of mental and physical health problems in prison. The studies found in the literature review have shown that men who have been in prison encounter many problems in accessing and using healthcare services in prison and the community.

Considered at a prima facie level, the Scottish Government's plan for public health and its subsequent framework for prisoner healthcare are credible in utilising the principles of health promotion and education to facilitate better health. However, at the practical level of policy implementation, a wide range of prison-based problems exists that make it difficult to implement. These include several barriers that cannot be easily overcome in the prison environment, for example:-

1. Misuse of drugs and/or alcohol
2. Reducing smoking
3. Improving diet and physical activity
4. Improving sexual health
5. Prevention and treatment of Blood Borne Viruses
6. Management and prevention of chronic illness
7. Improving personal skills development
8. Learning difficulties and mental illness
9. Poor use of health services prior to imprisonment
10. Prisoners distrust in healthcare workers
11. Creating supportive environments

There are gaps in the literature regarding the healthcare experience of prisoners with few first hand experiential accounts being found. As a result, I have decided to explore the health and healthcare experiences of male ex-prisoners further.

Chapter two will state the aim, objectives and research question for this study and will present the methodology and methods used.

Chapter 2. Research Methods

2.1 Introduction

Aim, objectives and research question

The aim of the study was to investigate the health and healthcare experiences of liberated men who have served a prison sentence and seek out how they view their health and use of healthcare services.

The study objectives were to:

1. Allow male prisoners liberated from prison and now living in the community an opportunity to voice their thoughts, beliefs, opinions and experiences of health and healthcare.
2. Focus on the ex-prisoners' accounts of their experience and investigate the nature of their experience of "health".
3. Identify the problems that they have encountered in accessing and using healthcare services in the community and prison.
4. Contribute to the body of knowledge that is growing concerning healthcare for men in the community and in prison.

In order to meet the aim and objectives there is only one question for the study:

"What are ex-prisoners' experiences of health and healthcare in prison and in the community?"

A commitment to deliver broadly equivalent NHS health care to the prison population was outlined in the Scottish Government (2007b) policy *Potential Transfer of Enhanced Primary Healthcare Services to the NHS. Report to Cabinet Secretaries for Health and Wellbeing, and Justice.* This significant policy change underpins the overarching study question.

> "What are ex-prisoners' experiences of health and healthcare in prison and in the community?"

The main objective and purpose of the study is to explore the healthcare experiences of males who have passed through the criminal justice system and re-joined the community in an effort to illuminate their experience of service provision. The aim was to gain an insider view of their experiences of using healthcare services. The discovery and interpretation of prisoners' healthcare experiences were the focus of this study because the literature reflecting prisoners' own voices have been underrepresented in the process of the legislative change. A desire to determine the impact upon the participant group affected by policy change was a key concern underpinning this study. Further, any 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 the two large bodies (the NHS and Scottish Prison Service) may lead to the success of relevant policies being ultimately undermined.

Much has been written about poor prisoner health. However, few studies are written from prisoners' own perspectives and little is known about the problems that they face when accessing healthcare services in the prison or upon liberation. This study will explore the experience of ex-prisoners' healthcare in prison and the community even though they are a difficult group to access.

To understand the experience of another, a question can be posed and a response made. However, difficulties arise in writing about the experiences of others such as prisoners where little knowledge exists on how that world impacts upon an "insider". Although I have not served a prison sentence, I have had a life long association with the prison service and the NHS due to my nursing background and the occupations of my family and friends. As a result, I have "insider" knowledge and from a research perspective must consider myself to be an "insider" in the sense of having come into frequent contact with prisoners in my experience as a nurse. From this position, it was vital to select an appropriate methodology that would allow me to meet this group and strengthen their voice in the community.

Central to this topic is the human experience of participants, for whom reality is constructed by subjective perception followed by interpretation. What matters in this research study is the participants' accounts of their experience as I am interested in how they tell their accounts and the way in which this provides access into their meanings of what health means to them. Thus, the interpretive paradigm and approach to data collection and analysis provides the most appropriate method in order to explore these experiences.

This chapter will begin by discussing the ontological and epistemological positions taken for the study along with an explanation of why a phenomenological approach was considered most appropriate. Following this, there will be a discussion of the ethical principles, which had to be addressed before the study could commence. The issues of access and recruitment and sample size will be presented, as will the data collection method of semi-structured interviews. Finally, the process adopted in transcription of interviews and the thematic analysis of data will be presented.

2.1.1 Ontology and epistemology.

Ontology is concerned with the nature of reality. The ontological approach taken for this study draws upon a constructionist ontological position. Three broad main ontological positions, constructionism, constructivism and objectivism were considered for this study.

Constructivism indicates that human beings try to make sense of the situation they are in, and therefore social phenomena are the result of human interpretation (Andrews 2012). As such people create certain social phenomena. Both constructionism and constructivism suggest that the world is constructed rather than existing objectively. However, constructivism would appear to assume that there exist cognitive processes and a conceptual framework which enables the individual to construct the world. In contrast, constructionism does not make any such assumption and indeed would suggest that the notion of cognitive processes itself is a social construct.

An objectivist ontological approach often renders social entities objective facts beyond human influence that have a reality external to social actors (Bryman 2004). The constructionist ontological approach adopted considers social phenomena as perpetually reconstructed by social actors via continual processes of social interaction. For Bryman (2004), constructionism implies social entities 'can and should be considered social constructions built up from the perceptions and actions of social actors' (Bryman 2004, p.16). Concerning this study, this reflects upon the 'question of whether the social world can and should be studied according to the same principles, procedures, and ethos as the natural sciences' (Bryman 2004, p.11).

The nature of knowledge is the general focus of epistemology and one of the main quandaries of epistemological debates. Numerous epistemological positions exist including

positivism, realism, critical realism, and interpretivism. In summary, 'an epistemological issue concerns the question of what is (or should be) regarded as acceptable knowledge in a discipline' (Bryman 2004, p.11). Interpretivism is the preferred focus for this study as it considers the subject matter of social science fundamentally different from that of the natural sciences and consequently requires altered research tools. Interpretivism places an emphasis on understanding (and not numerically measuring) social situations. This notion of participant understanding is fundamental to interpretivism.

2.2 Choice of methodology

The literature on prisoner healthcare presents prisoners as a homogenous group and considers specific diseases/conditions from a medical model perspective based on observations of symptoms and subsequent diagnostic labels. This empirical approach makes use of quantitative methods for its research with the result that the patient/client /participant voice tends to be lost. In contrast, the individuals' stories based upon their subjective perceptions of experiences were the focus of my study and provided the data that was crucial in giving a greater insight into the healthcare of those that have been in prison. Their accounts give an insight into the issues that they faced in trying to access and use healthcare within the prison environment and upon liberation.

A qualitative approach was considered to be most appropriate given the aims of the study. Holloway & Wheeler (2002, p.3) define qualitative research as "a form of social inquiry that focuses on the way people interpret and make sense of their experiences and the world in which they live". There are a range of research approaches within the qualitative paradigm

each with its own assumptions and procedures. It was important to explore the various methodologies and choose an approach compatible with the research question and aims of the study. Several approaches were considered in the initial stages of development of this study including ethnography and grounded theory. Researchers studying human behaviour use an ethnographic (observation in vivo) approach in order to describe "cultural rules, norms and routines" (Holloway and Wheeler 2002, p.135). This approach has the potential to allow an exploration of healthcare in prison and the community. It would also have provided data that could have been compared with the participants' stories. This would have provided a comparison to be made between their accounts of healthcare, particularly in the prison environment, and those observed by the researcher. However, direct contact would be required in order for an ethnographic approach to be taken. A conversation with the SPS Head of research also indicated that an application to conduct a long-term participant observation study from inside a prison may be rejected both on practical and security grounds. Therefore, there was a strong possibility that the primary requirement of ethnography, that it always involves prolonged direct contact with participants, could not be achieved (Boyle, 1994) and, as a result, ethnography as an approach was rejected.

Researchers that use a grounded theory approach generally set out to generate a theoretical account of a phenomenon. This often requires sampling on a relatively large scale. There is an overlap between the approaches of grounded theory and phenomenology in that both have a broadly inductivist approach to inquiry. However, the phenomenological approach can offer a more detailed analysis of the experiences of a small number of participants according to the guidelines for phenomenological research, outlined by Polkinghorne (1989). Given the aims of the study and that it was also anticipated recruiting

a large sample of participants would be difficult to achieve, a grounded theory approach was rejected.

A phenomenological approach was considered to be the most appropriate for this study as the researcher had the potential to produce a more detailed and nuanced analysis of the healthcare experiences of a small number of participants compared to, in contrast, a researcher performing a grounded theory study who would be more liable to produce a more conceptual explanatory level based on a larger sample. Phenomenology examines participants' subjective meanings of their own experiences (Holloway and Wheeler 2002). It is idiographic in that it eschews abstractions and tries to capture the quality and essence of experiences; is interpretative in seeking to understand participants' lifeworld and is reflexive in that it requires the researcher to reflect on their own position vis a vis those of the participants. Developed by Heidegger (1962), interpretive phenomenology emphasised interpreting and understanding, rather than simple description of human experience.

The purpose of using a Heideggerian phenomenological approach is to illuminate the specific, to identify phenomena through how they are understood, lived and represented by the actors in a situation. In this case how ex-prisoners have perceived the healthcare services provision and their use of these while in prison and in the community. This involves gathering 'deep' information and perceptions through inductive, qualitative methods.

Epistemologically, phenomenological approaches are based in a paradigm of personal knowledge and intersubjectivity, and emphasise the importance of personal perspective and interpretation. As such they are powerful for understanding subjective experience and gaining insights into people's motivations and actions.

Traditionally, researchers using a phenomenological approach sought to essentially describe phenomena rather than explain them, and to start from a perspective free from hypotheses or preconceptions (Husserl 1970). However, more recent humanist and feminist researchers refute the possibility of starting without preconceptions or bias, and emphasise the importance of making clear how interpretations and meanings have been placed on findings, as well as making the researcher visible in the 'frame' of the research as an interested and subjective actor rather than a detached and impartial observer, i.e. reflexivity which has become a more significant theme in qualitative research. Reflexivity is understood to be an acknowledgement of how researchers own experiences, thoughts, feelings, social and personal history can influence the outcomes of a study. However, the most important point is that I am interested in what the participants' accounts tell me about what health means to them not myself or other analysts.

2.2.1 The phenomenological approach taken for this study

This phenomenological study utilised participants' narratives of their healthcare experiences as a source of data. Their stories were obtained using semi-structured interviews. These were subjective interpretations of the participants' experiences of healthcare within prison and the community over a period of time and take into account the participants' relationship between the experience and the culture in which it was experienced. However, these narratives tell us a lot about the ways in which healthcare is delivered and used by this group, especially when the accounts of several participants are obtained and themes are repeated.

As there is a complex interaction between the world in which a person lives and their understanding of it, narratives are particularly suitable for portraying how people experience their position as "Embedded in people's stories we hear their feelings, thoughts and attitudes" (Etherington 2004, p.75), hence the value of this kind of research which is phenomenological in its approach. For example, the following extract from a participant's interview transcript gives the reader a strong sense that he was unhappy with the treatment he was receiving at a healthcare facility in the community. He expresses his feelings of frustration and fear, his thoughts about the number of workers he meets and attitude that he is unhappy with the inconsistent care he is receiving. In reading the account it is evident that he felt so strongly about his experience that he slammed his fist on the table and swore.

Richard. *And when I got told when I first started this. I would be in three different groups. There'd be a cored. There'd be transaction. There'd be core treatment and there'd be maintain treatment... And I should have only been seeing like three different workers (slamming fist on table repeatedly). And in the time I've been there six, seven year I've seen possibly maybe fifteen... fifteen to twenty workers. There's not. For me to open up to one worker and then go in the next week and it's a different worker and have to open up to that different worker again.. And then maybe get that worker for two weeks we're building a. we're…. relationship there and then bang, there's another new worker that I've never met and time before "Oh Jenny* can't meet you. It's me today". It's just ongoing and ongoing, ongoing.*

JF. *And how does that make you feel?*

Richard. *For me. I'm sorry for swearing but pissed off.*

JF. *Given what you have said. Has it got to the point where you just think there's no point in developing any relationship?*

Richard. *I'm just frightened.. I'm just. Now I'm just now frightened in case I say the wrong thing… and I lose my medication.*

(* indicates the use of a pseudonym so that anonymity and confidentiality are maintained in accordance with the conditions for ethical approval of this study.)

Realist (or Realistic) and Transcendental (or Constitutive) phenomenology are attributed to Edmund Husserl who attempted to make phenomenology a rigorous science within the tradition of its time collectively these schools of phenomenology are often referred to as descriptive. These involve use of a technique known as Bracketing in which the researcher actively sets aside or 'brackets', what he already knows about the experience under investigation and approaches the data with no preconceptions about the phenomenon under investigation (Dowling 2004). However, Martin Heidegger (Heidegger 1962) modified and built on Husserl's theories in his book "Being and Time" which takes as read that the observer cannot separate himself/herself from the world and thus cannot have the detached viewpoint asserted by Husserl. It is therefore a combination of the phenomenological method with the importance of understanding man in his existential world. This is known as Existential phenomenology but is also referred to as interpretative phenomenology.

Interpretative phenomenologists believe it is impossible to rid the mind of preconceived ideas and approach something in a completely blank or neutral way. Instead, it is believed that we use our own experiences to interpret those of others. This means that as

researchers, we are interpreting something in which we ourselves exist; therefore, we have no detached standpoint (Koch 1995).

In descriptive phenomenology research, the expectation may be to see a discussion about the researcher's bracketing of their experiences in order to take a neutral approach to the topic. Unlike descriptive phenomenology, there is no requirement for those performing interpretative phenomenology to bracket their experience. Those conducting interpretative phenomenological research need to show how their experiences have shaped their choice of research topic, the questions and their analytical interpretations. This will be presented and discussed in section 2.4.

In this study, I have chosen to take a Heideggerian approach to explore the health and healthcare experiences of male ex-prisoners. However, before I describe the methods utilised in the data collection and analysis of this research, there is a need to discuss some of the concepts behind Heidegger's work, why they are pertinent to this study and the way in which the data/results have been presented. These include Dasein, In der Welt sein (Being in the world) and Das Man.

1. Dasein

   Dasein is a fundamental concept in the philosophy of Martin Heidegger. It is a German term that means 'being there' or 'presence' but it is often translated into the English word 'existence'. Heidegger proposed that everyone is Dasein and that every human is a meaningful being. Basically, Heideggerian phenomenology considers what it means to Be-in-the-world and Heidegger claimed that the aim should be to discover, or uncover "…the universal structures of Being as they manifest themselves in phenomena" (Heidegger 1962).

2. In der Welt sein (Being in the world)

   Heidegger was concerned that philosophy should be capable of telling us the meaning of Being, of the where and what Dasein is. Heidegger argued that we are not entities that exist parallel to our world. Rather we are, at all times, submerged in our world. Hence, Heidegger coined the term Being-in-the-world.

3. Das Man

   An important concept in Heidegger's book *Being and Time* (1962) is 'Das Man'. This is often translated as "the they" or "people" but is more accurately translated as "one". Heidegger uses this concept to explain many forms of social existence, in which Dasein, instead of choosing to do something, does it because "that is what people/one do/es". Das Man creates a possibility of Dasein's being, and so das Man is not a particular person. Rather, the existence of "the they" is known to us through, for example, linguistic conventions and social norms. Heidegger states that, "The "they" prescribes one's state-of-mind, and determines what and how one "sees'" (Heidegger 1962, p.170).

The use of Heidegger's work to underpin this study is that his philosophy allows the researcher to be reflexive in dealing with the phenomena under scrutiny. Heidegger postulated that the researcher is as much a part of the research as the participant, and that their ability to interpret the data was reliant on previous knowledge. He also suggested that there is no such thing as interpretive research, free of the judgement or influence of the researcher. He sees the researcher as *Being-in-the-world* of the participant and research question. Heidegger emphasized that there was no discernible difference between

epistemology and ontology. For him, knowing is extrapolated from interpretation and understanding. In other words, we construct our reality, and therefore, comprehension from our experience of being in the world.

Paley (2014) argues that many disciplines including nursing take the view that the philosophy of Martin Heidegger facilitates the study of lived experience and that studies will take the form of qualitative interviews seeking to explore the respondent's experience of a particular phenomenon. However, Heidegger rejects Erlebnis (the German word for experience). As a result, according to Heidegger, there is no such thing as 'lived experience' as this is embedded in subject–object dualism that he rejects, as it is part of the Cartesian framework that he wished to overturn. He argued that Dasein is not an 'experiencing subject' and that the world is not an 'experienced object'. This dualism he replaced with the concept of being in the world.

How then are we to explore people's experiences if Heidegger rejects 'lived experience'? Observational studies would appear to be more in keeping with Heidegger's philosophy but there are circumstances, such as those that were encountered in this study, where the presence of an observer/researcher would not be possible practically or ethically. As a result, the alternative use of interviews appears to be an opportunity to obtain the 'lived experience' of participants. However, as Heidegger does not think in terms of lived experience, interviews that attempt to explore 'lived experience' can only reproduce the voice of das Man, the 'They', not the voice of unique individuals. This suggests that the purpose that interviews have is not to elicit the 'lived experience' of someone who has been in a particular type of situation, but rather to identify what das Man has to say about situations they have encountered. Given the first aim of this study was to give the

participants an ‘opportunity to voice their thoughts, beliefs, opinions and experiences of health and healthcare’ then interviews appear to be in keeping with the philosophy of Heidegger.

To conclude, Heidegger did not support the study of ‘lived experience’ because he rejected Erlebnis. By utilising interviews and asking people about their experiences fails to acknowledge the importance of Heidegger’s concept of Being-in-the-world and his assertion that Dasein’s form of understanding is not a mental representation. What participants say in interviews about their experience comes from das Man and is not an individual ‘meaning’ that they have attached to it.

2.3 Research Methods – The study design

2.3.1 The research context/location

This thesis is about men's health in prisons. Men were chosen for the study as statistically the Scottish Government (2012) prison statistics and population projections show that more men than women are imprisoned in Scotland. In April 2016, (Scottish Prison Service 2016) the respective numbers of men and women in Scotland's prisons were 6979 and 362. There were also another 321 prisoners that were recalled or convicted and awaiting sentencing but their gender was unspecified in the statistics. This population is constantly changing as many serve short sentences and are located within the perpetual "revolving door" between prison and the community. Taking a pragmatic approach there was a greater opportunity to recruit a group of male participants than women within the six months planned for data collection.

I chose to perform the study in the community because the number of studies performed within the SPS raises the potential for respondent fatigue (Ben-Nun 2008); a well-documented phenomenon that occurs when research participants become tired of the task and the quality of the data they provide begins to deteriorate. The Head of Research at the SPS confirmed this when enquiries were made about conducting the study in the prison. There was also the possibility that participants could be selected by those in authority in order to minimise disruption to the prison routine. This would undermine prisoners' rights to give their informed consent and participation. As Pont states:

'Prisoners are vulnerable to exploitation and abuse by research because their freedom for consent can easily be undermined, and because of learning disabilities, illiteracy and language barriers prevailing within prisoner populations' (Pont 2008, p.184).

There were concerns over participant confidentiality in the prison, as the environment does not afford individuals much privacy. Further, recording and transcription of interviews lend potential problems, as recording equipment cannot be taken into the prison for security reasons. As the focus of the study was the men's healthcare experiences both in and out of prison, it was decided that performing the study in the community would remove the above obstacles, achieve the goal of allowing men to talk about healthcare experiences in both settings, and ensure that participation would be voluntary and confidential.

2.3.2 Recruitment

Recruitment of ex-prisoners could begin upon ethical approval of the study. They were accessed via three recruitment centres; a GP practice, a third sector substance misuse service and a health centre that provided services to groups that were not registered with a GP. All recruitment and data collection took place between April and December 2013.

Managers of these centres were formally contacted and a meeting arranged during which the study was explained and details of participants required for the study were presented. A supply of Participant Information Sheet (PIS) forms with researcher details were supplied for distribution. Potential participants were identified by recruitment centre staff using the NHS computerised patients' records system used in GP practice and health centres' and the initial assessment documents used by the substance misuse service.

The implications of using the recruitment sites used for this study were, firstly, that they helped lessen the public stigma associated with having served a prison sentence as there was no need to advertise for participants. Secondly, the sites regularly dealt with men released from prison so gave ready access to the required population. However, it is

acknowledged that this restricted recruitment to the Tayside area. Thirdly, the sites provided access to those men who were motivated and taking an active interest in their health. Finally, I had to rely on the skills and judgement of those working in the recruitment centres to correctly distribute the Participant Information Sheets to those men that fulfilled the recruitment criteria.

2.3.3 The role of gatekeepers in participant recruitment

A gatekeeper is any person or institution that acts as an intermediary between a researcher and potential participants, a gatekeeper may also have the power to grant or deny permission for access to potential research participants (Arcury and Quandt 1999). In this study it was essential to use a gatekeeper as I did not have legitimate access to the personal data (names and contact details) of potential participants. In this situation a gatekeeper with this access was required to make the first contact on my behalf. The three agencies previously mentioned acted as gatekeepers and introduced the study to clients that met the recruitment criteria which are listed in table 2.

Table 2. Inclusion criteria for participants

Recruitment criteria	Included	Excluded
Gender	Male	Female
Age	Over 18 years	Under 18 years
Country where prison sentence served	Scotland	Outwith Scotland
Length of prison sentence	Greater than three months	Less than three months

As previously stated the study only explored the health and healthcare of males as they represent the majority of inmates within the Scottish Prison Service (SPS) and it was anticipated that recruitment of men would be facilitated more easily than for women. In order to give legal consent to participate in the study, participants had to be aged 18 or over. This study was exploring the experiences of men with the healthcare services in Scotland so it was imperative that they had served their prison sentence within an adult estate of the SPS. The minimum term of three months' imprisonment was chosen, as offenders with shorter sentences than this, have higher reconviction rates compared to those with longer sentences (Scottish Government 2012). As well as ensuring that participants had served a long enough sentence to access and experience the prison healthcare services, it would also help reduce the numbers of participants unavailable for a second interview, if required, due to reconviction.

The involvement of the recruitment centre staff in a gate keeping role had the potential to influence the research. Firstly, they could have only offered the study information to patients that they judged would be suitable, or give a good account of their experience. In order to minimise this effect, the inclusion criteria were reinforced verbally to staff and also on the printed PIS's given to potential participants. However, it must be acknowledged that access to potential participants may have been influenced by the recruitment centre staff's value judgements regarding suitability.

The fact that recruitment centre staff introduced the study was possibly experienced by patients as a validation of the study with the result that they were more willing to volunteer to take part. Several strategies were employed within the research to try to ensure that participation was voluntary. Firstly, the involvement of recruitment centre staff was

restricted to initially introducing the study to potential participants. Whilst patients might have said at their consultation that they would participate in order to please staff it was up to patients whether or not they made contact with me following their consultation. This ensured that potential participants had time to reflect on whether they wished to participate. Secondly, I did not ask potential participants to consent to participation when I initially met them. Formal written consent was only requested prior to the interview when issues of participation and consent were discussed before the form was signed. Potential participants were informed they could withdraw from the research at any time, without having to give any reason why. This right was stated in the PIS (Appendix G). The twenty individuals that enquired but did not participate could be taken as an indication that they felt able to withdraw their consent.

It became known by word of mouth that a study was taking place at Abertay University requiring participants that had served a jail sentence. This meant that those given details of the study, from one of the recruitment centres or by enquiring/participating, had spoken to others that could potentially take part. This meant the men themselves had become gate keepers and had the power to influence others.

The recruitment centres performed their function well and introduced the study to a client group that would have been difficult to recruit otherwise. However, it has to be acknowledged, the third party sector drug misuse service was less effective than the other two centres at distributing PISs. This was possibly due to a number of factors; the manager that had agreed to help with the study was promoted to another post outwith the centre, there were staff redundancies and a cut in funding by the local council. All of these factors

may have affected the moral and motivation of staff remaining, with the result that the research and distribution of PIS's became a lower priority.

2.3.4 Anticipated problems.

The main problem that I anticipated was recruiting enough participants for the study. Due to the need to preserve confidentiality, privacy and dignity I could not openly advertise for ex-prisoners to participate so it became necessary to utilise the services of gatekeeping organisations that dealt with ex-prisoners upon their liberation. Three recruitment centres were used within the Tayside area and their role and the recruitment process has been explained previously.

As there was the potential that some of the participants might have mental health or behavioural problems, and might have been convicted for violent offences, it was anticipated that there was a potential risk to my safety as I would be working alone with the participants. This is explained later in the ethics section under the heading of safety.

2.3.5 The research participants, recruitment and sample size.

Participants

Suitable participants were males, aged over 18 years who had served a sentence of three months or more in an adult prison within the Scottish Prison Service. The minimum term of three months' imprisonment was chosen, as offenders with shorter sentences than this, have higher reconviction rates compared to those with longer sentences (Scottish Government 2012). As well as ensuring that participants had served a long enough sentence

to access and experience the prison healthcare services, it would also help reduce the numbers of participants unavailable for a second interview, if required, due to reconviction.

Three months was considered to be the minimum sentence term for men to have experienced health services within the SPS as all men are given a health screening by nursing staff upon induction to the prison. This will take place on every admission to an SPS estate regardless of whether it is the prisoner's first time in a prison, is returning from a court appearance or being transferred from another prison. If the man has long term health or urgent health conditions, then he will be seen by a Doctor within 24 hours or sooner if their condition requires it. If the man requires medication, then he will have daily/weekly contact with healthcare in order to have his medication dispensed. However, even though a man has no health issues he will still have encountered healthcare staff as they visit the prison halls at various points of the day and the routine of the prison is partly designed to accommodate this. As healthcare is a major source of discussion within the prison then he will have an experience of the healthcare system. This study aimed to explore that experience regardless of whether the man had required to utilise the services or not. There was no limit on the maximum term of sentence served by participants. As mentioned earlier, males were chosen as they form the majority of the prison population within Scotland (Scottish Prison Service 2015). Participants had to be 18 or over in order to be classed as adults and legally give their consent to participate.

A total of twenty nine men volunteered and consented to take part in the study. However, twenty did not give their consent to having their interviews recorded. Those that did not consent were asked if they would give a reason for their decision. Ten refused to give any reason and ten voiced that they did not wish to be recorded given their experience of

recorded police interviews. The nine participants that consented to being recorded were all from the East coast of Scotland and resided in or around the Tayside area. Their ages ranged from early twenties to early sixties which has implications for the health experiences of some participants to be more complex than others. All participants had been convicted and served prison sentences of over three months. The majority had been involved with the criminal justice system since their early teens and served numerous short term sentences but there were also those that had served a single long term sentence. All participants had served sentences in more than one prison within Scotland so had experienced healthcare within different prisons.

It is acknowledged that the sample of twenty nine participants interviewed cannot be viewed as representative of the whole prison population within Scotland. However, given that this is an exploratory study, the participants do make a contribution to the narrative about healthcare in prison. Table 3 gives demographic details of all twenty-nine participants. It should be noted that in order to maintain their right to confidentiality, pseudonyms are used throughout the thesis.

Table 3. Participant demographics

Name	Age	Criminal conviction	Prison sentence
Michael	32	Assault/ bodily harm	4years
John	28	Reset	1year
David	25	Assault/bodily harm	18months
Todd	35	Drug dealing	7years
Robert	52	Manslaughter	10years
Mark	29	Drug dealing	7years
William	60	Murder	20years
Richard	30	Vehicle taking	4years
Thomas	58	Theft	1year
Jeffrey	60	Drug dealing	10years
Kevin	42	Drug dealing	7years
Scott	35	Burglary	3years
Joseph	28	Drug dealing	3years
Steven	55	Death by Dangerous driving	10years
Timothy	43	Murder	15years
Charles	65	Theft	2years
Paul	30	Theft	6months
Kenneth	29	Armed robbery	7years
Daniel	25	Drug dealing	4years
Brian	37	Assault/bodily harm	6years
Gregory	46	Burglary	3years
Anthony	35	Drug dealing	4years
Ronald	28	Drug dealing	5years
Gary	29	Theft	1year
Donald	33	Assault/bodily harm	18months
Christopher	25	Assault/bodily harm	3years
Edward	27	Vehicle taking	2years
Douglas	44	Assault	1year
Steven	26	Theft	6months

As illustrated in the above table the age range of participants was from 25 to 65 years and had committed a range of offences necessitating sentence lengths from 6 months to 20 years. This allows for an insight into a wide range of different and similar health

experiences. Although some participants had a history of repeat offending only the last offence for which they served a sentence is recorded in the table.

Recruitment

Recruitment centre managers were presented with details of the study and the participant criteria. A supply of Participant Information Sheets was also provided for distribution. Potential volunteers were identified in the GP practice and health centre using the NHS computerised patient's records system while the substance misuse service used their initial assessment process documents.

One recruitment strategy that was not planned for or expected was that of word of mouth recommendation. It was anticipated that only those attending for appointments at the recruitment centres would potentially participate in the study as they would be given written and verbal details of it. However, once the recruitment phase of the study commenced I began to receive enquiries via telephone and also people turning up at the university wishing to discuss the study. This was unexpected but a positive development as it increased recruitment numbers. A total of thirty-seven men enquired about the study, twenty-eight were made by telephone and nine in person at the university.

Once recruited via the method outlined above, each volunteer participant contacted me and suitable arrangements were made to meet, discuss the study and, if required, conduct an interview. In order to clarify the recruitment process, a flow diagram showing the steps involved is shown in Figure 4.

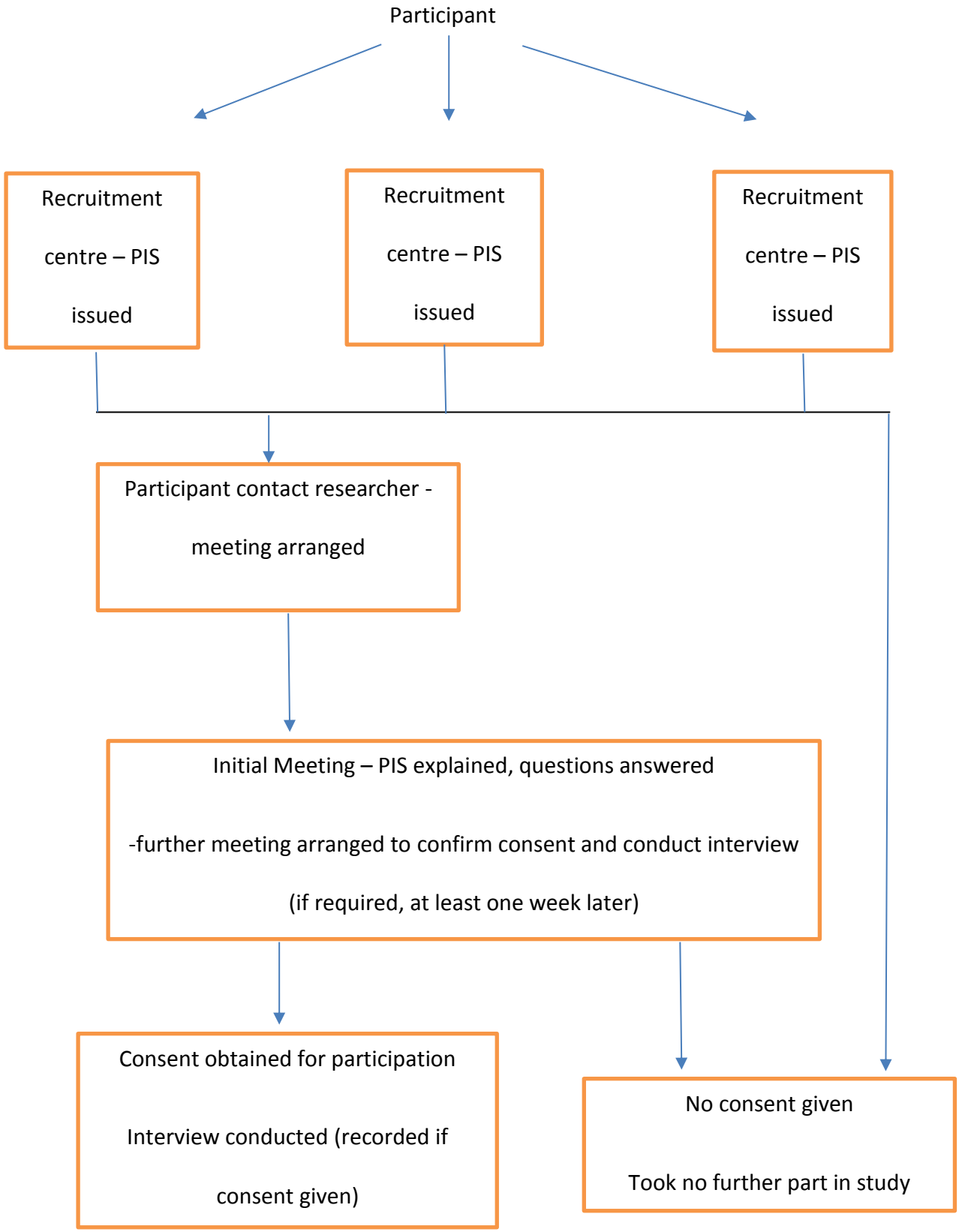

Figure 4. Flow diagram of the recruitment process

Sample size

In this study a purposeful sample with inclusion/exclusion criteria is utilised. As the study is an example of qualitative research there are no compulsory guidelines as to the number of participants that have to be included in the sample.

Morse (2000) considered sample size as a function of the type of study, the nature of the topic, and the data collection method in terms of how much data is likely to be generated. She suggests that in a study where large amounts of data are likely to be generated for each participant then the sample need only be six to ten participants, for example in a phenomenological study.

There is no right answer to the question of sample size. The issue is of the quality, not quantity of accounts from individuals' and so I performed a thematic analysis to look for meaningful points of similarity and difference between participants. As interviews generate large amounts of data it is important not to become overwhelmed, therefore, a small number of participants were suitable for the phenomenological approach to this study. According to Smith et al. (2009) it is the number of interviews and not the number of participants that are crucial in qualitative studies. They suggest that between four and ten interviews is an ideal number in order to allow for the analysis and development of similarities and differences between participants. Twenty nine interviews were performed in this study and it could be argued as to whether this sample is in keeping with a phenomenological study. However, it must be stated that the analysis of data centred on the nine recorded interviews, as these were a reliable record, with the field notes from the remaining participant interviews being used to confirm and support points raised in the recorded interviews.

The sample raises questions regarding the transferability (external validity) of the results as the study was performed within the Tayside area only. This issue will be discussed later in the section addressing rigour of the study.

2.3.6 Ethics

Ethical approval

Prior to the commencement of the study it was necessary to gain ethical approval from the University and local NHS research ethics committee as all participants would be NHS patients. The application procedure, situated within the context of the NHS, was medically oriented and focussed on issues of harm and risk. As such, my obligation to participants was perceived as the prevention of harm as a consequence of participation in the research. The nature of the study made it impossible to know at the beginning what might cause harm to participants therefore, I had to remain constantly aware of ethics throughout the study. This places a continuous awareness of ethics within the domain of an honest and respectful research relationship (Hollway and Jefferson 2000).

Ethical approval for this study was granted by Abertay University (Appendix E) and the East of Scotland Research Ethics Service (Appendix F).

The main ethical principles underpinning the research were voluntary participation, informed consent, anonymity and confidentiality, safety of the researcher and protection of the participants from harm. Each will be considered in order to highlight the ethical principles involved in the study and the actions taken to protect the participants from any potential harm or distress.

Voluntary participation

In order to uphold the individual's human rights, participation in research should be voluntary (Dench, Iphofen and Huws 2004). The recruitment strategy for the study ensured that potential participants were not forced into taking part in the study. Voluntary participation was ensured by informing the participant of the study and seeking his consent. Gaining initial consent from the participant however, did not imply that he continued to give consent. Participants were able to withdraw their consent at any time and cease their participation in the study. This was made clear to participants in the Participant Information Sheet (PIS) (Appendix G) given and fully explained at initial contact with questions answered.

Informed consent

O'Neill (2003, p.6) defines informed consent as follows:

"Patients, research subjects, and tissue donors give genuine consent only if they are neither coerced nor deceived, and can judge that they are not coerced or deceived; yet they must not be overwhelmed with information. This balance can perhaps be achieved by giving them a limited amount of accurate and relevant information and providing user friendly ways for them to extend this amount …as well as easy ways of rescinding consent … Genuine consent is apparent where patients can control the amount of information they receive, and what they allow to be done".

For O'Neill at the heart of informed consent lies the participant's perception that they have been neither deceived nor coerced during the research process. Therefore, informed

consent becomes a continuous process, a facet of the research relationship, not simply a procedure to be followed at the beginning of the research relationship. In this respect it becomes the responsibility of the researcher to protect the participant from harm through the development of a relationship based on the values of honesty, empathy and respect (Hollway and Jefferson 2000). Seeking informed written consent from participants had a very positive effect on the relationship. They responded in a positive manner and appreciated that their opinions were respected. It was remarkable to many of the participants that anyone would ask them for their consent as they had been so accustomed to people taking from them and ordering them about that it was a surprise to them to be treated as a human being and shown respect by a stranger.

Some researchers advocate the use of an informed consent form (Seaman 1987, Holloway and Wheeler 2002). Seaman (1987) indicates that the form and accompanying information sheet must include all the information that the subject needs in order to make an informed decision to participate in the research or not. With this guidance an informed consent form was constructed, and given ethical approval, which the participants were asked to complete. An example of a consent form utilised during the interviews is provided in Appendix H.

Informed consent, then, is regarded by most researchers as a core element of ethical practice, alongside related concerns such as the avoidance of deception, harm and exploitation, and the principles of confidentiality and anonymity. Central to these concerns are the concepts of agency and competence; that research participants are able to express their own agency within the research process, rather than being treated merely as 'subjects' upon whom research is 'done', and that their ability to express their own agency arises from their competence at decision making. This includes their competence to make informed

decisions about whether or not to participate in research, predicated upon ready access to adequate information about the research process and the uses that might be made of the data generated by their involvement.

It was also necessary to obtain written consent to ensure that copyright legislation was adhered to as the participants' interviews were recorded. The Copyright legislation (2003) requires written consent for two things:

1. The words spoken
2. The recording of those words.

As copyright for the spoken words is held by the participant, written consent was required from each participant in order to quote passages of their interviews in the thesis. It was also required for recording and archiving their interviews for scrutiny by external examiners. Participants were assured that recordings would be destroyed after completion of the study and would not be archived for any future research.

To finalise written consent, the consent form was discussed face-to-face with and signed by myself and the participant prior to the commencement of the interview. I kept a copy of the completed, signed consent form for my records and gave the participant a copy. This process ensured that the participants were made aware of their rights, the purpose of the interview and its future use thus ensuring that their interview would not be subject to exploitative or other undesirable uses.

Anonymity and confidentiality

This study with its dependence upon the narratives and detailed stories of people's lives, leaves its participants open to being recognised. Anonymity refers to attempts to hide identity within the products of research (Grinyer 2002), which reduces the likelihood of recognition by others.

Several measures were employed to ensure that confidentiality and anonymity were maintained. The requirements of the Data Protection Act (2005) were adhered to at all times. Only the researcher had access to the data and it was only shared with the research supervisors for the purposes of completing the study. All audio, documentary and transcribed material was kept in a secure location with restricted access. All information stored electronically was accessible only via password protection and encrypted for added security. Participants were assured anonymity by ascribing to each a pseudonym in the reporting of the data and that any personal details were deleted from recordings and transcripts of interviews.

Safety

The safety of the researcher from physical threats or abuse had to be addressed for ethical approval. To ensure this, supervisors or a family member were phoned prior to an interview and given location details and also upon completion to confirm they were safe. If the supervisor/family member had not been called back after two hours then they were to phone the researcher. If there was no reply, then the police were to be contacted and informed that the researcher was possibly in difficulty. This procedure concurs with some of the recommendations made by Craig et al.(2000). No safety issues arose while conducting

the interviews. When exiting the field with participants I drew their attention to the support organisations that were available should they require any support following the study. I took all possible precautions to protect the participants from harm and to my knowledge no participants reported any ill effects or distress as a result of having taken part in the study. Participants were informed that I would make every attempt to contact them with results of the study using the contact details they had provided. They were also informed that once the data collection process had been completed then I would no longer be contactable by mobile phone as the number would be deleted.

2.3.7 Introducing the study to potential participants

Potential participants attending a recruitment centre were informed at the end of their consultation that a research study was taking place and given a Participant Information Sheet. This sheet was explained to them and that it was their choice whether or not they wished to contact the researcher regarding volunteering for the study. It was felt this approach placed less pressure on the men to participate and gave them time to think about the study, consult with the independent advocacy centres and the researcher, if required.

All the potential participants contacted me by telephone or in person and a mutually convenient meeting was arranged. At the initial meetings participants were issued with a PIS (see Appendix G) and the aims of the study, consent, anonymity, confidentiality, and the recording of interviews were discussed and any questions answered. The information sheet and discussion provided the potential participant with the information required to allow an informed decision about consent, without overburdening them (O'Neill 2003).

The PIS held contact details for the local independent advocacy service that had agreed to meet with the men and to manage their queries about participating in the study. This strategy was implemented to ensure that consent was based upon the amount of information that each participant felt they needed in order to make a fully informed decision on their inclusion.

During the initial meetings I also offered salient information regarding my background as a nurse and current status as a postgraduate student. Although this information was received favourably and participants were pleased that I was not employed by the SPS it did cause doubts as to how this information would affect what participants might disclose in their narratives. The reasons for this being that the literature mentioned that male prisoners can hold a mistrust of healthcare workers (Howerton et al 2007) and also that I did not wish to influence or inhibit their responses by offering my thoughts on prisoner healthcare. However, I felt that a relationship reflecting honesty with regard to my identity was important to the participants and the overall study. Considering O'Neill's (2003) definition of informed consent, not being transparent in the researcher/participant relationship might be considered as deceitful, and therefore, informed consent may be invalidated. Potential participants were not asked to consent to take part at this point, but were encouraged to think about it for a week. At the end of the initial meeting the men were informed that I would contact them promptly seeking a decision with regard to participation. At this point, if appropriate, a meeting would be arranged which would cover questions and gain their written consent before commencing with the recorded interview. At this stage, eight men dropped out and did not proceed any further with the study. As previously mentioned a

written consent was also required in order to fulfil the requirements of Copyright legislation (2003).

Confidentiality has been strictly maintained and no staff at the recruitment centres or any academic supervisors has been informed about the identity of anyone who has taken part in the study.

2.3.8 Data collection method

A variety of methods are deemed appropriate in phenomenological-based research. Semi-structured interviews were used for collecting data and, therefore, interview technique was crucial. It was important to ensure that a balance was struck between keeping a focus on the research issues and avoiding undue influence on the participant. The establishment of a good level of rapport and empathy was critical to gaining depth of information, particularly in this study where the participants' had a strong personal stake in the issues being investigated.

An interview is essentially a conversation with a purpose (Berg 1995). My purpose was to collect participants' stories regarding their healthcare experiences in prison and the community. A semi-structured interview is an interview where there is some framework to the discussion (Lanoe and Ogier 2002). An initial interview guide was developed (see Appendix I) as this was required for ethical approval. It was devised utilising recommendations from Drever (2003) and Barriball and While (1994), to demonstrate transparency in the research process, with the research question identifying the information that was required from participants which was then used to formulate several open ended questions. According to Fielding (1994) although more focussed, semi-structured interviews

still offer flexibility as to the sequencing of questions and the depth of exploration. The interview schedule provided me with guidance and focus to ensure that each interview was tailored towards interviewees' preferences and responses, in the form of a guided conversation (Lofland and Lofland 1984).

Interviewing the participants and subjecting their stories to a thematic analysis raised the subject of my characteristics and preferences as a researcher along with the concept of conformability. It can be argued that the quality of the study can be affected by my experiences and "insider" knowledge of the prison healthcare system. These in turn may influence my interactions with participants and subsequently, influence the stories they divulged and subsequent analysis of them. To ensure that the findings of the study are those of the participants and not mine, I have been transparent in explaining my background, the decisions made and methods adopted during the study.

I conducted the interviews using an informal, conversation style to help assist frank and open discussion. In Fielding's (1993, p.138) view, this is best achieved if the interviewer is relaxed, neither condescending nor deferential, displays interest without appearing intrusive, and strives to personalise issues in order to reach underlying attitudes and beliefs. The first two participant interviews were treated as pilot interviews in order to practise my interview skills and accomplish these criteria. However, the data obtained was utilised in the analysis.

Recruitment of participants and conducting the interviews took place over a period of eight months. I interviewed the participants in the community within six weeks of their liberation from prison and made a decision as to the maximum time span for each interview. Edwards & Talbot (1994) suggest that an in-depth interview can easily take an

hour. In order to encourage people to participate, and to allow for adequate data collection, I decided that participants would be interviewed for a maximum of 1 hour and 30 minutes. The length of interviews varied but on average an interview lasted approximately 1 hour. Each interview was arranged at the participant's convenience and generally took place within the University. However, if they preferred to meet somewhere else then this was accommodated as long as it was in a public location and not in their home. This was to ensure my safety and adherence to the ethical guidelines approved for the study. The interviews, with the participants' consent, were audio recorded to facilitate data analysis (Barriball and While 1994). For those that did not give consent to being recorded, field notes were made following the interview in order to aid analysis. Field notes were not made during the interview itself as it was felt that it was important to listen to the participant and give them my undivided attention.

Field notes were made of the twenty participant interviews for which recording consent was not given. These notes were made within twenty-four hours following the interview using guidelines from Emerson et al (1995) and Mulhall (2002). The notes comprised the following:

- The details of date, time and place where interview was conducted.
- Demographic details of the participant.
- Diary of the events that took place during the interview
- Details of the dialogue that took place
- How the participant behaved during the interview?
- Reflections on the participant's account of their experiences

As the interviews proceeded, my interviewing technique and questions evolved and developed. Some of the earlier attempts were overtly formal and structured. With greater confidence and awareness, the interviews began to flow better and I felt able to relax more into a conversation style. I found that the early part of an interview commonly involved building up a degree of trust and rapport. This was accomplished through trying to ensure that the setting for the interview was comfortable and as free from distractions as possible with interviews being opened with questions that the participant could answer confidently along with friendly conversation. I would also explain in broad terms the goals of the research and ensure that they understood the purpose of the interviews and what would happen to the data contained within them. The self-disclosure of my background, motivations for conducting the study and the ethics that were being adhered appeared to be significant in building trust with participants. Also, I found that participants became more engaged when they were asked at the beginning to talk about their experiences of prison healthcare.

2.3.9 The research relationship

The interaction of researcher and participant is important in the research process. In order to encourage participants to tell their narratives they need to feel safe to do so, and this depends upon the research relationship (Riley, Schouten and Cahill 2003). Qualities such as trust and rapport are built as the participant experiences the reactions of the interviewer to their narratives. As participants gain a sense that they will not be judged, and that their thoughts and opinions are valued and respected, they feel more secure in the relationship (Riley, Schouten and Cahill 2003).

In order to represent the participants' experiences, it was crucial to focus on the issues that they perceived as important. From my own experience I brought knowledge gained from a nurse's perspective to the study which had tended to focus on nursing rather than patient issues. Being aware of this meant that during the interviews I ensured that my actions were focussed on the participant's story and were used for the purposes of gaining clarity. By doing this I attempted to overcome the tendency to assume that I knew what participants meant based upon my own knowledge and experience.

Utilising semi-structured interviews as a data collection strategy raises the issues of subjectivity and intersubjectivity. It is acknowledged that participants gave a subjective interpretation of the healthcare experiences that they had chosen to divulge. Equally it is acknowledged that I was also a participant in the interview and my responses influenced the responses of the participants. My experiences and understanding of the world and of prisoner healthcare were shared with the participants while they gave their accounts of their experiences. As a result, the interviews were dialogical and the meaning of the life experiences was a result of the co-creation between myself and the participant.

Reflexivity should be an important research goal (Heyl 2001). Researchers must be continually self-reflective, self-critical, and self-conscious. Reflexivity requires researchers to recognise they are entangled with their methods and the politics of the social world they study (Holliday 2007). It is essential researchers identify, address, and benefit from the complexities of their presence within the research setting (Holliday 2007). My report is a personal response to a situation, as I am a social being that cannot rise above the realities of social life (Hughes and Sharrock 2007). I cannot escape subjectivity, so it must be embraced and accounted for (Holliday 2007). Therefore, it is recognised that the relationship between

the researcher, the participants and the location are not impersonal; it is, instead, interpersonal, related, and convoluted. As mentioned above, this implies that the meaning of the participants' accounts is co-created between myself and participant. Hence, for the purposes of ensuring rigour in the study there is a need for me to be transparent about my background and how my perspective and knowledge influenced the interviews and analysis. The issue of reflexivity will be discussed more fully in section 2.4.4.

2.3.10 Data

In this study I recorded semi-structured interviews with nine participants. The material contained within these recordings has provided the data for the study. The participant interviews are viewed as big stories or narratives, which as Freeman (2006) states, the participants have reflected and decided upon the significance of events that they have experienced. These have then been recounted in the interviews and tell us about the participant's overall experience of healthcare in and out of prison. However, in this study, the view has been taken that these big narratives are composed of many smaller narratives which deal with particular aspects of the overall experience. These can stand alone and offer a view on particular aspects of a participant's experience but when viewed together with all the other small narratives builds up the large narrative which constitutes the participant's experience of healthcare in and out of prison.

Interviews are also used for the window they offer to look at the narrative environment external to the interview itself (Weiss 1994). However, looking out at environments from inside a narrative and using the metaphor of the window for the narrative limits the way in which the narrative environment is viewed and also how much of it can be seen. Taking this

limit into account Riessman (2008) argues that ethnographic study of participants' settings facilitates stronger understanding of their stories including those told during interviews. In order to deal with this issue, I visited a number of healthcare venues that were mentioned by participants in their interviews. These included community healthcare centres, substance misuse services, health centres in the Police custody suite, Perth and Castle Huntly Prisons, third sector organisations and a number of hostels used by recently liberated men. These visits gave me a greater knowledge and awareness of the environments that were being talked about in the interviews which allowed the narratives to be placed in an environmental, as well as chronological, context which aided analysis. They also provided me with more information and insight into the issues, such as accommodation and substance misuse that many of the participants talked about in their accounts.

2.4 Approach to data analysis

2.4.1 Approaches to analysing narratives

Thematic Analysis (TA) (Braun and Clarke 2006) is often regarded to be a realist/essentialist method or an effective method for identifying patterns in data. However, TA is theoretically flexible and can be utilised across a wide range of theoretical approaches and can be used to produce descriptive overviews of the key features of the semantic content of data or complex and sophisticated conceptual interrogations of the underlying meaning in data (within a constructionist framework). As a consequence, TA is not a solitary process. It can be used to produce a relatively straightforward analysis or one that is as sophisticated as an Interpretative Phenomenological Analysis (IPA), grounded theory or discourse analysis.

As this study used a phenomenological approach there were two methods of data analysis that were considered, namely Thematic Analysis (TA) and that used in Interpretative Phenomenological Analysis (IPA) (Smith, Flowers and Larkin 2009). In order to decide which would be more appropriate, divergent routes were considered as the end result of an IPA and a TA analysis can be very similar. Firstly, IPA is more than an analytical tool and better thought of as a methodology (a theoretically informed framework for how you do research) rather than a method (a technique for collecting/analysing data), whereas TA is a method alone (Smith, Flowers and Larkin 2009).

There are a number of differences of procedure between IPA and TA. In IPA, all the design choices have been made. As well as outlining a range of analytic procedures, IPA specifies the ontological and epistemological underpinnings of research are critical realism and contextualism (Larkin, Watts and Clifton 2006), the theoretical framework is phenomenology and research questions ask about people's experiences and perspectives. The sampling strategy used tends to be fairly homogenous with small samples and ideally data is collected in qualitative interviews. Despite this being a simplification, the main point is that IPA provides an entire framework for conducting research. In contrast, TA is a method and the main quality of TA is its flexibility as it can be used across the epistemological and ontological spectrum underpinned by phenomenology. Therefore, it may be used to address a wide range of research questions (including questions about people's experiences and perspectives), there are no specific requirements for sampling in TA and it can be used to analyse most types of qualitative data including interviews.

In terms of analytic procedures, both IPA and TA involve coding and theme development, but these processes are somewhat different for each method. Coding in TA begins after a

process of data familiarisation, in which the researcher notes any initial analytic observations about each data item and the entire data-set. The researcher then codes across all of the data items. The researcher then collates all the relevant data at the end of the coding process. By contrast, coding in IPA consists of a process of initial noting in which the researcher writes their initial analytic observations about the data on the data item. These initial notes are brief commentaries on the data. Another difference is that in IPA, the researcher codes their first data item then progresses to developing themes for that data item, rather than coding across the entire dataset, and then progressing to theme development. So IPA focuses on developing each stage of the analysis for each data item, before moving to the next; whereas TA involves developing each stage of analysis across the whole dataset.

In terms of procedures for theme development, there are two levels in IPA and one level in TA. In IPA, these are referred to as emergent and superordinate themes. Emergent themes are noted on the data item. Superordinate themes are developed from emergent themes. Once coding and theme development is complete for each data item, the researcher develops superordinate themes across the dataset. In TA, themes are developed from the codes (and collated data), across all data items.

Overall, IPA analytical procedures help the researcher to stay close to the data, because they develop codes and themes on the actual data item, and focus on the unique characteristics of each individual participant, because they code and develop themes for each data item in turn. In contrast, the procedures of TA help the researcher to identify patterns across the entire data-set. Taking these differences into consideration, as the focus

of this study was to gain a more patterned meaning across the data-set it was decided to use TA as the method for data analysis.

2.4.2 Transcription.

Transcription of the interviews is where analysis of the data starts (Riessman 1993), however, ideas arise while conducting the interviews. I transcribed all of the interviews from audio to text. The way in which narratives are spoken contributes to their meaning, therefore, to aid analysis, it meant that transcripts of the interviews in this study had to include more than just the spoken words and had to include information about the paralinguistic features of the interview. Poland (2002) developed a useful list of paralinguistic features for inclusion in transcripts along with the notation to be used for each feature (Appendix L). Once transcripts had been completed using this notation they were checked against the tapes for accuracy.

In order to ensure that an accurate transcription had been made and also to contribute to the authenticity and credibility of the interviews, transcripts were issued to one-third of the interviewees (i.e. those I could still contact when the transcripts were completed), with a request to check it for accuracy and comment. None of the participants came back with additional comments, feedback or request to change anything.

2.4.3 Data analysis

A thematic analysis is utilised in the study, primarily because it is suited to exploratory research. For example, Condon et al. (2007) and De Viggiani (2006) successfully use

thematic analysis in their prison studies that explore prisoners' opinions concerning, and experiences of, prison mental health.

Thematic analysis is a reductionist technique that is concerned with the creation of themes. Identification of the thematic framework is carried out by drawing loosely on *a priori* issues as derived from the study's question and the objectives of the project, as well as issues raised by the respondents themselves, and unexpected views/experiences that occur in the data (Pope, Ziebland and Mays 2000).

Themes within data can be identified in one of two primary ways in thematic analysis; in an inductive way, or in a deductive way. This study adopted an inductive approach which means that the themes identified were strongly linked to the data themselves (Patton 1990). Therefore, inductive analysis is a process of coding the data without trying to fit it into a pre-existing coding frame.

Thematic analysis commenced with reading all of the transcripts thoroughly several times in order to immerse myself in the data to the extent that I was familiar with the depth and breadth of the content. Following this, all of the transcripts were then coded. A short extract taken from Michael's interview helps to illustrate how this process was performed. In this extract he is talking about the dental services within the prison: -

203. Michael. Yeh. You have got to remember that like there is maybe like 700. 800 people right in the dentist right *Code: Dental service numbers*.

204. So the list is. Like he will maybe see maybe about ten people one week. Another ten the next week and it goes on and on. *Code: Limited dental service.*

205. And you just have to wait until you are on the list. And it could be three, four months. *Code: Dental waiting list.*

206. Can you imagine having a toothache for three four months? *Code: Effect of waiting list.*

207. JF. Well.

208. Michael. It makes you. makes you ratty. It makes you like like you cannae think of anything else. You are unapproachable and it makes me ratty. *Code: Not coping, feelings "ratty" and unapproachable.*

As can be seen from the extract the participant was describing the demands upon a dental service with long waiting lists which had resulted in him experiencing a lot of pain.

This process of coding was part of the analysis as data was being organised into meaningful groups. This step in the process is known as microanalysis of data (Strauss and Corbin 1998). As Wainwright (1994, p.44) states "Microscopic line by line analysis (or coding) is necessary to achieve a detailed interpretation of the data and to unravel the complexity of the phenomenon studied and making convincing sense of it". Code words or labelled concepts, as they are called by Strauss and Corbin (1998), were written in the wide margins of the transcript for easy identification next to phrases, words or comments in the text.

This coding was done manually by systematically working through all the transcripts. The purpose of this was to match up the identified codes with data extracts that demonstrated that code. Whilst completing this task it was important to ensure that all data extracts were coded, and collated together within each code.

After coding had been completed, the analysis re-focused at the broader level of searching for themes, rather than codes (Braun and Clarke 2006). This involved methodically sorting the different codes into potential themes, and collating all the relevant coded data extracts within the identified themes. Essentially, this was an analysis of the codes and considering how different codes might combine to form a theme. A sample of extracts is shown as examples of how this process was performed within Appendix D. It became clearer as I progressed through this process that there were four distinct themes contained within the transcripts that were coherent, clear and identifiable with distinctions between them. These four themes were: -

1. Healthcare-related experiences of adult males before and after release from prison: Part 1. The meaning of health.
2. Part 2. – Access to healthcare in prison and community.
3. Part 3. - Difficulties in interagency communication of care.
4. Part 4. – Vulnerability and hope.

A schematic diagram showing the main themes and sub-themes and the relationships between them is shown in Figure 5.

The themes were also discussed with participants to gauge their views on my interpretations and representation of the data. It is acknowledged that the themes generated are broad; however, they are rooted in the experiential accounts given by participants.

Having identified the four major themes, the next step to be performed was an analysis of the data that existed within each of them. This involved going back to the complete

transcripts and highlighting in different colours the data from each theme within the transcript as suggested by Braun and Clarke (2006).This helped to identify the elements such as words, phrases and extracts that, in keeping with the phenomenology approach, I interpreted to be representative of what was interesting about each theme.

2.4.4 Rigour of study

Koch (1994) presents a number of factors used to ensure the rigour and trustworthiness of qualitative research. First proposed by Guba and Lincoln (1989), they are credibility, transferability and dependability. However, Edmunds and Scudder (2009) also added authenticity to this list. Credibility refers to the believability of the data and the confidence one has in the truth of the findings. Transferability refers to the ability of the findings to be transferred to other contexts (for example, do the results have applicability to other groups?). Dependability focuses on the stability of the data over time and in different contexts and conditions. Authenticity focuses on the degree to which researchers faithfully and fairly described participants' experiences.

Credibility

Patton (1990) states the credibility of a study is reliant on the credibility of the researcher they are seen as the instrument of data collection and central to the process of analysis. As a result researchers should state what experience, perspective and qualifications they bring to a study in order to enhance its credibility (Patton 1990). These were mentioned in the introduction to this chapter where my nursing background was disclosed.

In order for the reader to assess the degree of rigour applied in the study it is also important that there is complete transparency of the methodology and methods used. This chapter has provided details of both.

Transferability

With such a small sample, statistically the results are not generalisable over the whole of the prison population. However, the word generalisability generates a picture of statistics being used to generalise the results from small samples to populations. However, this is not the aim in qualitative research. In particular, one of the key goals should be to make that research as relevant as possible. For that reason, the term transferability rather than generalisability is best applied when discussing what has been learned from the research.

Transferability relates to whether the findings of a qualitative study are applicable in situations other than the one studied (Seale 1999). Transferability is usually applied by research readers to make links between elements of a research study and their own experience. As a result, it is imperative that there is a thick description of the phenomenon under study in order to allow the reader to have a proper understanding of it. This allows them to compare the instances of the phenomenon explained in the research with those that they have seen in other situations. To enable this, I have explained the boundaries of the study and ensured that I have given information regarding:

- The organisations involved in the study and their locations.
- The inclusion/exclusion criteria and demographics of the participants who provided the data.

- The method of data collection in this study; semi-structured interviews.
- The number and length of interviews.
- The period over which the data was obtained.

As mentioned earlier in this Chapter, participants came from a variety of locations across the Tayside area and had served all or part of their sentences in prisons across Scotland. It is acknowledged that questions could be raised as regards whether the same results would be obtained in other parts of Scotland. However, given the way in which healthcare is provided for men within secure SPS estates, and that these estates are governed using the same philosophy, policies and procedures throughout Scotland, the findings are likely to be highly transferable. It is acknowledged that this would only be the case for prison healthcare provided within secure, closed conditions in men only prisons as the general prison conditions and healthcare facilities differ in the male open estate at Castle Huntly prison and that that provided within the current national facility for women at HMP & YOI Cornton Vale and women's units at HMP Greenock, HMP Edinburgh and HMP & YOI Grampian. With regard to the findings relating to healthcare in the community then these may not be as transferable due to variations in policy and priorities within the different Primary Healthcare Trusts throughout Scotland.

The sample of participants used was congruent with the phenomenological approach taken for the study and the results provide a contribution to the general debate regarding healthcare provision for this vulnerable group.

Dependability

Involving participants is a strategy that can be utilised to demonstrate the dependability of research. Sandelowski (1986) highlights that an important role can be performed by participants in strengthening the trustworthiness of qualitative data. As mentioned earlier transcripts of interviews, along with the study findings were given to participants to determine that I had interpreted and presented a fair representation of their narratives. The participants' comments supported that their perceptions were compatible with the study findings. Sandelowski (1986) emphasises that rigour in qualitative research will only be achieved if research reports clearly describe and justify what is done at each step in the study.

Lincoln and Guba (2003, p.275) consider trustworthiness as "defensible reasoning, plausible alongside some other reality that is known to author and reader". Therefore, readers assess trustworthiness by evaluating the methodological and interpretive decisions of the researcher with existing knowledge. For this to be performed, these decisions must be explicit to them in the research report. This chapter sets these out in order that the reader can draw their own conclusions regarding the trustworthiness and authenticity of the study.

Reflexivity

Self-reflexivity in qualitative research is a process where the researcher reflects on how their ideas, values and experiences can influence the data collection and analysis within their study. It is relevant to this study as it helps the reader assess the rigour that has been

applied to the analysis of data and writing up of subsequent findings. This is performed by providing information regarding the motivations and decisions made throughout the study, the position taken towards the phenomena under scrutiny and attitudes towards participants.

I have had a lifelong association with the prison service and NHS through family members and friends who worked in the prison service/criminal justice system/NHS. I also chose to follow a career in nursing with all of my posts being within NHS establishments.

The motivation to research the healthcare experiences of ex-prisoners comes from my experiences as a staff nurse in two Scottish cities where I cared for many men that had been admitted from nearby high security prisons. I accepted that they required care like any other patient and endeavoured to provide that in keeping with the concept developed by Carl Rogers (1957) that all patients should be treated with unconditional, positive regard. However, not all my colleagues agreed with this and they voiced many different opinions especially with regard to those that had been in prison. While I accept that people are entitled to their opinions, it concerned me that their attitudes may possibly affect their behaviour and the quality of care that was given. At that time my duties prevented me from doing any research into the care given to the prisoners but I would talk with the men who would tell me stories about themselves, their family and medical conditions. However, they would not comment on their treatment as they were always accompanied by two prison officers. Although their stories were interesting, and it helped to build up a good rapport with them, I always had a feeling that they wanted to say more but were prevented from doing so due to the presence of the officers. I wondered about the stories they were not telling and what they might contain but the opportunity never arose to research it further.

When I learned about the proposed changes to prison healthcare I decided that the time had come for me to satisfy my curiosity and perform research to explore the untold stories.

What I have found in performing this study is that undertaking full time research is not easy. It is a way of life that requires motivation, commitment and hard work as there are generally more questions than there are answers. I also found that to try and investigate experiences is a lot harder than it would at first appear. As one participant, William, said when we were discussing his experience of coping with a chronic medical condition in the prison:

William. *Yeh. The only real way you would do it. Get sort of like. You would have to go to jail yourself Jim and you don't want to do that (laughs).*

JF. *Exactly.*

William. *Jim. It would certainly open your eyes because it certainly opened mine I can assure you. I got an education in the nick.*

In talking about his condition he made the valid point that short of serving a prison sentence it is very hard to write about the experiences of those that have served sentences without having the knowledge and understanding of general prison life as an "insider". I do not consider myself an "insider" as I have not served a sentence or worked in the prison but I was brought up next to the prison, have visited it while performing this study and have spent a lifetime listening to family and friends talking about their work inside of it. This has meant that I have become accustomed to the vocabulary and discourses used in the prison environment with the result that I felt comfortable speaking with the men and asking them

probing/clarifying questions while conducting their interviews. However, given my background and knowledge of the prison system, I was accustomed to many points raised by the participants which made the analysis particularly hard to perform and I had to stand back from the data and try and observe it from different perspectives.

2.5 Summary

This study was conducted using a qualitative approach as this was most appropriate for investigating the healthcare experiences of men that had served a prison sentence.

The ontological position was that of constructionism and the epistemological position that of interpretivism. Taking these positions into account a phenomenological approach was taken to the method chosen for the study as this was most appropriate given that the phenomena of experience was being investigated, that no hypothesis was proposed and that no attempt was to be taken to generate a theory to explain the healthcare use of the participants.

It was decided to utilise semi-structured interviews with the participants given the reported levels of illiteracy within this section of the population and also to be sympathetic to the men's feelings and self- esteem. I did not want any participant to feel that they could not take part in the study because of their literacy level as all of the men had experiences that would help to illuminate the healthcare afforded to them. I therefore, wanted all potential participants to feel included and that they were making a valued contribution in the study. Semi-structured interviews also allowed the men freedom to talk about other things, other than healthcare, that they felt were important or contributed to their overall experience. This freedom to talk freely and be listened to was important as participants reported that they felt excluded from all areas of society except that of their peer group. This may contribute to why many get caught up in the revolving door between prison and the community and feel that there is no escape for them and accept that this is their fate.

Recruitment of participants was ethically and practically difficult. The prison population is recognised in law as a vulnerable group and they are subject to labelling and stigma from

the rest of the population due to the attitudes towards crime and punishment that exist in Scotland. All of the participants were acutely aware of the way in which society in general views them and I avoided contributing to such views. Rather, I aimed to explore healthcare that is afforded to these men and highlight the difficulties they encountered. This meant that recruitment had to be pursued in a way that did not reveal the men's past, hence, the use of gatekeepers in the recruitment centres which afforded the men privacy and attempted to preserve their dignity.

A sample in accordance with phenomenological studies was utilised as this allowed for an in depth analysis into the participants' experiences without being overwhelmed by the large amounts of data that can be generated from semi-structured interviews. However, the sample does raise questions regarding the generalisability and transferability of the study findings. As previously discussed, the sample size was in keeping with the approach used and it is acknowledged that the results are not generalisable to the whole population. However, they are transferable with regard to the prison environment but due to a number of regional differences in primary care priorities and policies across the country they may not be transferable in the community setting. However, they make a contribution to the debates surrounding healthcare for this group of men.

The recruitment strategy worked and a suitable sample of men took part in the study. One strategy that had not been expected was the effect of word of mouth recommendation. This was a very welcome development which certainly boosted numbers of those enquiring about the study. Even with this occurring it took longer than the expected six months to recruit participants. This was largely caused by the request to record the interviews which deterred a lot of men from participating. The sample of participants contained a good cross

section of ages and experiences with the criminal justice system, however, due to the sample size it has to be acknowledged that the sample is not statistically representative of the whole prison population within Scotland but their stories help to illuminate the difficulties they face in using healthcare services.

What became apparent during the recruitment of participants was that prisoner healthcare is not just provided within the prison walls, it exists in the community because of the effects of labelling, stigma and prejudice. Prisoner healthcare is an unfortunate term and implies that healthcare services provided for prisoners serving their sentences within a prison. This would appear to reinforce stigma, labelling and exclusion experienced by this vulnerable group. However, it could be argued that it is an appropriate term as there are a small proportion of convicted prisoners serving Home Detention Curfew orders (HDC) and home leave from the open prison within the community.

Semi-structured interviews were used to collect narratives from the men. These narratives contained the data which was then subjected to an inductive thematic analysis. This analysis method was chosen as it gave a more patterned meaning across the data-set and subsequently it produced four major themes: -

1. The meaning of health.
2. Issues related to access to and use of healthcare provisions in prison and the outside community.
3. Difficulties in interagency communication of care.
4. Vulnerability and hope.

These will be discussed in greater detail in chapters' three to six.

Chapter 3. Healthcare-related experiences of adult males before and after release from prison: Part 1. The meaning of health

3.1 Introduction

This chapter presents the first major theme; how participants understood the concept of health on the basis of their experiences. This theme does not exist in isolation. Elsewhere in the analysis, the themes identified are inextricably connected to each other as illustrated in the schematic diagram in Figure 5.

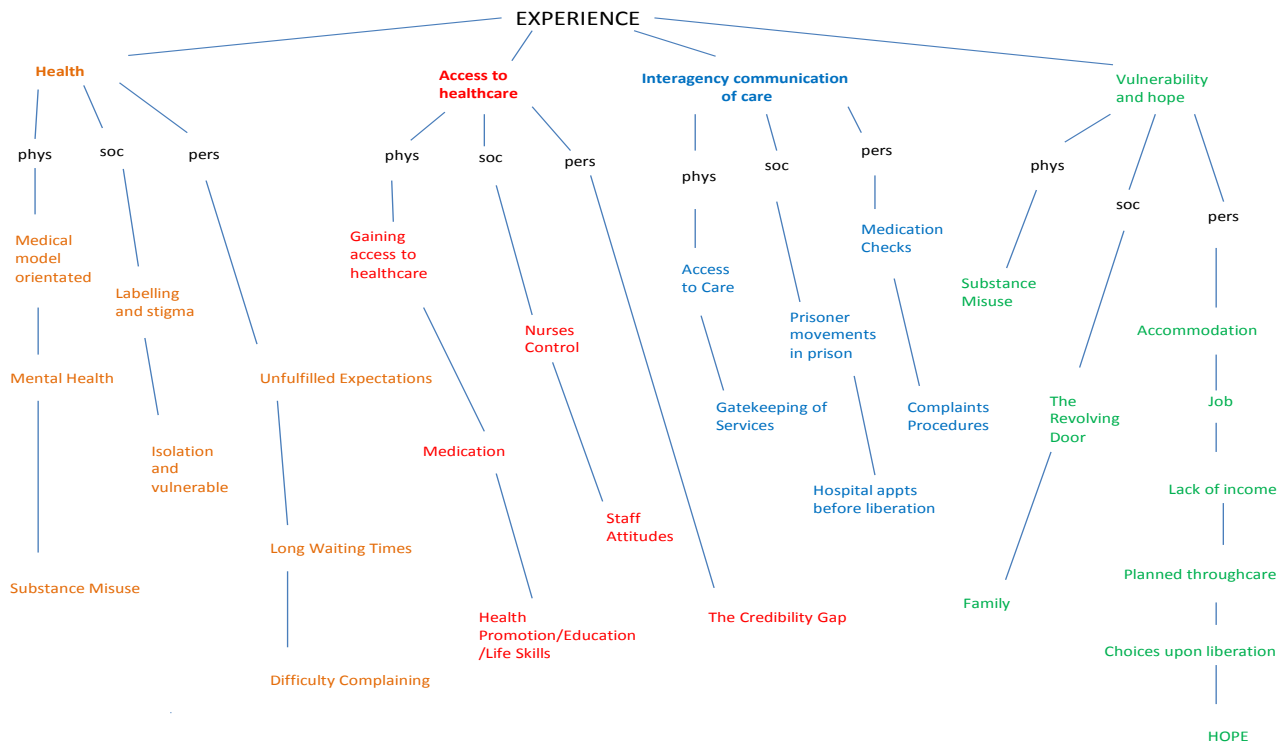

Figure 5. Schematic showing themes and sub-themes

Themes

Health = Orange

Access to Healthcare = Red

Interagency Communication of Care = Blue

Vulnerability and Hope = Green

These themes represent an extraction of the participants' voices and their collective experience of health and healthcare in prison and the outside community. The participants' own words are presented to illustrate the development of the themes. This helps retain how they voice their personal experience of health.

Issues relating to the health of participants' form a strong theme running across the interviews, binding the narratives together in this thesis. This is hardly surprising given that the focus of the study and the questions in the schedule form the basis of the semi-structured interviews (see Appendix I). In their accounts, they indicate their experiences of health and the effects that the healthcare system has had upon them. All the participants have considerable experience of imprisonment and the healthcare system operating within it. Following liberation, and with ex-offender status, the participants are able to reflect upon their experiences of prison healthcare and compare them with those they have experienced in the community.

In trying to understand experiences, Binswanger (1958) suggested a model of existential analysis with three basic levels. These were based upon Martin Heidegger's description of the Umwelt, Mitwelt, and Eigenwelt (Heidegger 1962, p.113). The Umwelt is a person's awareness of physical environment, in the sense of an ordered arranging of tools or equipment, which are directly accessible to the objectives and practical tasks of the people within it. The Mitwelt is how a person exists in the world with other people and is how they relate to others and develop relationships and as such is the social component of existence. The Eigenwelt is an introspection or reflection performed in trying to make sense of our lives and experiences by reflecting on our behaviour, values, and desires. These three levels are the basis of Binswanger's (1958) model. This model is used in this thesis as a framework

for categorising and portraying experiences, in particular due to the symbiosis of the model with Heidegger's phenomenological framework and the strong agreement on the core elements of the Umwelt, Mitwelt and Eigenwelt. This allows for an effective presentation of the findings of this study, while preserving clarity of terms and themes.

3.2 Umwelt - Physical and functional aspects

All the participants gave accounts of their experiences and the way this has shaped their understanding of health. The majority of participants understood health as orientated towards a medical model, which focussed on either the presence or absence of a disease, with the resultant effect upon the ability to function. For example, when asked what health meant to him, Robert spoke about the presence of disease:

Robert. *Eh, I've got problems with my back, legs; I've got a frozen shoulder. Health ways…. I struggle with stairs and things like that.*

JF. *So getting about is hard.*

Robert. *Getting about is a hard, hard problem for me……. I'm trying to think…... That's probably about my…….. eh…...my health.*

(See Chapter 2.4.2. for detailed account of Poland's notation for transcribers; see also Appendix L)

As can be seen from the above quotation that Robert alluded to medical problems without giving the formal medical diagnosis. He then elaborated on the functional effect that this had had upon his ability to live his life.

When asked the same question, Michael gave the following account:

JF*. How do you think about your health?*

Michael*. I have got quite poor health as I say because eh*

JF*. And it is poor because of?*

Michael*. With the hip and knee replacement. I am due to have another one but I don't know when it's eh*

Michael*. I've got pain relief for that from that*

JF*. OK.*

Michael*. I've got Hepatitis C and severe cirrhosis of the liver.*

JF*. Right.*

These two examples illustrate commonly expressed experiences throughout the interviews in relation to the participants' reflection on their health status. Furthermore, Participants acknowledged the existence of mental illness and substance misuse, but did not express these as being related to or a potential cause of their lack of health and well-being.

By definition, health is complex and there are many components that contribute to it as well as a person's ability to function in the world. Mental illness can have a large impact upon people's physical as well as mental ability to function. However, most participants experienced mental illness as not adequately addressed by the Criminal Justice system per se, if at all. . Some participants were frightened by mental illness and the preconception associated with it. In particularly, the lack of adequate mental health provision within the prison community, resulted in participants experiencing other prisoners suffering from mental illness as dangerous and, thus sought to avoid these people. One participant illuminated this thought in the following quote:

Michael*. There are some people that should not even be in prison that should actually be in psychiatric wards.*

JF*. That is actually very true. Have you ever come across boys like that yourself?*

Michael*. Lots. And I am very concerned about these people because they are very dangerous and very unpredictable.*

JF*. Really? So there is a lot of guys that are quite mentally ill in prison?*

Michael*. Aye. Aye.*

It is notable, that Michael indicates his personal concern due to the unpredictable and dangerous nature of prisoners suffering from mental illness. One of the main functions of prisons is to protect the public from potentially dangerous individuals, yet this participant

experienced mental illness in other prisoners as a threat to him while in the prison. As he put it:

"You can't very well tell him to fuck off or they create havoc."

Like Michael, others in the study talked about mental illness, yet not about mental health. Little was reflected in the interviews, however and when the matter was raised, it tended to be linked to issues surrounding personal safety from those suffering from observable mental health symptoms or those they knew had a pre-existing mental health condition. In summary, many participants' experiences of mental health focussed on the lack of provision in relation to the threat thereof to their personal safety. Thus, better provisions for prisoners with mental health conditions could be interpreted as contributing to an improved sense of personal safety in the prisons as well as more confidence in the effectiveness of health care provision.

Participants explained that men would access the mental health service if they had an existing chronic condition or if they needed help in relation to a significant life event, for example, the death of a parent or relative. Suicide was experienced as an extreme reaction to a life event, rather than caused by a mental health issue. Some voiced that they had suicidal feelings and thoughts, which had resulted in real attempts to end their life. For example, Brian gave this account of a suicide attempt he had made after the death of his partner:

Brian. I tried to jump out a 15th floor window. That window up there.

After my partner, my son's mother died in my bed next to me, eh.

JF. *Right.*

Brian. And two weeks after it, I was half in the window and half out.

I had to be pulled back in by three people eh.

JF. *And was that a conscious thing? Were you really wanting to take your own life at that time?*

Brian. Aye. Aye.

Brian elaborated on the reason for this attempt in further detail later in the interview:

I done a four-year sentence then a six-year sentence then, when I got out from my six year sentence I met this girl. I was with her for seven years. We had a child and that together and then her liver and her pancreas collapsed. She had blood coming out of her eyes, her nose, her mouth and her ears. And eh.

He stopped after this as he became visibly upset. He then changed the subject and continued by telling me about his son. Given the level of intimate detail he had already disclosed and the obvious distress, I thanked him for sharing such a personal story and

asked him at this point if he wanted to continue discussing this. He took a moment to compose himself and then he continued to tell me more about his son and the efforts he made to visit him. I took this to mean that he did not wish to pursue the discussion about the death of his partner and respected that decision by not revisiting it.

Not all participants had a physical disease or condition that they thought affected their health, however, many had substance abuse issues for which they were receiving treatment. The concept of addiction was acknowledged and many alluded to problems with this in the past, yet did not consider this a health issue. Substance misuse issues were important for all participants as they experienced these as a cause of problems, not only personally, but also for many others within the prison. Many participants stressed the issue of accessing a Methadone substitute programme. Some participants had commenced their programme outwith the prison, yet faced problems in relation to the continuation thereof after commencing their prison sentence. Similar experiences were revealed in the reverse scenario, when participants had commenced Methadone substitute programmes in the prison and sought to continue these once liberated. In summary, the participants often experienced substance misuse as a problem of poor service provision rather than an issue which affected their health or ability to function.

3.3 Mitwelt - Social aspects to health

The participants talked about various social aspects that impacted upon their health and their understanding thereof. One aspect that came over strongly in the interviews was their sense of having been rejected by society and the stigma of having served a prison sentence, which affected their willingness to seek healthcare provisions In particular, this was based

on their experiences in relation to the way they were treated by staff within healthcare establishments.

Several participants described having been treated as a "junkie" by SPS and NHS staff. One participant had experienced being labelled due to his associating with "ex-prisoners" or "junkies." He expressed having been treated as a "second class citizen", as illustrated in this extract:

Mark. *It's like when you go into the chemists for your Methadone. It's like you're getting treated as a second class citizen.*

JF. *That's interesting because chemists are part of healthcare. So, "second class citizen". How does a second class citizen get treated?*

Mark. *Well they're looked down upon... or they would think you were in to steal or... eh they would think you were in for needles or something like that if you are in an exchange chemist.*

To clarify, when Mark talks about an exchange chemist, what he is referring to is a chemist who participates in a needle exchange scheme for intravenous drug users.

In interpreting a wider meaning in relation to these experiences, the rhetorical force of the social category label "second class citizen," as used by Mark, highlights the way this kind of experience of being treated unfairly on the basis of categorical judgement can affect the way ex-offenders see themselves within their Mitwelt after liberation.

Several participants had experienced labelling and stigma due to their associations with other known offenders. They felt excluded from the rest of society. Labelling encouraged some participants to continue their drug and/or Methadone use. Some elaborated on these feelings by explaining that they might as well continue with these habits, as they were treated like a "junkie" anyway. Applying the negative, stigmatising label of "criminal" or "junkie" as placed on them by their Mitwelt, served to promote their self-identification, i.e. their Dasein within their Eigenwelt, as being deviants, thus, encouraging this kind of behaviour as a self-fulfilling prophecy. David describes a situation in which he was labelled by a pharmacy assistant:

David. *The woman who works in the chemist, she does know me from when I had my house. The reason being is she used to live up the street. I was in one day picking up a prescription but because somebody I knew, which I didn't want to know… he came in to the chemist to pick up his daily prescription and she…. Basically put up a brick wall because she saw me speaking to him while he was waiting to pick up his prescription*.

Mark and David expressed their anger and frustration at being labelled and treated differently by healthcare workers on the basis of the stigma society places on ex-offenders. This treatment impacted upon their level of trust in others. The participants were careful who they interacted with and trusted. This was especially true within healthcare, as many members of staff had disappointed them and/or lied to them.

The participants appeared to be collectively describing a chronic process, whereby they were being demonised and dehumanised, not only by society as a whole, but also by the

Criminal Justice System, SPS and NHS. Such experiences demonstrate an awareness of the participants in relation to the issues of power, in the sense that is, the ability to make choices, were limited. Coinciding with this matter is the issue of the stigma involved in being an ex-offender. This point was illustrated by William when discussing the problems, he had experienced within the prison, and getting analgesia medication prescribed which he had required for a number of years for a chronic condition.

And this is where this kind of stemmed from like sort of thing. Because you're being treated basically as a junkie and no a patient. There's definitely a difference between… eh. And I brought that up a couple of times to certain doctors who I wasn't happy with. It was like you know "You're treating me as a prisoner. You're no treating me as a patient". Of course they will deny that. You know. Eh… but if a guy's basically in pain of some kind...

These feelings appeared to be compounded when a participant had to attend a hospital out-patient appointment. While discussing his treatment, Robert described the process in detail:

Robert*. Well that's another thing. Going to a sort of hospital... is eh… sort of eh... a daunting sort of thing. When you go... when you go to the hospital they strip search you before you go.*

JF*. Is that in your cell?*

Robert*. No no this is in the reception. They've got a sort of eh metal chair that you sit on and metal will show up and then they go on and strip search you before you go. So if you get told*

sort of like you are going to the hospital you'll maybe get told the night before right after lockup. Right so what you do is if you're going to the hospital…. You would sort of eh no wear socks because you know you're going to get strip searched and you might just wear one t-shirt or something, right. And then they handcuff you…... when you come out and you're handcuffed all the time even in the hospital.

JF. *Are your hands cuffed or are you handcuffed to someone?*

Robert. *To an officer. To one of the G4S fellas. So you're handcuffed all the time it doesn't matter if you go in……. and they take your t-shirt off, they would take the cuffs off and put it on another arm. So it is hard to get your t-shirt off.*

JF. *Do you see someone on a regular basis about your back?*

Robert. *Yes, you see the doctor.*

JF. *And did he need you to go to the hospital?*

Robert. *Yeh they can't give you the treatment in there. They are no qualified…. Whatever.*

JF. *When you are transferred to the hospital in the back of the van are you handcuffed?*

Robert. *Yes, you are handcuffed. You've got to stick your hand out and then they bring it back in so you are always under guard. You are handcuffed when you get out of the van and then when you are in the hospital you are still handcuffed all the time... right. And you sit and wait your turn, you get your turn. You're still handcuffed when you go into the room with the doctor.*

This participant expressed the difficulties involved with the sense of having little privacy or dignity when attending appointments out-with the prison and when being moved to a

different prison. However, the important experience that he highlights is the impact of being in pain and discomfort while also being handcuffed.

In Out Patient Department clinics/hospital wards he felt embarrassed at being continuously handcuffed, particularly during a consultation with doctor or specialist. In the above extract, he uses the phrase “still handcuffed” to rhetorically question the legitimacy of being handcuffed during consultations with doctors at hospital out-patient clinics. It is acknowledged that there are men that would require this level of security in order to protect the public/staff and prevent escape.[4]

The following example helps to illustrate the difficulty ex-prisoners may face in negotiating healthcare and being the subject of power dynamics. During Michael’s interview, the topic of social support was discussed. It is acknowledged that this is a large topic but was not the sole focus of Michael’s interview or those of the other participants. Michael had sustained injuries in the past, as a result of being brutally assaulted, which meant that he could only walk a certain distance before walking would then become a problem. As he himself raised this as a problem, I asked him if he received any support from family and friends:

JF. *Have you got many friends?*

4

However, this needs a risk assessment in order to try and achieve a balance between security, safety and dignity. Appendix K is a blank example of the Personal Escort Record which has the factors that should be risk assessed prior to any prisoner movement outwith the prison estate

Michael*. NO.*

JF*. No?*

Michael*. A lot of acquaintances but no many friends*

JF*. Ok. People that you say hello to in the passing but they don't.*

Michael*. Like they people there.*

JF*. Aye, but they wouldn't necessarily come in and check that you are ok or go the shops for you?*

Michael*. No.*

As a result, he expressed that he felt isolated and vulnerable with little opportunity to talk about the loss of his partner and subsequent suicide attempt. In prison, it had been the case that he could access the mental health team for assistance but in the community he did not know how mental health services could be accessed by himself in order to help him with his issues. He had gone to his GP seeking help. The GP had been off hand and dismissive of his mental health issues and request for support which I found very surprising. When I asked Michael about his GP's response and whether he felt it was appropriate, he replied:

Michael*. Naw. I think that I could be treated a wee bit better at the moment.*

JF*. How do you think that could be done?*

Michael*. Like somebody maybe could come in once a week just to see how I was and things like that, eh.*

After I had stated with some surprise that he was not in receipt of any community healthcare services he continued with the following comment:

"Aye, but why, if there's nothing physically wrong with us, would they visit? "

Given Michael's physical condition and resultant effect on his mobility, it was an interesting statement for him to make and suggested that at the time he did not fully acknowledge his own physical limitations. However, on visiting the GP, the response at the consultation had appeared to influence his expectations and ideas regarding his eligibility for any community based care. Surprisingly, he did not feel that he was entitled to/in need of any care services, as he did not think he qualified but it also highlights that he only saw illness in terms of the presence/absence of physical conditions.

Michael experienced the GP to heavily influence him in his views and opinions about his condition. Although Michael expressed room for improvement in relation to the support he had been provided with, he trusted his GP's judgement and explained that he had had no other choice than to accept his position. In particular, he added that he had not been referred for further treatment elsewhere and he did not possess the knowledge or skills to seek assistance. This example illustrates the power and influence of the medical profession,

which is viewed by Michael as a legitimate profession with a powerful voice in society. In comparison (ex) prisoners suffer from being stigmatised, labelled as untrustworthy, and from having little legitimate power or voice. Given their different positions within society, it is more difficult for offenders to assert choices in relation to their healthcare in contrast to other patients, as they face additional difficulties in negotiating care/treatment with healthcare professionals as a result of being subjected to exacerbated power dynamics.

3.4 Eigenwelt - Personal expectations of health

Participants talked about their expectations of the new NHS/SPS healthcare partnership and the possible positive effects that it may have upon their health. Two of the participants expressed that they had high expectations when they learned that the NHS became responsible for their health. They hoped that they would receive better quality staff and treatment from the NHS than what they had been accustomed to under the SPS. However, it appeared that little changed from their accounts. As Jeffrey put it:

We thought everything for a wee while. was going to be hunky dory and. life was going to be rosy. But…. The health centre manager was in charge of that doctor. This was the difference. They were telling the doctor "You can't prescribe dihydrocodeine. You can't prescribe MST."[5]

[5] MST is Morphine Sulphate Tablets. MST and dihydrocodeine are strong analgesic medications.

The above may begin to tentatively provide evidence that improvements in the system were not as imagined and may illustrate that the participants' expectations, regarding the access to care and medication, expectations were not as first imagined, hinting at further layers of perceived bureaucracy and power dynamics.

Not all of the participants' expected healthcare to change. William expressed his thoughts on the matter when he was telling me about a cellmate, Bobby Smith, who had suffered fractures in both hips as a result of a fall. Despite Bobby requesting medical attention for his pain, he had been dismissed as a malingerer and not examined fully. This resulted in his hip fractures not being diagnosed and treated at the time of his injury. He had been unable to move from his cell for some time due to the pain and further damage had occurred to his hips before he was eventually examined and treatment given. He had commenced court proceedings against the prison and health service for the pain and suffering he had experienced. As William explains:

William. *Yeh. Having said that Jim. I'm under no illusions. I still feel. that the SPS will try and manipulate. the way. the National Health Service doctors are. treating prisoners. there. I still think the SPS will try and say "Well look. Ok you've got this but you've got to remember you're in an environment here where they're all fucking junkies. They're all drug takers" and all this caper like sort of thing. And they will try and manipulate that. And whether the National Health Service succumb. to the SPS. remains to be seen. But what I am sure of... is. that… the likes of. the situation with Bobby Smith. If that happens within. Now. Is the National Health Service going to be held to task? Over the likes of that. Is the National Health Service going to be sued? Is it. And I. Bobby... Bobby Smith's looking for two hundred*

thousand pounds. The doctor has told him he's going to have to get two hip replacements. Eh. And its ten pound a side. Ten thousand pound a side... to go. there. and he's also been told they'll no last him the whole of his life. He'll have to get them done again. They'll only last about 15 years or something like that. So he's looking for that to be done. Twice. Twenty thousand pound at the moment. But if you look fifteen years down the line. with inflation and so on. he's going to be another forty thousand pound to get his hips done. They'll be double the price at least in fifteen years. Probably more. So. that's why he's looking for two hundred thousand pound which is made up by. what it's going to cost him for medical treatment to put right... the. damage that's been done. He's never ever going to be the same. And for the pain and. that's part of the claim. pain. is pain and suffering. Part of the claim is pain and suffering. So. he's banding about a figure. of two hundred thousand pound and they've offered him three. So effectively they've already admitted liability. All they're going be doing now is arguing over the cost. the money. And Bobby knows himself. Bobby wants to have his day in court because he wants this out in the papers and out into the public just to show just exactly what was happening. Eh… But the chances of him actually getting into court are quite slim. He will. probably be approached on the steps of Edinburgh Sheriff Court. by a member of the. Scottish Government or someone authorised by the Scottish Ministers to say "Look. We will settle on 180 thousand pound. Or you could go into court and. we may well lose the case but the judge might set it at 100 thousand pound" like you know. So. Bobby will have to. That is going to have to play on Bobby's conscience like you know. But at the moment he is adamant to have his day in court.

(Note. Bobby Smith is a pseudonym)

William expressed his opinions about the changes somewhat more cynically than the other participants and had no expectations of improvement. However, it must be acknowledged that he had a pre-existing health condition and had experienced many difficulties in obtaining his medication within the prison. This appeared to be largely centred around the power dynamics within the healthcare system and attitudes towards certain medications that can be sold and abused within the prison. As a result of this experience, he voiced that the SPS would exert an influence over the way in which the NHS conducted its business within the prison setting. He had served a long sentence and had a lot of experience in dealing with the SPS healthcare system due to his chronic medical condition and had also witnessed the treatment of others including the legal action by his cellmate against the SPS for mistreatment of his broken hips. William's account of his experiences in relation to healthcare issues he had witnessed from other prisoners, demonstrates the way the experiences of members of William's Mitwelt within the prison, result in his reflection on healthcare in his Eigenwelt, considering the wider issues of healthcare overall within the Umwelt of the SPS. Given his negative experiences, it is understandable that he was under no illusion that healthcare would dramatically change for the better. The point here is that, based upon their experiences, not all of the participants had high, or indeed any, expectations of the healthcare system. Access to healthcare is experienced as something, which needs to be fought for, rather than an entitlement, they expect to be provided with.

Many of the participants had experience of when they felt that their health had been poor and their expectations of treatment had not been met. As a result, they had felt the need to complain. Their experience of the complaints procedure was one of poor responses and resolutions unless they got a lawyer to make the complaint on their behalf.

On reflecting on their experience of health, several participants had issues and felt that they could be treated more quickly and effectively for their condition by the NHS. All of the participants seemed to expect long waiting times as this is what they had been used to in prison. They voiced that they were able to see services more quickly in the community. This was illustrated by Richard while we were talking about waiting times; here he describes his experiences with the dental services:

Richard. *The dentist is exactly the same. You go through here to see... You've got to contact the nurse to start with and then you've got to wait to hear from the nurse. You've got to contact the charge nurse and then from the charge nurse it goes to the. Dentist. And then from the dentist. it goes to "Listed to see the dentist". And that could take anything between…. a week to eight weeks.*

JF. *That's a long time –*

Richard. *- I know a guy in there that got. all his top teeth pulled out all his bottom teeth pulled out to get new teeth made... and it took him… sixteen weeks. to get. plates.*

JF. *So in the meantime he couldn't eat properly.*

Richard. *Sixteen weeks. Now I know. Because I've got bad. Eh I've got gum disease on the top of my teeth. My teeth… (Shows teeth and pulls on them) they move a little bit. So I need to get that taken out anyway. Which I am getting it done shortly anyway. but. it doesn't matter. Eh... I got told I'd only be like…. two to three weeks... tops... from the dentist at the top of the road. That's for... to get all my teeth taken out... and. my set of teeth made and fitted.*

JF. *That's here in the community from your dentist?*

Richard. *Yeh. But I mean in prison... it could take. Phtt.*

JF. *Anything up to eight weeks or even longer –*

Richard. *No. It could take anything up to sixteen weeks.*

JF. *Right.*

Richard. *It could take anything like... phew. what. eight months to see you. Eight months. Well I went. I came here in January, the boy got his teeth out in February and I was getting out on... September and that was him just getting his teeth... about three or four days before I was getting out.*

JF. *That's seven months.*

Richard. *Seven month he waited.*

JF. *So you've come out and you've went to your dentist and he's going to be doing all your stuff and it's going to be two to three weeks –*

Richard. *– Tops. No maybe even that.*

JF. *Quite a difference.*

Richard. *A big difference.*

Richard states at the beginning that the process for making an appointment to see the dentist in the prison is the same as for the other services, such as the nurse, physiotherapist,

optician, chiropodist, etc. As a result of this process, he had experienced longer waiting times for dental treatment in the prison than in the outside community. Other participants had experienced similar waiting times for dental services. Understandably, this was a source of anger and frustration for them, especially if they had painful dental conditions. From his and others accounts, the difference in waiting times between the prison and community services did not appear to be restricted to dental services but appeared to apply to all health services. Of course, it must be acknowledged that waiting times are variable across the whole country and have been likened to a postcode lottery.

The process of complaining about healthcare in the prison is difficult for the participants. While talking about the process of complaining and how this had changed, Todd had this to say of his experience:

There was a notice put up on the board. about if you wish to complain about your medical treatment. after like the first of November such and such there's a new. agreement. but if you were to go and ask any of the screws for a form…. There was nothing there. They knew nothing about it. or they were saying they knew nothing about it they just weren't giving you the form or whatever the case may be. but nothing there. However, like I say. the first. I think I left it until the seventh or the eighth of November... I think it was the eighth of November. Eight days after.

Todd was describing the situation he had experienced when the NHS took over primary care responsibility in the prison. From his account, he exhibited frustration over the

administration of the system as it was advertised that prisoners could complain about their healthcare yet the officers claimed to know nothing about it and did not have the appropriate forms. This appears to be a Kafkaesque situation, in which the process of complaining had become complicated for no perceivable reason and which left Todd feeling overcome by the senseless bureaucracy, frustrated and helpless.

The participants expressed how they would complain when in prison, however, they had low expectations of any favourable resolution. As a result, they felt patronised by the NHS and that that they needed to complain via a lawyer in order to be taken seriously. This is illustrated in the following extract from John's interview:

John*. You can go through a CP procedure, a complaints procedure but he just phoned or wrote his lawyer or solicitor to try and deal with it.*

JF*. Is that a strategy that lots of fellas use rather than using the complaints procedure?*

John*. Yeh, cause the lawyer seems to work more. If they get a letter from a lawyer saying that the healthcare has not been good then they're…it's going, they're going to look at it more than just somebody writing.*

The explanation John gives here is that using an external agent who has some legitimacy; raising the stakes to a legal level ensures that complaints in the prison are taken seriously. The process of complaining via a lawyer appeared to give the participants a feeling of being empowered.

3.5 Summary

This first theme presented the meaning of health to participants. Binswanger's (1958) model was used to present the theme under the physical, functional, and social aspects along with the participants' personal expectations of health.

The participants had all expected that the healthcare system in place within the prison and the community would take care of them and give them the necessary help to maintain their health when required. However, their experiences did not corresponded with their initial expectations.

Participants experienced health predominantly as physical, following the medical model and related to their ability to function physically in the world. Mental health had been experienced and was spoken about in terms of stigma and ensuring/maintaining personal safety. Substance misuse not seen as a health issue but more as an issue of poor service provision.

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 p 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 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.

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.

This chapter has presented the participants understanding and experience of health under the three factors of Binswanger's model; the physical, social and personal.

This chapter has revealed that a particular issue in relation to the experiences of healthcare within the SPS as well as in the outside community following liberation surrounds access to healthcare provisions. Thus, chapter four, will present the results of this second major theme in closer detail.

Chapter 4. Results - Part 2 – Issues related to access to and use of healthcare provisions in prison and the outside community

4.1 Introduction

This chapter will present the perspectives and experiences of access to the healthcare service and participant's use thereof.

The participants have all served prison sentences and all commented that they found the nature of prison life to be routine. Prisons are secure environments that cater for large populations of men that have either been convicted or remanded because they have broken the law. The philosophy of the SPS is known by the anagram COCO; standing for custody, order, care and opportunities. The logistics of dealing with the large numbers of men, some of whom exhibit and perform challenging behaviours is not an easy task. The SPS, as part of the Criminal Justice System, has a duty to protect the public from these men as well as punish by depriving the men of their liberty as well as provide an opportunity for atonement and rehabilitation. These functions are under scrutiny from Her Majesty's Inspectorate of Prisons, Visiting Committees and the media in order to ensure that the conditions within prison are humane and provide an environment conducive to its functions. However, while acknowledging that the physical architecture and facilities of a building can contribute to control and order within it, the people that administrate and work in it and the policies and procedures that they perform also contribute. These can have an influence on the choices and opportunities that prisoners have for accessing healthcare.

4.2 Umwelt – Physical aspect

Gaining access to healthcare was a prominent theme that emerged from the data. The participants found that accessing healthcare services in the prison environment were a constant source of frustration and described the access procedures in terms that made the healthcare system appear Kafkaesque, unduly bureaucratic and involved long waiting times especially for services such as dental, optician or mental health/clinical psychology. As the access procedure involved form filling, it was a particularly hard process for those that had difficulty with reading and writing.

Accessing healthcare could also be source of problems especially if the participant was prescribed and dispensed medications as many have a currency value within the prison environment. This would cause participants the physical problem of safe storage and could be the source of physical/mental coercion from others to sell/relinquish their medication.

Gaining access/being provided to/with health promotion and education services was extremely difficult as participants' experience was that these simply did not appear to be provided to any meaningful degree within the prison environment.

These factors are presented in further detail in the following three sections.

4.2.1 Gaining access to healthcare

Gaining access to healthcare services such as the doctor, nurse, dentist or optician was not a simple process and involved completing a referral form (Appendix J). This was a difficult process for some, especially those with reading and writing issues. The procedure experienced was described in detail by Richard:

Right. Procedure one would be (writes on paper) Contact nurse. Then you need to hear back from the nurse. Procedure two (writes on paper). We need to write to charge nurse. Contact charge nurse. And you need to wait to hear back from them. And once you'd seen her. If she thought, it was fine then she would refer you to see the doctor which would take anything between seven to twelve days to see the doctor. So if you'd a cold for a fortnight. Your cold would be gone by the time you seen the doctor.

As can be seen it involves a number of steps before the prisoner actually meets a nurse to discuss their issues. This process, like in the community, is highly bureaucratic as it involves prison officers, healthcare and administrative staff to collect/deal with referrals and it takes time. Richard's experience is that the process can take so long that the reason for the referral may have become redundant. He had found this process and the associated waiting times to be a source of great frustration and suffering/discomfort while in prison.[7]

[7] Of course, this process also may be a strategy that the NHS uses to discourage prisoners from referring themselves for what may be considered to be minor complaints. However, this relies on the prisoner actually having some insight and knowledge of their condition in order to make an assessment of how major/minor their condition is in the first place. They may consider their symptoms and condition to be of greater concern and priority than a Doctor or healthcare professional.

Illness is recorded and assessed outwith the immediate context. Without overtly stating that prisoners may be considered as trying to escape, this motive may be used to support the form filling. It is implicated in being a strategic tactic used by prison officers to dissuade, or make it more difficult for, prisoners seeking medical attention immediately. This is evidenced in the use of bureaucratic step-by-step procedures that must be followed in order to gain access to healthcare.

In the community, a person can phone their local health-centre or doctor's practice and make an appointment for a consultation with a GP. They will not be triaged for this consultation beforehand. In the prison, this is not possible and even in an emergency situation it is most likely to be prison officers and nurses that will respond. David agrees with the above participant's account when he described his experience of the process involved in gaining access to a doctor:

David*. If you are in the hall and you have been sentenced and what not. If you are there and say you wake up one morning and say "I've got a sore toenail. I need to see the doctor". What happens is, you go up to the desk in the middle of the hall. The hall is split up between North and it's also split up between South. That is, the hall is like that and if you want to go down and see the doctor what happens is, you get a form, you say alright I need to see the doctor and tick that box. And you write down on the form what your actual problem is and then you hand it to the PO. The PO then takes it down to the health centre, I do believe, and then it's up to the doctor if he thinks you are a grade A, grade B case or grade C.*

JF*. And then you wait?*

David*. It could take two, it could take three weeks. It could even take a month for you to see the doctor. And when you do see the doctor your problem has probably actually gone.*

Note that the process still involved form filling and that it depends upon a prison officer ensuring that it is then delivered to the health centre for processing. It is interesting that David expected the doctors to be the ones to process the forms, when the reality is rather that the administrators collate the clinic lists for the doctors and visiting specialists. It should also be noted that David believed that requests were graded. The other point to note from the above extract is that David's experience was that the appointment process took so long that in many cases the ailment had resolved itself before he was due to attend the consultation. As previously mentioned, the participants voiced that the access process took a long time and that there were lengthy waiting lists for some services. It was reported that waiting times in order to receive an appointment to see a doctor took on average of five days, however, dental services were noted to be particularly longer. The following extract gives an illustration of this:

JF*. No. What about if you needed to see an optician or something like that?*

Michael*. Aye, you would be able to see an optician but a dentist, it could take months. Even if you have a killer toothache, it could take months.*

JF*. Right, so you have problems getting a hold of a dentist.*

Michael*. Aye. Really bad.*

JF. *So, is it a case of you could put in to see the dentist and it could be days?*

Michael. *No. Three, four months.*

Michael is very clear and adamant that the waiting times to consult a dentist are long while his specific answers are an indication that he is telling this account from personal experience. Why the dental service provision was limited is open to question but having a waiting list so long is one way of accentuating the punitive effect of prison.

While discussing waiting lists for the dentist, Mark expressed that access to this service was severely limited if on remand.

JF. *How long do you wait on a dentist?*

Mark. *If you're a remand prisoner... you will not get to see the dentist.*

JF. *So remand can be up to 140 days.*

Mark. *140 days.*

JF. *So for 140 days you just wait your time.*

Mark. *There's been a few claims put in because of that as well.*

JF. *That's interesting. So if you're on remand you don't get to see the dentist at all.*

Mark. *At all…. Or an optician.*

JF. *Or an optician?*

From Mark's experience, remand prisoners' access to healthcare services is severely limited as it is not just the dentist but also the optician that they cannot access. As he points out remand prisoners have no choice but to endure the wait. However, Mark is making an implicit point that this situation is not satisfactory and is complaining about it without overtly making a complaint. However, he then expresses that he is aware of some prisoners that have asserted their agency by claiming compensation because of the lack of access. Only by raising the stakes to a level where they are claiming money for their negative healthcare experiences in prison are they taken seriously. This is in keeping with the participants' experiences and comments made regarding the complaints system, mentioned in the previous chapter, whereby the prisoner has to utilise the services of an external agent who has legitimacy in order for a complaint to be taken seriously.

As illustrated in the except below, the long waiting times result in anger and frustration ("ratty") as participants had experienced pain and discomfort while waiting for their consultation/treatment. Accordingly, as Michael put it:

Michael*. Can you imagine having a toothache for three four months?*

JF*. Well.*

Michael*. It makes you makes you ratty. It makes you like, like you cannae think of anything else. You are unapproachable and it makes me ratty.*

When Michael said this, he was talking about the waiting times for dental treatment as he had experienced a painful dental abscess that had gone untreated for three months. A dental abscess is classed as a dental emergency yet Michael did not receive any emergency treatment. He told me that he was given paracetamol and ibuprofen as analgesia and had to wait his turn. He commented that the medication did not ease his pain and he had sought pain relief by using illicit drugs until he had his abscess treated. Michael offered a magnanimous explanation for his experience by saying:

Yeh. You have got to remember that like there is maybe like 700, 800 people right in the dentist right. So the list is, like he will maybe see maybe about ten people one week, another ten the next week and it goes on and on. And you just have to wait until you are on the list. And it could be three / four months.

As well as its extremely long waiting lists, the standard of dentistry was also considered sub-optimal. For example, Richard recounted his experience of having a tooth removed while in prison:

Richard. *And they look at you as if you're somebody. When you're in the jail they just… I remember when I was younger when I was in prison and I'd to get my very. What's your back teeth called?*

JF. *Your wisdom teeth.*

Richard. *I remember I had to get it pulled out and the nurse actually had... his knee up on my chest... doing that (demonstrates pulling of teeth) to get my wisdom tooth out. And that's not the procedure to do that and while he was doing that he ended up snapping a healthy tooth right next to it. So that just shows you how much butchers they are in prison. And people wonder how people don't go to the dentist.*

JF. *Well yes –*

Richard. - *No I can't go to the dentist without taking five diazepam tablets.*

JF. *Are you nervous about the dentist?*

Richard. *After that yeh.*

From his account, it can be seen that he had a bad experience and that is why he does not like going to the dentist. However, if he has told others about his experience they may also have reservations. The comments expressed by participants regarding their experiences of dental care give an impression that dental health for prisoners is a low priority for the health board and, in effect, lip service is made to its service provision. However, in balance, many people have 'horror stories' regarding their experiences of dental treatment outside of prisons as well.

In conclusion, the participants of the study described accessing healthcare services as a frustrating process that involved form filling and long waiting times for initial consultations and treatment.

4.2.2 Medication as currency

Participants talked about medication in terms of it being a currency and that this could lead to a number of problems that could impact upon their health and safety such as drug seeking, theft, bullying and those in debt selling/trading their prescribed medication in order to reduce their debts. Participants explained that prescribed medications such as paracetamol and ibuprofen have very little, if any value; however, many analgesic medications including diazepam, gabapentin and pregabalin have a high value. Illicit drugs and alcohol were also referred to as having a currency value. Participants had experienced a number of problems such as safe storage of their medication, difficulty maintaining their personal safety from bullying and labelling of those with legitimate complaints as "drug seeking" by prison and healthcare staff. Participants also talked of two additional issues surrounding medication prescribing that they had experienced from their interactions within the prison. Firstly, it was experienced that the doctor would not prescribe certain medications because they were known to have a high currency value, even if there was a clinical justification for them. Furthermore, there was a common attitude that doctors would label them all as drug seekers anyway and not take their legitimate requests seriously. This had a large impact upon those with a legitimate condition and made the experience of coping with it all the harder to deal with. Secondly, prisoners that were forced into selling their medication because of debt/bullying would obviously not get any benefit from the medication and their medical conditions could deteriorate.

In order to minimise the effects of bullying and selling of medication, nurses administer supervised medications. This is where prisoners are administered medication orally by a nurse who will then check that it has been swallowed. This is to ensure that it has not been retained under the tongue, gum or roof of the mouth in order to be taken out later and sold

or given to others. A prison officer is always in attendance when medications are being administered in the halls and, if necessary, they will be asked to verify that medication has been swallowed. Those that are caught trying to retain their medication in their mouth can face consequences such as having the medication reviewed/discontinued and being placed on report by the officer. This may result in further punishment when they attend the orderly room to explain their behaviour.

Unsupervised medication is when prisoners are dispensed with weekly prescriptions of medication, which they are trusted to administer themselves. They can be asked at any time to produce the balance of their prescription at a medication check. This is performed by prison officers accompanied by nurses. This would appear to indicate that there is no trust present between prisoners and the prison/healthcare staff and, by implication, that prisoners are not trusted to look after their own health. The purpose of these checks is that they are an operational procedure to ensure that medication is not being used as a currency or given to others not prescribed it. The checks can also highlight whether or not prisoners are taking their medication as prescribed. However, the checks are an operational issue and it is questionable whether nurses should be involved in this part of prison routine due to the ethical issue of confidentiality of their condition and treatment. By participating, nurses are, in effect, divulging confidential information regarding the prisoners' treatment with another agency: the SPS, although it could be argued that this is being done in the interest of patient safety and protection of others.

One of the main difficulties that participants had experienced regarding the dispensing of the weekly medication prescription was its safe storage. This was highlighted by Mark in the following extract:

JF. So you could get prescribed a weekly prescription?

Mark. Yep.

JF. For certain things.

Mark. Yeh.

JF. And you have a safe inside your cell?

Mark. (Laughs) Well they've got safes. But the safes they bought... the keys are too... big and they're like... daggers if you know what I mean. So they don't issue the keys for the safes which is. pointless (laughs).

So although a safe was provided in a cell it was rendered useless because there were no keys available because the SPS discovered that these could be made into dangerous weapons and subsequently confiscated them. The result was that Mark, and others, had to employ other strategies to ensure the safekeeping of his medication. Mark explained this further, when we had a conversation regarding the potential strategies utilised:

JF. So you've got your weekly prescription-

Mark. -Yep. And it's not in a safe place.

JF. And it's not in a safe place.

Mark. No. It's maybe stashed under my mattress or. between my mattress or wherever eh. They're the best place that no one is going to have a chance if. to get to it. So there is nowhere you can keep your medication and know it's going to be there when I come back from having a shower.

JF. Yes. So you have to stash it somewhere.

Mark. Yeh. Or you have to get your door locked and lock your door. And then when you are away for a shower you have to get the staff, annoy the staff to go and open your door again.

JF. But that's the only way that you know that it's going to be there when you come back.

Mark. Yep.

Admittedly, from the above extract, it could be argued that I interpreted his responses during the conversation and that this may have influenced the course of the conversation and the responses given.

Having his cell door locked/opened by officers in order to ensure the safe storage of his medication reinforces the power and control that officers assert in the operational running of the prison and the subordinate position held by prisoners. From Marks account, it would be noticed by other prisoners that he was interacting with officers and asking them to lock his door. This is a behaviour that would raise questions amongst prisoners as it is not acceptable to fraternise with officers unless essential and may endanger his personal safety as well as raising suspicions as to why he was having his door locked in the first place.

Prison officers regularly perform cell searches in order to look for weapons, illicit drugs or unauthorised prescription drugs that are being traded. Although this is considered part of prison officers' routine duties, Daniel had this to say about it:

Yeh well. The staff will have a note of what cells they have searched. in their office. I know that from a person being on the pass. But eh...no… like recently I've just. If staff have got suspicion or they smell maybe like burning foil or cannabis smoke then they will. go in and check. But they've got a notice in their office to what cells have been checked but sometimes. I know this myself. Staff just. mark it off. as it has been done with mine. quite a few times. It's been searched when. it's not.

When Daniel mentions the phrase "being on the pass" he is referring to his job as a pass man which can involve tasks such as cleaning and tidying office areas, delivering mail, etc. within the prison. This afforded him access to many areas that other prisoners could not and he took advantage of that by reading notices left in offices, which gave him a knowledge of the policies and protocols being utilised by prison officers.

However, although he knew that his cell could be searched he did not see that as any form of deterrent as his experience was that the procedure was not performed rigidly. As a result, he was of the opinion that cells would only be searched if prisoners gave officers cause/evidence that illicit behaviour was being performed and that something may be found if searched. What he is saying is that officers are not being diligent in their duties. This is questionable but it may be true of some staff. It may also be that officers are exercising

some degree of flexibility in the routine in order to ensure that prisoners cannot predict when their cell will be searched.

Mark had experience of being in possession of medication that made him vulnerable and put his personal safety at risk as he was at risk of bullying. The bullying could be physical, with six participants voicing that they had been assaulted for their medication. However, Mark expressed that bullying can also take a different form if medication is not surrendered readily. In the following extract, Mark and I were discussing his experiences of bullying regarding medication and the pressures that he and others had dealt with in order to get it prescribed:

Mark*. (Sharp intake of breath) eh... bullied into go and actually ask for it. Yeh, I've he... I've he... I've actually heard that yeh. I've heard somebody saying I'll go and ask for for... for eh this and eh you'll be able to sell them to me.*

JF*. And what sort of things, if they don't do it, what will happen to them?*

Mark*. It's not what will happen to them. It's not what they'll not get. They'll not get anything... eh. Like tobacco the guys no money, he won't get any tobacco. He'll be left with nothing; nobody will speak to him or they'll put about stories about him if he's not done it. If he's not went away and got medication they'll spread stories about him.*

JF*. So they won't be beating him up but he won't have any money...*

Mark*. Your feart of it but it's…. a different form of bullying.*

Mark states that men would be shunned or stories would be spread about them if they failed to provide bullies with the medication they wanted. This is interesting as prisoners are using these strategies as a mental means of coercion in order to exert some degree of power and control within the prison.

Participants see the root cause of this as being due to the fact that many medications are used as a currency within the prison as well as in the outside community. Drugs that are traded due to their currency value include, for example, Diazepam and Gabapentin. Diazepam, commonly known as Valium, is a medication from a group of medicines known as benzodiazepines that is used for many conditions and typically produces a calming effect. Gabapentin is a medicine that is used in the treatment of epilepsy and neuropathic pain. One of the common side effects of Gabapentin is sleepiness. These medications have a value and are traded for their sedating effects.

Bullying can occur for a number of reasons but some participants voiced that they had witnessed men in prison, without any known medical conditions, being bullied to the extent that they feigned injuries and symptoms in order to try to obtain prescriptions for medications that have a value. While we were discussing the issue of bullying to obtain medication, Mark gave more details in the following extract:

Mark*. Yes……. Yep…. Or they'll go and try and access... some sort of medication... which is currency… to get themselves... eh tobacco and things like that. I've seen that happen.*

JF*. So what things are currency then?*

Mark*. Diazepam, dihydrocodeine, gabapentin, eh... mitazapine, seroquel... eh… oh there's even other things that... wouldn't even…. Eh what are they things called... oh……?*

JF. *Don't get too hung up on that because I appreciate that some of the names can be tongue twisters.*

Mark. *Amitriptyline and things like that as well eh.*

JF. *So to get on to the medications people have to access healthcare don't they?*

Mark. *Yeh and go and see the doctor and say whatever. They say, "I can't get to sleep or…."*

JF. *Right and is that all thought out beforehand?*

Mark. *Oh yeh it's all pre... premeditated eh… stories what they're going to say before they go in or they'll go and ask somebody... who's on something, "Oh how are you on them" and they will try and say the same story... to the doctor.*

JF. *So getting drugs gives you a currency?*

Mark. *Yep.*

JF. *And currency gets you toiletries and things like that.*

Mark. *Toiletries, tobacco mostly things like that.*

From Marks experience and his account, it would appear that prisoners as a group are quite knowledgeable about medications and are aware of those that should be sought as they have a value. If obtained, then the medication can be used to placate the bullies and cease or influence the bullying behaviour because this strategy works. However, if staff discover that they have lied to obtain medication then this serves to widen the credibility gap for prisoners (this will be discussed further in section 4.4); staff may question the level to which

they can be trusted and attitudes may be hardened. As a result, prisoners' claims of ill health may be dismissed as "drug seeking" behaviour. Participants expressed that this was a source of frustration and anger for those with legitimate conditions requiring treatment. This frustration sometimes resulted in them making verbal arguments and protests which led to being put 'on report' and having to explain their behaviour the following morning in the Governor's orderly room (a process that deals with infringements of discipline). If an explanation was not believed it may result in punishment with loss of certain privileges thus adding insult to injury.

Participants talked about "drug seeking" as a common behaviour in the prison and about seeking drugs not only to obtain currency but also to "get a charge". This is a term that participants used that meant that they got some form of stimulant, sedative or hallucinogenic effect from the prescribed medication/illicit substance they were using. However, it was also mentioned a means of exerting some power and control within the prison. Many participants experienced this as one of the few means of exerting personal choice within the prison/healthcare system, whilst also providing a legitimised diversion from work duties. Participants seemed to believe that being able to subvert the system was an accomplishment.

This illustrates the contradictory nature of health and illness for (ex) prisoners. On the one hand claiming illness can be used strategically by prisoners, or they can be bullied into feigning it, to obtain medication. At the same time, distrust and the use of the healthcare access system can be considered as a strategic response by the prison officers. The result for the participants of the study is that prisoners have to ensure that there is a high visibility of illness or injury. This was expressed by Todd when talking about accessing healthcare:

Todd. *Yeh. Unless they can see that you are… that you're really…. unless they can see that you're really, really ill. You are in your bed, you're really, really ill or you are in real pain…….. then... there is two paracetamols, you can wait till tomorrow, ken what I mean. Basically, eh, fill the form in but then if you are no working then you have to wait a couple of days, ken…….*

However, this was seen as subject to feigning and, as a result, still viewed with suspicion by officers.

In conclusion, being prescribed medication within the prison can pose a number of problems for those with a legitimate condition. It can affect their personal safety, as safe storage of their medication is difficult and this can make them vulnerable to theft and bullying. They can also be put under pressure to sell/trade their medication in order to pay off debts. Prisoners could also be labelled as "drug seeking" by prison and healthcare staff as this was a behaviour that was performed in order to obtain medication to sell/trade/pay debts. This made it more difficult and frustrating for those with legitimate complaints to obtain the appropriate medication and treatment.

4.2.3 Health promotion/education and life skills training

Health promotion and education are services which are provided by the NHS in Tayside and one of their aims is the targeting of health improvement programmes towards those most in need, particularly towards the most socioeconomically-deprived communities and families. It is argued that many prisoners would come from such backgrounds and that being in

prison presents an ideal opportunity for the NHS to deliver health promotion /education to this vulnerable group.

From their accounts, it appeared that all the participants considered themselves the recipients of healthcare and rarely mentioned any personal role in maintaining their health. All the participants regarded health promotion/education as low priorities within the prison environment, with few opportunities or places available on any initiatives. As Richard explained:

JF. *What classes can you get about health or health promotion?*

Richard. *Um... I think it's just like um……. what was it again. It's just like…. I think a coach comes in and you could do em…… you get this wee monitor on your side and you could do swimming and then steps. Do running on a beep test thing. But that's only. that's only. there's only like ten people could do that.*

JF. *So it's not for the whole prison.*

Richard. *Eh yeh. It's for the whole prison. ten at a time…. every six months.*

The striking implication from Richard's account is that, from his experience, health education/promotion was not performed or given a high priority within the prison.

What Richard was referring to was a cardiac fitness programme that was facilitated by the physical training instructors within one of the Tayside prisons. Although it is a health promotion initiative, as he explained, the numbers that could actually participate in it were

extremely limited with only ten men twice a year being able to take part. This is disappointing given that the prison holds seven hundred men.

It was interesting that no participant mentioned the use of health promotion/education strategies within the community setting. A number of the participants voiced that they were not aware of the health promotion messages within the community. This was surprising given that many visit chemists and their GP's on a regular basis. It was also striking that participants did not view dental health as important as they never talked about wishing to see a dentist for a check up to maintain their dental health; they would only access the dentist if they had an actual pain or specific problem.

Participants voiced that there was a greater need for more health education and development of life skills especially within the prison. John and Todd talked positively about life skills training that had been provided by a third sector organisation called Waverley Care. This organisation had conducted a course that had offered them support and life skills coaching. They voiced that this course had helped reduce their institutional behaviours and reliance on prison as a way of life. This had been achieved by helping them to develop life choices in preparation for their liberation. Some of the areas they had covered in workshops included: self-identity, confidence and self-esteem, goal setting and problem solving. John in particular voiced how this approach had helped him to break free of the revolving door. He now gave the impression that he had a life where he enjoyed better health and higher self-esteem. He had achieved this as the course provided him with knowledge, skills and increased levels of confidence. He explained that it was his belief that this had enabled him to contribute and 'put something back' into the community and society. He comprehended that he now had a life with a purpose; a job with a third sector charity that involved visiting

prisons and schools to talk about his life experiences involving drug addiction and blood borne viruses. This job had led to a number of opportunities for further education and training.

There was a lack of health education and promotion performed within the prison for the participants. Health promotion is the focus of the document "Health Promoting Prisons: A shared Approach" (Department of Health 2002) and it is viewed as being essential if the health of the prison population is to be improved. It is stated in the document that:

"Good health is central to successful rehabilitation and resettlement, and in turn requires an environment in each prison that is supportive of health." (Department of Health 2002)

This involves the prison-providing healthcare services, but it is not tied solely to health education and promotion. However, it would be reasonable to expect the NHS to be active in teaching health promotion and education. However, participants observed little evidence of this within the establishments they had served their sentences. Richard said this about the subject:

JF. *Is there any health promotion done in the prison?*

Richard. *A little. Very little sorry.*

JF. *And by very little what things have you seen. If any?*

Richard. *Uh…… a bit of fruit.*

JF. *A bit of fruit. Do they put up any posters or do you get any booklets or leaflets?*

Richard. *Sometimes there is.*

JF. *Sometimes.*

Richard. *Yes.*

JF. *Ok but it's not a regular –*

Richard. *– It's no. It's no like eh…. you get a bit of fruit every day. You don't get your five a day.*

We continued the interview by focussing on a specific health promotion campaign that had recently been conducted in conjunction between the SPS and NHS:

JF. *Ok. Thanks for that. Have you ever heard of a thing called the "Keep Well Project?"*

Richard. *Yeh.*

JF. *What do you know about the Keep Well Project?*

Richard. *I don't know much about it. I'm sorry.*

JF. *Where did you hear about it?*

Richard. *Eh, I heard about it from a… I think it was... a nurse.*

JF. *Right. Was it in the prison or was it out-with the prison?*

Richard. *It was... in the prison when we first came in.*

From his account, he has observed few health promotion strategies within prison. He is aware of the "five a day" portions advice regarding the consumption of fruit and vegetables that was widely promoted in the public arena. However, Richard was of the opinion that it was impossible to actually achieve the "five a day" target consumption while in prison due to the limited availability. Overall, he had not perceived health promotion/education strategies being advertised within the prison that would help improve a prisoner's health.

Richard had not taken part in the Keep Well Project; a project that was launched in 2006 and extended to include prisoners in Scotland's prisons in April 2012 (NHS Health Scotland 2014). The project's main aim was to tackle the main issues that contribute to health inequalities and its vision was "to increase the rate of health improvement in deprived communities by enhancing primary care services to deliver anticipatory care". It aimed to achieve this by identifying those at risk of ill- health, offering appropriate strategies and services to help them and provide monitoring and follow up. This was performed by inviting individuals to participate in Keep Well health check in the prisons. The checks included screening for cardiovascular disease (CVD) and its main risk factors, such as high blood pressure, cholesterol, smoking, diet as well as discussing wider life circumstances such as employment and literacy. Although Richard stated that he was aware of the project and that he did not know much about it, he was a bit vague about who had informed him on his

entry to the prison. His lack of knowledge, for whatever reason, about the project may help to explain why he did not participate but, ultimately, he did not give any explanation why.

According to the experiences of the participants, neither the SPS nor the NHS provide adequate health promotion or education. Participants sensed that there is poor communication between the SPS estate management teams and NHS Health Scotland to provide targeted strategies to the SPS prison estate population, via the prison health centres, that may have an impact upon prisoners' lives. The result is that neither the SPS nor NHS is actually doing it well. Participants were left without adequate opportunities to improve their overall health and this appeared indicative of the organisational attitudes towards prisoners and offenders in general.

Participants did not talk about health promotion/education in the community setting as part of their healthcare experiences. This was a little surprising given the amount of health messages that are advertised and broadcast in the media and readily available in many pharmacies and food stores. It is understandable that the SPS organisational priorities are custody and order within their estates so health promotion is not their number one priority. However, the NHS has a role and responsibility for this in the community and it could be argued that the "Keep Well" project should follow up more men upon their liberation.

Participants' had experienced limited evidence of effective health promoting strategies being performed. Participants' said that there were limited opportunities to participate in, and practise, health promotion within the prison. There were limited classes that taught life skills training in preparation for liberation and life beyond a prison sentence. More surprisingly, participants made no comment of any in the community setting but did not give any reason for this. While health promotion/education and life skills training is not a

high priority for the SPS it is part of the NHS's core business and it should be organised, and elevated to a position where it more widely known in the prison and community with more initiatives such as the "Keep Well" project.

In conclusion, not only did participants find it difficult and frustrating to access health services but also it was noticeable that services such as health promotion and education were not highly visible to them.

4.3 Mitwelt – social aspects

Accessing the healthcare services did not only depend upon the motivation and literary abilities of prisoners, given that the healthcare service in prison is led by nurses, then their attitudes and use of power are a major factor in prisoners being able to access and use the services available.

4.3.1 Nurses control

The majority of participants voiced that in their experience it was nurses that controlled access to healthcare and medication prescribing as well as conducting the process of sick parade, authorisation of "bed downs" and medical markers. A "bed down" allows prisoners to have a day off their work, is generally sought when reporting sick, and is authorised by the nurse who examines the "sick parade" in the hall first thing in the morning. A medical marker is effected on the PR2 (Prisoner Records 2) computer system when patient's need something related to their medical condition. As a result, all SPS staff can see it if they access a prisoner's records on computer. Healthcare markers will be recorded and staff can

find what is assigned and what is current. So, for example, a diabetic or an asthmatic could be assigned a marker so that all staff would know that they may need an inhaler or can have an asthmatic attack. Information will also be visible for guidance, for example, to call for an ambulance if no nurses are available. These can be abused by prisoners, for example, requests for single cell accommodation, own pillows, etc. A medical marker could also be used to give a prisoner a day off work after being declared unfit by the nurse. Officers could then see that the prisoner was legitimately off work and not dock their wages as their day off had been authorised by medical staff.

Prisoners experience was that they would be triaged by a nurse before gaining access to a doctor. This was viewed by many participants as an unnecessary barrier, because it was believed that only doctors were qualified and had the authority to make a diagnosis of illness. This is illustrated in the following quote by Richard, made in reply to being asked a question about accessing a doctor:

JF*. So you can't see the doctor without seeing the nurse?*

Richard*. You can't see the. You could say to the nurse "What's that there on my hand" and she'd go "Oh that looks like a wart". She's no even qualified to tell me what that is on my hand.*

It is interesting that Richard viewed ill health as something that could only be legitimised by a member of the medical profession. While respecting his views, it does display his perception and experience of the healthcare service because his final comment appears to

indicate that he had never experienced any of the nurse led specialist clinics that exist for many conditions including skin disorders, diabetes and blood borne viruses. It should be noted that in the community, this process is also performed except it is carried out by medical practice receptionists. However, Richard and the other participants did not appear to perceive this as a similar barrier to care being performed by staff that possibly had no healthcare qualifications.

For those wishing to report sick in the prison, the appropriate procedure had to be performed early in the day. In effect, this meant that prisoners had to have their illness to order as reporting sick outwith the allotted times would not be dealt with unless it was life threatening. The experience of reporting sick was explained by Todd:

Todd*. Right, you need to get out of your bed, you need to walk along the landing to the gate and say to them "Can you put me down sick". It needs to be done in the space of between, say, I think it is quarter past eight is the last time you can do it. You get opened up between eight and quarter past but you might get opened up at ten past so you have got five minutes to do it. You might have got opened up at eight and you got 15 minutes to do it, ken.*

JF*. And if you don't do it before the cut off time?*

Todd*. It means you dinna get to see a nurse that day and if you are working… you can put yourself…. You are only allowed to do it if you are working. If you're not working then you need to put in a sheet, tick it and say you need to see a nurse. They will take over, write a referral saying "right we'll see you" and you wait three days to see them.*

For Todd, and others in the sample, nurses were thought of as subservient to doctors and possessed less knowledge and power. However, this was only in relation to the ability to make a diagnosis of a condition and experience showed them, that in relation to gaining access to medical services, nurses were a powerful group. There appeared to be a contradiction in the relative powers of diagnosis between doctors and nurses.

The power that nurses had in relation to the prescribing of drugs was also talked about. The general experience of participants was that only doctors were authorised to prescribe medication. Although a couple of participants thought nurses could prescribe certain medications, they had not actually experienced this, or been prescribed any medication by a nurse for any condition in the past. Participants experience was that the doctor prescribed medication and the nurse administered it. This experience reinforced the participants' perceptions of the different positions of power that healthcare workers hold and the subservient position that is held by themselves. As a result, this could explain why participants felt powerless, that they were the recipients of healthcare with little or no part in maintaining their own health. It may also help to illuminate the participants' negative experiences of health promotion and education, as they may not be fully receptive to the messages and services that may be on offer to them because they believe they have little power to take any control of their health or make any positive changes.

John had experienced a situation where a nurse had influenced a doctor's decision to prescribe medication. In relation to this subject, he said:

John*. Yeh. The nurses, if you are in to see a doctor…. This has just come to us…. The nurses seem to have more control of the healthcare that you get than the doctor. The doctors always turn to the nurses and the nurse will go, say if it's a strong pain killer, "Oh! Well we don't think he should get this doctor" for whatever reason. Because they work every day in the halls and they work close with the officers. The doctors are only in for whatever. The nurses seem to have more say.*

JF*. Right. In the prison it is the nurses that control the healthcare.*

John*. It's them that makes the decision… yeh.*

Given his experience, it is not surprising that he maintains that nurses have more influence in making the decisions regarding medication prescribing. However, he appears to be giving a mitigating reason as to why this may be the case; he acknowledges that the nurses have more contact with prisoners and the officers than the doctors. Whether this would be true for all nurses, in all cases, is questionable. However, it is probably true that prison nurses would have more knowledge of the drug behaviours within the prison, through more frequent contact with prisoners. As a result, they would be in a position to advise the doctor as to potential problems and suggest that other alternative medications or treatments be considered.

In conclusion, accessing the healthcare services, particularly seeking a consultation with a Doctor, was a difficult experience for participants that could be exacerbated by the nurses who were perceived to be the most powerful group of healthcare staff. Participants voiced that nurses could not only control when they were given an appointment for a Doctor's

consultation but that they could also heavily influence the outcome of the consultation with particular reference to the medication that may be prescribed.

4.3.2 Staff attitudes

Staff attitudes have an impact upon the experience of prisoners. These are exhibited in all areas of the Criminal Justice System. While exploring the points of contact that prisoners have in their journey through the Criminal Justice System, I interviewed a senior manager for the police custody nurses who voiced that they and their staff did not trust anything that a person brought into custody said. When asked what they did if an offender stated that they were due a medication for a legitimate condition, for example insulin to control diabetes, the reply was that nothing would be done until the offender's medical history and prescriptions had been verified with their GP. This exemplifies the credibility gap that offenders experience; the general attitude being that prisoners are liars and that their accounts cannot be trusted. However, information had to be verified with a GP even although the NHS computer system gives access to sometimes critical information in people's medical records and it could be established quickly whether or not an offender's account of their current medication was accurate.

Prisoners' accounts are not believed in the prison either. In giving his account of making a complaint, Todd remarked:

"They are believed; they are believed because they are a nurse so she was believed at that point. "

Thus, what is being extended here is the credibility gap, which is discussed further in section 4.4. He was reiterating the point that, in giving his version of the events that led to the complaint, his account was not believed because he was a prisoner. In contrast, the account of a member of nursing staff was regarded as more credible. He implies that there is a difference in the power and influence of the different groups. It appears that the credibility gap may be playing a part in his particular scenario, as others may believe that his account differs from what actually happened. It also stresses the issue of the level of influence exerted by different groups in society. In this particular instance those in the subordinate position; prisoners are unable to exert as much influence as that of someone in a more powerful, legitimised group; nurses. This problem disadvantages those with legitimate conditions as they can face difficulties in convincing healthcare staff that they are telling the truth. In the following extract, William was explaining the difficulties that he had experienced in getting his medication prescribed for a long-term condition:

William. *See especially when it comes to things like opiates, for example. If you've got guys that are in that have got genuine disabilities and this is what's. this has always been the bug bear again. It's no the junkies that they're hurting. with not prescribing dihydrocodeine. It's the individual who has got. likes of gout, arthritis or whatever complaint he's got. That they're withholding that medication from someone who has got a genuine illness because of other people who. are junkies. But having said that, the amount of times that I've heard them turning round and saying that being a junkie, an addict is a disease.*

Not only does this highlight that William had experienced difficulties in getting the treatment for his condition, it reflects the attitudes that he encountered amongst the doctors and healthcare staff he had encountered; that prisoners are all drug seeking in order to feed personal habits or gain currency. The credibility gap plays a part in that the healthcare workers attitudes that William had encountered; they appeared to show little concern for his health and welfare by not prescribing medication based upon his long-term condition. It is also indicative that attitudes are based upon the popular belief system within the prison and that everyone is treated the same with not much flexibility for dealing with individuals. In this case, having a long-term condition requiring an opiate analgesic was viewed in the same light as "junkies" who seek drugs to feed their habit. William was angered by his experience of healthcare staff treating him like a "junkie", resented their entrenched attitude towards his treatment and did not agree with their voiced statement that drug addiction was a disease.

When we were discussing the attitudes that staff displayed towards the prisoners Todd made the following comment:

Todd*. It also depends upon what nurses…ken… I mean if you were with some nurses that they actually don't like…. cons.*

JF*. I was going to ask what distinguishes them.*

Todd*. There seems to be ones that…. Are doing it as a job…... but other than doing it, they are doing it as a job and a career and that is what they went into healthcare for is to give*

healthcare and be…ken… then you have got other ones that are like... work here because I get money for it and I get a good pay for it because I'm working in the jail I get more money than what I would get working in a hospital so…. I don't really give a damn, ken what I mean. And you've got other one's that go "Well I do give a damn" and you've got the other one's that come in and do give a damn but as time goes on they start no giving a damn

Clearly Todd had encountered a number of nurses while serving his sentence, some of which he thought did not like working with prisoners. It is interesting that he distinguishes nurses that wish to work in the prison from those that do not. It would appear that he makes that distinction based on the concept of care. He takes a very black and white approach to this with there being those nurses that care and those that do not. He asserts that those nurses that do not "care" for their patients are simply pursuing a career. In relation to his assertion regarding nurses' salaries, this is not true as they are based upon a national grading scale with increments within grades for years of experience. He makes an interesting observation that nurses' attitude towards caring changes over time as they gain more experience of the prison. In effect, what he appears to be describing is the institutionalisation of the nurses.

While discussing staff attitudes, the consistency of their attitudes was expressed by Todd in his comment:

Todd*. It seems to be the ones that have been there a lot longer that are more consistent with being alright or more consistent and just being like they're no good now and bad then or would ken… they're either really good with you or they're really bad with you.*

JF*. So they are consistent with the way they treat everybody then.*

Todd*. So you would rather have one that was set in their ways and you know that they are actually set in their ways and that is how she is doing what she does... rather than somebody coming in being all good with you and then all of a sudden they're all… nippy with you all the time.*

From the statement, "that are consistent with being alright" it is implied that those nurses that have worked in the prison environment for a long period are generally more caring than punitive in their attitudes and consistent in their interactions with prisoners. What exactly he means by "that have been there a lot longer" is unknown, but it implies nurses that have a number of months /years' experience of working in the prison compared to newly qualified nurses or those that have newly come from a more traditional healthcare environment. It also seems to suggest that it may also be about prisoners' familiarity of staff. Whether their attitudes were caring or punitive, the participant said that it was better that they were consistent. The implication of his comment would appear to be that he sensed working in the prison had an effect upon the caring attitudes of nurses in the long term.

Healthcare in the prison can be accessed via the process known as "sick parade". Participants expressed that they had witnessed tensions between staff while this process

was being conducted that they sensed as having been caused by differing attitudes. These have been mainly witnessed in the morning sick parade when nurses consult with officers as to whether a prisoner is given a "bed down" (explained in section 4.3.1). This could be argued to be unfair from a prisoner's perspective but nurses and officers could argue that they are just discussing welfare and progress in order to establish whether a "bed down" is the correct procedure to be followed for that prisoner at that time, as opposed to mobilising the prisoner to be seen as an emergency. However, participants noticed that the "sick parade" in the morning had become heavily influenced by the prison officers. This process seems to minimise the importance of ill health and could be argued that it is for show, that is, something that is seen to be done. This was explained in detail by William:

William. *The nurse would come in. in the morning eh… Say the hall was opened at say 7. 15. The nurse may well come in at 8 o'clock. and kind of anybody that had their name down had gone sick. You had to go to the office and say "I want to go sick. I want to go sick boss". Right. So. She would have to come in. to the hall. into the office and pick up the sheet with a list of names on it. there. and she would say to the prison officer "Who do you want me to give a bed down today".*

JF. *That just undermines your –*

William. *– Well this is it. Her. Her eh. That was the done thing. because she was probably more in the mind that the officer would know who was swinging the lead and who wasn't swinging the lead like if you get my meaning. Right. So if you got somebody wh… Just take for example the junkie... who had been sitting smoking fucking smack all night. Right. He's*

maybe got through an ounce of smack sitting smoking smack all night. and he's fallen asleep like that at six o'clock in the morning. and of course the screws come to the door. and he's going "You. Get to your work". And he's going "Ah boss I'm no well. I'm no well like you know" Eh ken. He says "Right. Put yourself down sick". So he put himself down sick. and of course the officer said "That bastard's been up smoking fucking kit all night again. Give him fuck all" ken. But that also. That shouldn't have been done. It should've been down to the... individual nurse. But you see this is where the SPS and the health clash again like sort of thing.

Professional healthcare staff and prison officers should be able to see through the malingerer's but treat all the serious people as genuine. However, participants sensed that abuses of power were taking place that had a direct impact upon those seeking health care. This is an example of institutional power. Another consequence of the "sick parade" is that those found reporting sick, but assessed as being fit to attend their work placement, are placed on report if they subsequently refuse to attend work due to ill health. The result of this is that there are sanctions and the outcome of this means requires them to attend an orderly room hearing in front of a Governor or Hall manager and offer an explanation as to why they 'refused' work. The above account implies that the "sick parade" is being used as a means of discouraging prisoners from reporting sick. The implication is that prison officers are legitimising the sanctions and consequences of refusing work by using the nurses' assessment at sick parade. This assessment is also being heavily influenced by the prison officers thus exerting power over prisoners to work.

In conclusion, the staff attitudes which were reflected in the behaviour experienced by the participants were a factor in making the healthcare services difficult to access and utilise.

4.4 Eigenwelt – personal aspects

There is a personal aspect to accessing healthcare services that prisoners meet within the prison and community; the credibility gap. From the participants' accounts, healthcare workers, prison staff and the general public make judgements about their character, whether they can be trusted and believed and also the motivations for their healthcare requests. There appeared to be a range as to how participants dealt with this aspect. It appeared to vary from an acceptance that this was part of the price to be paid for having committed a crime and served a prison sentence to anger and frustration that people failed to acknowledge they had paid their debt to society by having been punished by serving a prison sentence.

4.4.1 The credibility gap

Participants experienced difficulty in accessing healthcare services and being allowed to make choices regarding their healthcare in not only prison but also the community. As all of the participants in the study have broken the law and served a prison sentence, many in society may consider that the participant group is tainted in the sense that such characters may be considered untruthful or likely to give false accounts.

The phrase "credibility gap" refers gap that can be found in "an apparent difference between what is said and what is true" (Butterfield 2015, 152). As a result of the credibility

gap many prison and healthcare staff may have doubts regarding prisoners' requests for healthcare. This factor may be relevant as some of the men may have been trying to overcome any credibility gap, which they themselves are conscious of; they have been called liars and had their accounts challenged by many, throughout their journey in the Criminal Justice System and prison.

While going over the Participant Information Sheet and consent forms, Brian said to me, "It's a good thing that you're doing". I thanked him for his comment but asked him why he thought it was such a good study. His reply was that it was good that someone was taking time to look at the health of prisoners because "nobody cares what happens to us". Whilst this reflected a passing comment made by one participant, it may have given an indication of the level of self-esteem that he had and the way in which he saw himself as part of a group. The fact that he used "nobody" and said "us" than rather than "me" indicates to me that he had an insight into the stigma that is attached with having been in prison. The judgement being made is that the group are not important to society as a whole and that this reflects an attitude that may be found within the general public. It may also be a rhetorical move that sets up the fact that the participants should be listened to. The participants' have all spent time in prisons, which are often, associated with a "them and us" discourse. These are not just social categories but legitimise the views and opinions held within them and how and what are voiced.

The credibility gap posed a problem for participants in trying to access healthcare. For example, the following extract gives a detailed account where John describes the time taken for treatment to be given to a fellow prisoner following a football injury:

John*. There was this one guy. He was always off his face, failing drugs tests and one day we were out playing football and he hurt his foot. Went into a tackle, hurt his foot and he was taken back to the hall. He asked one of the officers if he could see a. Nobody came and seen him for two days. This one nurse came and because they knew his history and that he was on drugs, they thought that he was just at it to get something…… Some pain killers from them. The next day a doctor came in, took one look at his foot, took him to Ninewells hospital and it ended up his foot was broke. So they left him for three days, thinking he's at it, he's wanting something from us.*

John states that the prisoner had requested to see someone about his injury soon after it had occurred, although he fails to state in his account whether it was a nurse or Doctor that was requested. It would appear that officers and a nurse did not believe that the prisoner had sustained an injury and it took three days for a Doctor to examine the prisoner's foot and deem that it required hospital treatment. In this case, the prisoner had been telling the truth but, due to the credibility gap, he was not believed and suffered as a consequence.

In the extract, John is performing the role of the animator, as discussed in Goffman's deconstruction of the speaker in his second essay "Footing" within the book "Forms of Talk" (Goffman 1981), while the author and principle of the story contained within the extract is actually the other prisoner or "this one guy" that he refers to. There is an implication being made here about issues surrounding a lack of trust between inmates and prison staff trust with regard to health and illness. This is based upon what prison staff may believe what they think they "know" about a particular prisoner. In the example above, prison staff had knowledge of the prisoner's drug use perhaps making it easier to assume that this was

simply a case of drug seeking. John's account, and those of other participants, reflect that they have experienced a high level of mistrust in them and the issues surrounding their health status, as a result of the credibility gap, which has impacted upon their ability to access health care whilst in prison and the community.

4.5 Summary

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. They also gave accounts that they had not experienced this within the outside community either.

Participants' 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.

In Chapter 5 I will present part three of the results; the third major theme highlighting the difficulties in interagency communication of care between the SPS and NHS that were experienced and perceived by participants.

Chapter 5. Results – Part 3 - Difficulties in interagency communication of care

5.1 Introduction

Chapter five presents issues and inconsistencies revealed as difficulties in interagency communication of care for participants trying to use the SPS/NHS healthcare partnership.

This study explored the experiences of healthcare that men had in prison and the outside community. Throughout the interviews, it became apparent, that the participants had a wide range of different experiences, in particular in relation to the way they had experienced the different organisations, i.e. the SPS and NHS and the different roles, messages and operating procedures. In the course of conversation, all of the participants gave descriptions of their experiences and compared the healthcare system in place now with the former SPS system. They also made comparisons between the prison and community settings. In giving their accounts, it was explained that a number of issues and inconsistencies cause the participants difficulties in using healthcare. These are presented in the following sub sections.

Prior to November 2011, the SPS were solely responsible for providing primary care within its prisons. This meant that the SPS had its own in-house healthcare service, employing its own Doctors and nurses with other healthcare specialities such as dental and optician services contracted out to external providers. For prisoners, this meant that they had two sets of medical records; those held by their GP and those by the SPS. No information was shared between the GP and SPS, which meant that continuity of care from community to prison and vice versa was problematic. Within the prison, prisoners knew the healthcare

system, the staff and what to expect from it. Participants in this study also voiced that they experienced little stigma or negative attitudes from the SPS healthcare staff.

However, the SPS healthcare service had grown to a point whereby it could not provide the range of services required of it and the staff working in it were in danger of being alienated from healthcare colleagues working in the wider NHS and had limited professional development opportunities. As a result, prisoners with a wide range of healthcare needs were in danger of being denied the opportunity to access the appropriate healthcare services required, due to a potential lack of contemporary knowledge and skills.

Change was required in order to ensure that Scotland fulfilled the legislative requirements of the United Nations (The United Nations 1990) and the guidelines from the World Health Organisation's Health in Prisons Project (World Health Organisation 2011). Change was also required to address the growing deficit in the range of services available to the prison population compared to those provided to the general population by the NHS. It was also anticipated that change would ensure that SPS healthcare staff would be provided with more opportunities to liaise with NHS colleagues and participate in activities that would ensure continuous professional development.

In November 2011, the major change that took place was that responsibility for primary care within the SPS estates became the responsibility of a newly formed partnership between the SPS and the nine health boards within the NHS in Scotland. This partnership has been agreed in law between the SPS and NHS (The Scottish Government 2011) with the common purpose to improve prisoners' access to an appropriate range and quality of NHS health care services according to their needs. It was also anticipated that the new partnership agreement would help to reduce health inequalities, preserve life and reduce

harm, provide safe, secure environments for the health assessment and treatment of prisoners and that the SPS/NHS would work with other agencies to maintain this common purpose. It is also worth noting that the company G4S plays an important role in prisoner healthcare, as it performs all the prisoner transfers between the police stations, courts, prisons and all external visits, including hospitals in Scotland. This is performed as part of a separate contract with the SPS and involves the transport of approximately 180,000 prisoners each year.

This new partnership means that prisoners receive all their primary care from the NHS, whether in prison or the outside community. As a result, in theory, it should be easier to facilitate the smooth transition and continuity of a prisoner's care between the outside community and prison and vice versa.

Throughout the interview process, the participants voiced differences that they had experienced between the NHS and SPS. Participants talked about the lack of health service provision, which they received after office hours. The transfer of prisoners to hospital appointments was talked about at length. Since the inception of G4S as the company responsible for all prisoner transfers, participants highlighted the ethical issues of privacy and confidentiality, especially when consulting with a specialist doctor at a hospital outpatient department. Participants also talked of the movement of prisoners within the prison to the health centre and it was noted that the SPS were responsible for whether a prisoner attended his appointment or not.

Participants expressed a difference in nurses' attitudes post November 2011, and they remarked that the old process of accessing healthcare via the "sick parade" had changed.

Medication checks were felt to be more problematic following the change of primary care responsibility in November 2011 due to the different status of nurses within the prison. The access procedures within the NHS were seen as having become more bureaucratic as had the complaints procedures.

5.2 Umwelt – Physical aspect

Participants voiced that access to healthcare services had become more difficult because of the new SPS/NHS partnership. Prior to the change in 2011, healthcare had been easily accessed via the "sick parade" process, held in the prison halls every morning or with a referral from a prison officer. However, following the change it became harder, as the sick parade was no longer regarded as a legitimate means for prisoners to refer themselves for healthcare services, and they were now expected to fill out a referral form requesting a specific service and outline the reasons for this.

5.2.1 Access to care

The document "National memorandum of understanding between the Scottish Ministers, acting through the Scottish Prison Service and NHS Scotland" (Scottish Government 2011) is a framework for the respective roles and responsibilities of the SPS and NHS in providing health services for prisoners serving sentences and upon liberation. It outlines the roles and responsibilities that the SPS and NHS have to perform in partnership, to ensure the delivery of the new healthcare service for prisoners. However, as in many partnerships, these roles and responsibilities are not always performed in harmony, and power struggles and tensions can develop. Participants expressed that they had witnessed inconsistencies between the

SPS and the NHS, particularly with regard to the way in which the healthcare system was administered.

Participants were aware of differences in the prison routine. One of the most noticeable changes was the provision of healthcare after hours, which, in prison, were after 8pm until 7am on weekdays and 5pm until 8am at weekends. During these hours, their perception was that no healthcare staff were available to deal with pain relief, accidents or emergencies. The important issue here is that people are not ill to order and there should be healthcare cover within the prison, 24 hours a day.

During the hours mentioned above, when prisoners are locked up in their cells, officers are responsible for dealing with any health-related issues. While discussing the issue of pain relief, a participant gave the following account, which illustrates this point:

Todd*. You get paracetamol.*

JF*. Who gives you that?*

Todd*. A prison officer… prison officers on the landing but you are only allowed six or eight a day. Em…I find that sometimes you need to take more than that because, and I know it's dangerous but, you are in pain and if you are locked up… and at weekends you get locked up at five o'clock at night. You can get two for going behind your door with but no one will hand any paracetamol in to you while you are locked up till the next morning... till eight o'clock. So, between 5 and 8 you canna get any painkillers whatsoever.*

JF*. So for the 15 hours you have got two paracetamol.*

So, now prison officers are having to make these health-related decisions as no NHS staff are on duty in the prison estate during these hours. Although they can contact a doctor on call for advice, it is left to the officers' judgement, whether or not this is performed.

Prison officers are not trained in health care, which means that, if required, they will have to call upon the emergency services. An example of this was given by Todd, who had gone on to elaborate on his point about out of hours care:

I mean, dinna get us wrong I was in a while back with a guy that had appendicitis. Appendicitis… you know his appendix and I actually, basically, they moved from there to there before they done anything, ken. I mean you went on his bell; it was a weekend I remember it clear as day. He's went on his bell, went "Listen I'm in pain" and went eh... em... they brought a nurse over and the nurse has went "Well he had pain" ken, right away. A wee while later I'm on the bell again "Listen, he's in agony. Get in here" ken what I mean. So they have come in again "Right, take these" away again. And he was lying on his bed, he could not move and I'm like "Listen, that is his appendix. You are gonna have to…." I'm no a doctor, I knew it was his appendix. I'm like "That's the appendix. You are gonna have to get him up to the hospital" ken. And they went right eh… take another couple of pills, went away, come back 10 minutes later, took him out and then took him up to the hospital. The next time we seen him was a week later with a stick. He'd had his appendix out. Ken what I mean, if they had waited any longer it would have burst and I would have been sitting in a cell with a guy with his appendix burst, not knowing, ken what I mean. So when they

eventually brought him to the hospital but they... when he was describing that they should know what he was on about or the general area because I was able to… I knew what he was on about and I've never had my appendix out.

This incident had taken place during a weekend, while a nurse was on duty. As he explains, it took some time before the prison staff made the decision to get the prisoner taken to the hospital:

If he was in on his own, he would not have been able to get up and press his bell because he was in that much pain. I had to do it. Well the first time he would've but the second time he wouldn't have. He was lying on his bed really no well, ken and he canna move. I mean, they knew he was not faking it. They knew he was in pain and they knew…ken, they gave him tablets and knew he was in pain, ken. They knew that something was up with him…. but they waited for quite a few hours because basically, the guy told me, basically when he got took out and took to the hospital, he basically got took right in and they took it out straight away. He was told that if they had waited any longer it would have burst, ken.

It could be argued that if Todd's cellmate had been living alone in his own home, nobody would have been immediately available to assist him and that he may have faced life-threatening consequences. In this instance, however, it was serendipity that he was in the prison at the time when he developed appendicitis.

In this instance, the participant had correctly assessed that his cellmate was suffering from a serious ailment, which required immediate medical attention. The account of the incident by Todd demonstrates his experience of having to persist in notifying relevant authorities before being taken seriously, as well as experiences of delays in receiving emergency medical provisions, Accordingly, it is notable that in the described experience, the participant witnessed a prisoner having been seen four times before decisive action was taken to transfer him to the hospital for medical examination. SPS and NHS staff were so distrustful of the prisoner, that it was not until he had been exhibiting extreme levels of pain for a number of hours, which had not been relieved by the medication given on two occasions, that action was taken. This demonstrates the way the participants feel labelled as untrustworthy by prison staff, as they need to persist that their need for accessing healthcare is genuine.

In conclusion, prisoners have limited access to out of hours healthcare services from trained professionals. They are in a situation, particularly with regard to medical emergencies, in which prison officers have to make healthcare decisions with little or no training.

5.2.2 Gatekeeping of services

Participants expressed that it was impossible to gain access to a doctor, or any other service, without having to go via a nurse or prison officer who would perform the gatekeeping role. Part of the access/gatekeeping process requires prisoners to complete a written referral form. However, many prisoners cannot read or write. This is supported by a Freedom of

Information request by the Scottish Conservative Party to the SPS in 2013, which resulted in the following reply:

"Approximately 81 per cent of prisoners screened were assessed as lacking functional literacy."

(Scottish Conservatives 2015)

Having to offer a compelling explanation as to why you wish to see a healthcare professional may discourage some people especially those with literacy problems. This requirement forms a barrier and could be viewed as an exertion of power over prisoners in order to discourage them from accessing health care unnecessarily. In addition, as a result of this, participants noticed that prisoners medicate themselves using whatever medication is available in the halls, as they cannot deal with the difficult bureaucratic access procedures. This may partly explain and illuminate the currency for the illicit drug use amongst the prison population.

In contrast to the access administration within the outside community, prisoners are faced with further administrative hurdles. In this sense, access to doctors in the outside community is usually administered by receptionists in GP surgeries, often over the telephone. Conversely, the situation in the SPS comes with additional formalities, such as additional paperwork, which not only lengthen the timeframe for access, but also make the procedure more onerous for the participants.

Following liberation, despite the fact that these additional formalities are no longer required in order to gain access to services, an ex-offender still has to deal with the attitudes of receptionists and ancillary frontline staff. Participants experienced this to reflect the stigma and negative attitudes held towards (ex) prisoners. Robert expressed this while giving his account of registering with his GP following liberation:

JF. *Since you have re-joined society, have you registered with a GP?*

Robert. *Yes. Now there is another thing about the National Health. I came out of prison… eh I phoned up my doctor and I says "Could I get an appointment with the doctor" and they says "Oh I'm sorry you've been struck off. You're not in the surgery list now".*

JF. *Was this the GP you had before you were in prison?*

Robert. *Yes, I've had all my life.*

JF. *So you've been there all your life, you've been in prison, you came out, you phoned that GP and they say you're struck off.*

Robert. *You're struck off…. And nobody told me that in the jail. I never got told that I was struck off and when I went back, when I says that my GP which is Queen Street surgery.*[8] *I says to them, "Is it alright if I reregister then"? They says, "No problem". So I had to go up on the Thursday I reregistered and then eh... I says "Can I get an appointment?" They says "You*

[8] Note that the street name in the above extract has been changed in order to help preserve the participant's anonymity and confidentiality.

know the rules. You have to phone on the day". So I phoned them on the Friday morning at 8 o'clock. I says, "Could I get an appointment for the morning". "I'm sorry, we're fully booked". I says, "Well, one in the afternoon then?" and they says, "The only one we've got is ten past five". I says, "Well that'll do then". So….

JF*. Fair enough. Did they give you a reason for having been struck off?*

Robert*. They says that my files had been sent to Aberdeen……*

JF*. Right. When you were open with the receptionist about having been in prison did you detect any change in their tone of voice or their attitude towards you.*

Robert*. Yes.*

JF*. How would you describe it?*

Robert*. Eh…… the receptionist was…. boiling.*

JF*. Boiling?*

Robert*. Yes, boiling mad. She was really angry. You could see it in her face, ken… that she was not amused.*

Robert's use of language, in particular the phrase "struck off" to indicate that he had been removed from his GP's surgery list, is interesting. This is because it is a phrase more commonly associated with healthcare professionals, to indicate that a Doctor, nurse or other regulated health professional has been removed from their professions register,

which indicates to others that they have lost a position of power, responsibility or stature within their field.

Robert described the conversation he had with the practice receptionist, while making an appointment, which would be the same for any member of the public. Robert expressed that the receptionist was "boiling mad" towards him. Whether she was "boiling mad" at him or this represented feelings of rejection and exclusion within Robert and reflected his discomfort, nonetheless, the justification for the treatment offered at the practice reception would be concerning for the new prisoner healthcare protocol that has been put in place. The important point here is that Robert witnessed a visible change in the receptionist's attitude and display of anger towards him after she became aware that he was reregistering as a result of having been in prison.

In conclusion, participants expressed that it was difficult to access healthcare services without having previously been seen by a nurse. They also explained that they experienced more bureaucracy in the referral process as they now had to fill in forms. This caused difficulty, in particular for the participants with challenges to literacy. Participants also experienced behaviours directed towards them by the gatekeepers of community healthcare services, such as the GP receptionist, which reflected negative attitudes and emotions in relation to their status.

5.3 Mitwelt – social aspects

Communication between the SPS and NHS has an effect upon prisoners being able to attend their healthcare consultation. This is due to the fact that within the prison, SPS staff are required to escort prisoners to/from the health centre, as well as being present to help

supervise the safe administration of medication within the halls. There is also a security aspect to escorting prisoners to healthcare appointments outwith the prison that involves the use of handcuffs. This strategy has implications for perpetuating social stigma of prisoners as well as raising questions regarding prisoners' ethical rights to privacy and confidentiality while consulting with healthcare staff and receiving treatment.

5.3.1 Prisoner movements to healthcare

A major issue is that the prison routine is not very flexible. This can cause friction between the operational needs of the prison and the priorities of the healthcare centre. Participants described that the movement of prisoners to the health centre for consultations with the doctor, nurse specialists, dentist, optician, etc. as being totally dependent upon the prison officers that are allocated to be "runners" for the healthcare centre. The role of these "runners" is to escort prisoners from the halls, work or gym to the health centre and vice versa. As prisoner movements are controlled by the SPS, there can be difficulties in ensuring that prisoners attend their NHS appointments. Problems can occur with the allocation of prison officers to be "runners" especially if the prison is experiencing staff shortages due to illness, holidays, etc. There can also be administrative errors in the drawing up of healthcare clinic lists by administrative staff with prisoners listed/omitted in error. These lists are vital as they inform the "runners" as to the times that prisoners are required in the health centre. It is extremely difficult for officers to plan prisoner movements without these lists being sent to them in a timely fashion. Communication is key to the smooth delivery of healthcare in the prison and any breakdown can lead to delays or non-attendance of prisoners to their consultation. As revealed in the interviews, for the participants, this constituted another

means to control their access to healthcare, and thus, was a source of frustration and anger, especially in situations in which they had missed an appointment as a result of this system.

The experience of attending the health centre was described by Robert:

JF. *Do you get any advance warning of when you are seeing the nurse?*

Robert. *No.*

JF. *An officer just comes and tells you.*

Robert. *To say that you are needed for something. That's correct.*

JF. *Is that an officer in the hall?*

Robert. *That's a runner from the jail. It is usually like a prison officer just comes to the… where ever you are working or whatever and say, "Right I'm needing Robert to go to the health centre" and they take you over with maybe more people.*

As well as describing the role of the "runners", it is interesting to note that Robert expresses that he did not get any advance notice of his appointment at the health centre. This is in contrast to the prescribed process whereby participants are meant to be given an appointment. Participants highlighted that inconsistencies like this caused them a lot of frustration. Interestingly, given the reality of prison, participants rarely commented on the need for security procedures and the effect these had. As a result, therefore, it could be argued their accounts were necessarily partial and incomplete.

Another example that demonstrated the different priorities for the SPS and NHS was the waiting area in health centre, which participants referred to as “the Tank”. They experienced treatment, which made them feel like they were prisoners’ first, patients’ second and that, even within the prison health centre, maintaining order was the overriding priority compared to that of providing healthcare. It could also be argued that this serves to remind prisoners of their status, where they are and that the SPS control the building and everything that happens within it, as well as every aspect of their lives. Participants explained that they were able to sense that the NHS was an organisation that had not taken over fully from the old SPS healthcare system and that it was not working in a partnership with the SPS despite the rhetoric of the Government, NHS and SPS.

5.3.2 Outpatient hospital appointments before liberation

Prisoner escorts to hospital appointments are performed by a private company G4S. Historically, all prisoner escorts outwith the prison were performed by prison officers. However, in November 2003 the Scottish Government decided that this function should be performed by a private company to allow prison officers to focus on their duties within the SPS estates. A contract was awarded to the private company Reliance, which ran from November 2003 to January 2012. During this period, controversy arose in relation to Reliance’s ability to perform their contractual duties and fulfil terms of contract awarded by Scottish Government because there were a number of incidents where prisoners escaped from custody. As a result, a new contract was awarded to G4S, formerly Group 4 Securicor in March 2011, which commenced in January 2012.

Robert talked about the routine transfer of prisoners to hospital outpatient appointments as being a daunting experience. When I asked him how it was daunting, he proceeded to explain the procedure that he had experienced

Robert*. Well that's another thing. Going to a sort of hospital... is eh… sort of eh... a daunting sort of thing. When you go... when you go to the hospital they strip search you before you go.*

JF*. Is that in your cell?*

Robert*. No no this is in the reception. They've got a sort of eh metal chair that you sit on and metal will show up and then they go on and strip search you before you go. So if you get told sort of like you are going to the hospital you'll maybe get told the night before right after lockup. Right so what you do is if you're going to the hospital…. You would sort of eh no wear socks because you know you're going to get strip searched and you might just wear one t-shirt or something, right. And then they handcuff you…… when you come out and you're handcuffed all the time even in the hospital.*

JF*. Are your hands cuffed or are you handcuffed to someone?*

Robert*. To an officer. To one of the G4S fellas. So you're handcuffed all the time it doesn't matter if you go in…… and they take your t-shirt off, they would take the cuffs off and put it on another arm. So it is hard to get your t-shirt off.*

Robert's detailed account demonstrates that he knows the prison routine very well and that is his reality; he knows what to wear if he is going to the hospital for an outpatient appointment, and the reasons for this.

Being taken to an OPD appointment in hospital is not a simple process and participants voiced their opinion that custody appeared to take precedence over care, although the security officers would argue that they are protecting the safety and welfare of the prisoner in carrying out the procedure. At a local level, prior to the transfer, a prison officer performs an assessment of the prisoner and completes a Personal Escort Record (PER) (Appendix K). The PER contains personal details about the prisoner and the reason for his detention and transportation. An assessment has to be made as to the medical, security, or other risks posed by the prisoner. For example, if they pose a suicide risk or self-harm, this has to be recorded on the appropriate part of the form. This form is given to the G4S officers when the prisoner is handed over to them and accompanies the prisoner wherever they are going. This procedure is not unique to hospital visits and would be expected in other scenarios when leaving the prison estate. For example, attendance at funerals, transfers to/from court, etc.

The sharing of highly personal information raises the ethical issue of privacy. The punishment element of imprisonment revolves around the prisoner forfeiting their right to liberty. However, this does not automatically mean that they are not entitled to their privacy. The 1998 Human Rights Act (UK Parliament 1998) made it unlawful for the authorities to act in a way that was contrary to the provisions within the European Convention of Human Rights. It could be argued that sharing prisoners' health records, as described above, contravenes the right to privacy as laid out in Article 8 of the Convention.

However, although this article allows for certain exceptions to the right to privacy in relation to prisoners, such as being stopped and searched at any time and the vetting of prisoners' phone calls and correspondence with the outside world, there is no specific exception relating to privacy in relation to healthcare.

As Robert had mentioned the use of handcuffs in relation to being escorted to hospital, we discussed his experience of this further. He told me that he had experienced this procedure on a number of occasions as he had to attend hospital outpatient clinics in connection with a chronic condition that he suffered. When I asked Robert about the use of handcuffs during his hospital visit, he replied:

Robert. *Yes, you are handcuffed. You've got to stick your hand out and then they bring it back in so you are always under guard. You are handcuffed when you get out of the van and then when you are in the hospital you are still handcuffed all the time... right. And you sit and wait your turn, you get your turn. You're still handcuffed when you go into the room with the doctor.*

JF. *When you go into the room does the officer or G4S man come with you?*

Robert. *Yes.*

JF. *And does he stay all the time?*

Robert. *Yes, two of them.*

He had experience of being handcuffed to G4S security men during his visits and was denied privacy during his consultation with the doctor, which is a crucial aspect of healthcare provision in the outside community. This is an example of the Custody versus Care dichotomy. The scenario described also raises the ethical issue of confidentiality regarding the participant's condition and healthcare. As two G4S/prison officers were present during the consultation between the doctor and participant, patient confidentiality was compromised. Though one could argue that if it is risk assessed there may be a case for confidentiality to take second place to the doctor's safety.

JF. *And if the doctor needs to examine you then do they let the cuffs off?*

Robert. *No, they don't even take the cuffs off.*

The issue of lack of privacy while being escorted to attend hospital appointments was also voiced by Todd, who expressed anger and strong negative emotions through the tone of his account of this intrusion into his private life. This is demonstrated in the following extract where we were discussing his experience of hospital visits:

Todd. *That is a thing as well. If you are in the hospital ken and they want to be in the room with you as well. It's your healthcare but they are in there and I ken that security reason about it but if you are going into an office that has not got a window then there is no reason for them to be in there with you or when you are trying to get changed or dressed. I*

remember when I was trying to get changed into my dressing gown, and this just to prove my point, he was in there and he's got cuffs on so I had to take this half of my clothes off change it to that side and then I'm like, there is a door, there is nowhere else out of here and he stands at the door, I take my clothes off and then chap on the door and he opens it up, you know what I mean. What's the matter with that ken what I mean?

JF*. There is issues about privacy isn't there.*

Todd*. Exactly ken. It's mental especially now that it's G4 security. Everyone is really, really bitter about it ken.*

As well as highlighting the difficult issue of privacy, being continually handcuffed to security officers throughout a consultation may have an effect upon the dynamics of the consultation.

Participants expressed concern about the prison not sending prisoners out to hospital due to operational difficulties, i.e. shortage of SPS/G4S staff, despite clinical need. As Todd explained:

Todd*. See them that is G4 security that is who provides the transport.*

JF*. Yes, I have seen them.*

Todd*. That will be an important thing for you. That is who takes you to hospital. So basically, if they have no got a van... you dinna go. And there is a lot of times that you are meant to go on the Monday and they dinna turn up. The appointments already been put off to the*

following Monday but they just didnae turn up. The reason they just didnae turn up, you ken cos, is say communication problems. And you are better if your appointment is from the hospital and then the prison always change it because I ken, it's for security reasons right but they always change it and you are like, ken, say I've got a visit on next Saturday and I've got a hospital appointment on the Monday. They will change it to the Saturday, ken, so you've got to take it but they dinnae tell you so your visitors are on their way up and you dinna ken when you're gonna come and take you to the hospital and you say "My visitors have just travelled up. I'm no gonna go. I canna go to the hospital the day; I want a visit" ken. They should be telling you a couple of hours afore it and saying "Do you need a phone call to phone anybody to tell them no to come up" ken.

It could be argued that some of the consequences described by the participant are to be expected due to the loss of liberty and that he, and other prisoners, should not expect any better while imprisoned. However, when their healthcare is being affected this could be seen as a further punishment.

The SPS/NHS partnership for healthcare is based upon the principle of equivalence; prisoners should receive the care equivalent to that of the general public but not necessarily the same as it is subject to the caveat; where feasible and appropriate. The general public would expect their consultation with the doctor to be held in private to ensure confidentiality. There are occasions when they may have been asked to give their consent for others, for example, medical students, to be present or not. However, the important issue here is that they would have to give their consent to their presence and as a result accept that others are privy to the information divulged in the consultation. They have the

choice to withhold this if they so wish. From his account, Robert explained that it was his belief that prisoners handcuffed to officers are not afforded the choice whether to have students present or not, presumably because of the argument of public protection. Robert conveyed in his account that he perceived custody was the overriding priority and that care was secondary to this. While accepting that there may be occasions when a prisoner may be assessed as being an escape risk, and justifiably appropriate security measures taken, it would appear that this needs to be balanced against the individual's rights to consent and confidentiality, i.e. different categories of prisoner and their risk assessment.

5.4 Eigenwelt – personal aspects

Medication is an important issue within the prison, as it is recognised and used as a currency. In order to stamp out the illicit trade in medications, individuals have their cells checked for medication and, if required, the legitimacy of any found medication is checked. Although this procedure has been performed for many years, participants described that it had changed following November 2011. They noticed that there were changes with the frequency of checks, procedure for performing them and the powers of nurses and officers in relation to them. All of these changes appeared to have put the focus on custody with potential consequences for the continuity of care for prisoners.

5.4.1 Medication checks

Some participants understood the practice of allowing prisoners to keep their prescribed medication in their cells while subjecting them to inspections of their cells and medication checks as a hypocrisy from the internal management of the prison. Nurses' employed by the

NHS cannot perform any searches or checks on a prisoners' medication, as they have no authority or power to do so. Prior to November 2011. Nurses employed by the SPS had the power of search, which gave them the authority to make checks on the medication that a prisoner had in his possession. However, the power to initiate and perform medication checks are now fully outwith the lawful remit of NHS nurses, as they have no power of search attributed to their status within the prison. As it is also a breach of confidentiality for nurses to reveal details of a prisoner's care to third parties, prison officers are placed in a position, in which they are unable to find out whether any medication found in the possession of a prisoner has been legitimately prescribed or whether it has been obtained by other illegitimate means.

Mark described his experience of how the checks were performed:

Mark*. Yeh they do but some are... most. well not most... well yeh I would say actually most of them turn a blind eye to it… but there's maybe, through experience, there's one or two officers that... wouldn't turn a blind eye to it and they would phone up the medical... eh... team and say eh such and such... eh suspicion of selling his medication or distributing it to other prisoners and then they would maybe come across and do a medication check.*

JF*. So they do check medication?*

Mark*. Huh yeh... but not very often but… I think it should be done on a weekly basis or a fortnightly basis but... it's only done if… the staff are phoned up and…*

JF*. So only if an officer was to alert that there was a suspicion of something going on? Then is it healthcare that comes across and does it?*

Mark*. Healthcare yeh. Two nurses will come across or one nurse will come across and get an officer and ask to see your medication.*

The medication checks were also observed by Richard who described the procedure as follows:

JF*. Who performs these medication checks?*

Richard*. It's um…. a nurse that does that.*

JF*. So how does that happen?*

Richard*. The nurse appears. Gets an officer. The officer takes the nurse to the cell. The door gets opened then. locked but no. locked as in locked. It gets opened and locked and the door gets pushed over. The nurse and the officer go in the cell and the medication gets checked.*

JF*. It's the nurse that's checking it?*[9]

Richard*. Yes.*

JF*. With an officer in accompaniment?*

Richard*. Yes.*

[9] It should be noted that when Richard, or any other participant, refers to a nurse, that this can be a female or male nurse.

JF. *What happens if?*

Richard. *He's one short?*

JF. *He's one short. What happens?*

Richard. *He gets them taken right off him.*

JF. *Even if it's one short?*

Richard. *One short. Two short. You get it taken off him and you'll get put on supervised medication. Depending on what…. depending on what drug it is.*

The NHS did not have a protocol to follow for medication checks, as it was viewed as being unethical. As a result, medication checks by NHS staff were all stopped and any future checks were to be led by the SPS. However, after the initial adjustment period to the changes in these practices, the conscious decision was made, that not all medication necessarily required as rigorous checks, as both the NHS and the SPS were more concerned about checking the legitimacy of medication, which was known to have "currency value."[10] However, this meant that patients who were legitimately proscribed medication prioritised in relation to medication checks faced differential treatment, which subjected them to more inspections than other prisoners, merely due to their health conditions. The current situation is that medication checks should not be performed unless they are intelligence led i.e. that the IMU (Intelligence Management Unit) within the SPS has asked for a prisoner's medication to be checked as it is suspected that it is being stolen/traded to raise funds or

[10] The term currency value is used in this context to describe medications commonly known to be traded illegitimately within the prisons.

given away as a result of bullying. The procedure is that the Prison Officer makes a request to the healthcare centre asking which medications should be available to the patient. The prisoner is then checked to see which medications they have in their possession. The nurse then checks this against their prescription and can ask, "You are prescribed (name of drug), you have not declared any to the officer, do you have any in your possession?" Pending the outcome of this, the Prison Officer can place the prisoner on report if found to be dealing/stealing/bullying. The nurse can have the prisoner's medications reviewed, changed or stopped completely depending on the circumstances. What this means is that potentially a prisoner has no medication left from a prescription and they have their medications stopped because the view is taken that the prisoner is not adhering to their prescription, due to alleged overuse/bullying, etc. It could also be argued that prisoners do not require the medication if they are selling it. However, participants seemed to believe that within a matter of a couple of weeks, the same medication would be recommenced by another doctor because the prisoner will feign symptoms and allege that they are in pain. Perhaps controversially, due to the medication check, the previous apparent overuse of the drug can result in the medication dose being increased. This can lead to a vicious circle of overuse/dealing/bullying and further medication checks. However, Mark experienced these checks being inconsistently performed:

Mark. *Sometimes see. when they are dispensed weekly medication they may ask you to sign a form to say you will not eh sell your medication or things like that and you... and they can check on... your medication can be checked. Yeh there is that form but... not all the time do you get handed that form to sign.*

JF. *So there is a form to gain your consent to these searches and checks but it is not always performed.*

Mark. *It's not always done because that last time I was in there it wasn't done.*

5.4.2 Complaints procedures

One of the biggest changes that participants noticed after November 2011 was the difference between the SPS and NHS complaints procedures. Prior to this date, the only complaints procedure that had been available was the SPS procedure. This involved a number of stages as explained by William:

William. *Yes, the internal SPS complaints procedures. Right. So you've got like five procedures to go through*

The procedures for the SPS complaints procedure are:

1. Part one of the complaint is to attempt and resolve the complaint locally by talking with/writing to a prison officer in the hall. If a prisoner is unhappy with the response they receive then they can proceed to part 2.
2. The next stage is to write to the Hall Governor with the complaint. Again, if the prisoner remains unsatisfied with the response they can proceed to the next stage.
3. Write a complaint to the Internal Complaints Committee (ICC). This initially involves the complaint being put before a panel of three Hall Governors and adjudicating.

4. The Internal Complaints Committee will make recommendations to the Governor. The Governor will look at the ICC's recommendations and write to the prisoner within 20 days with a final decision. This is the last stage in the complaints procedure within the prison.
5. If the prisoner remains dissatisfied with the response from the Governor, then they can refer the complaint to the Scottish Public Services Ombudsman (SPSO).

Once this process is exhausted, the only remaining action a prisoner can take is to attempt to take their complaint to court.

It should be noted that prior to November, this procedure was also used for complaints about healthcare within the SPS. Now, however, now healthcare complaints have had to be made using the complaints procedure for the local health board in which the prison lies. As nine health boards are responsible for providing the primary healthcare within the SPS estates, this means that there are nine different complaints procedures. For example, not all health boards offer a medication service to deal with complaints. However, the general process will follow the following steps, yet subject to variations:

1. Talk with local healthcare staff within the prison in an effort to try to resolve the complaint.
2. Submit a form to the health centre manager within the prison outlining the complaint. Acknowledgement of its receipt should be sent to the prisoner within three days.
3. The form will be passed to the local health board's complaints team and an investigation will be performed.

4. A written response should be sent to the prisoner within 20 days of original receipt of the complaint form.
5. If the prisoner remains dissatisfied with the response, then they can refer the complaint to the Scottish Public Services Ombudsman (SPSO). However, the prisoner must have used and exhausted the local health board complaints procedure before taking it to the SPSO.

As there is no national complaints procedure, it is a source of confusion and anger for prisoners, given that they can be moved around SPS estates depending on their sentence and security risk level.

When the NHS took over responsibility for primary care in the SPS, participants had initially been optimistic about the new NHS complaints procedure:

William*. Like I mentioned the complaints procedure. Right. So. When the National Health Service came in. they brought in a new complaint procedure. You went direct to the National Health. You didn't have to do anything through the SPS. There was a. if you wanted. If you were complaining about your medical treatment you went straight to the National Health. Service.*

Participants experience was that it was not communicated to prisoners that separate procedures existed for the SPS and NHS and they were confused and angry about this and sensed this with prisoners and staff alike. In effect, participants had a negative experience of this change, which was one of exclusion. This was explained by William:

JF. *Were you informed about the new complaints procedure as a group?*

William. *Well. No really. No until actually after the National Health Service took over. There was a notice put up on the board. about if you wish to complain about your medical treatment. after like the first of November such and such there's a new. agreement. but if you were to go and ask any of the screws for a form…. There was nothing there. They knew nothing about it. or they were saying they knew nothing about it they just weren't giving you the form. Or whatever the case may be. but nothing there. However, like I say. the first. I think I left it until the seventh or the eighth of November... I think it was the eighth of November. Eight days after (whistles).*

It is possible that prison officers had not been informed of the new NHS complaints procedure or provided with the appropriate forms. However, there is the implication, in the participant's account, that the changes were used as a strategy by prison officers to discourage, delay or prevent prisoners from making any complaints about the health care they were receiving. It could be argued participants seemed to believe that the NHS complaint system was designed in a deliberate fashion to ensure that prisoners did not complain. This is demonstrated by the comment by Todd:

Todd. *Yes. Oh that's another thing, the complaints procedure. That's terrible for the nurses. Ah, how am I going to explain this. They have got a form right and a complaints procedure that goes NHS outside but what Jane Smith* has actually done is went "NO! NO! NO! You*

have to fill this out first. Which is a feedback form. It is no a complaints form its feedback." So they're wanting me to write to a nurse to say I'm no happy with the treatment that you've supplied to me blah, blah, blah then they write back to you seven days later... to get it back. So it takes seven days for this to happen saying "oh well blah, blah, blah complain about it". (laughs) So then, now you have to go and get the complaints to NHS, which takes another up to 21 days I think it is my mate was waiting, ken, 14 or 21 days or something it is and he's writing that and so he has got to wait for an answer from them. I never actually went through that procedure but you are like "If surely if I have got a complaint to make against you as a nurse, I would write to the NHS I would not write a feedback form to your hospital and say I don't like the way this guy is" … ken what I mean. I don't like the way I got treated from this nurse that works for you. If you work for the NHS Tayside surely I should be writing to the NHS Tayside saying that I don't agree with the way this guy's…. ken.

JF*. It is like they want to know what you are thinking first.*

Todd*. See what you are complaining about them for so they can get a story about it and say "No. This is not what happened" because if you just phoned them up and went "Right, look I've had a complaint saying blah, blah, blah, blah, blah" they would be put on the spot and they would be "eh……" (laughs). It's like they can get themselves prepared for what they need to say. It's crazy eh. I just think that the way they do things is…. crazy, ken. Especially that…. That that is a crazy... that is a complaint to the surgery… ken. That is what you've got to do, you've got to do a feedback form which isn't a complaint in my book.*

JF*. No it is not.*

Todd*. That is for me saying "Oh I got excellent treatment from this guy" or "I got shabby treatment. That is my feedback put that in your book". Complaints forms when you are going "listen I really wasn't happy with the treatment. I'm wanting something done about this and I want this person spoke to". (laughs).*

*Note that Jane Smith is a pseudonym for the prison healthcare manager

From his comment, "That's terrible for the nurses", it gives an indication that prisoners do consider anyone else other than themselves. A point of note is that, given Todd's experience of the complaints procedure and the stringent way it had been applied, it is hard to see how the use of forms is congruent with the health care needs of prisoners; forms and health needs do not seem to go together.

A key experience, highlighted in Todd's account, is the waiting times experienced by prisoners to get a response to their complaint. Todd explained that he thought the NHS complaints procedure was designed to discourage prisoners from making complaints. One of the main points to note is that the form he refers to is not actually labelled or designated as a complaints form. It is known as a "feedback" form. However, until this protocol is complied with, no complaint can commence. He expresses that feedback is not a complaint and he explains how he distinguishes between the two. Admittedly, feedback can take many forms, both positive and negative, however, what is important here is that the participant did not believe that it constituted a complaint. Participants stated that the time it takes for prisoners to get any reply from their submitted feedback forms is lengthy. They also believed that, should they continue to pursue the complaints procedure and escalate it from

"feedback" to a formal complaint, it would take even longer to get a reply. This procedure, which is arguably ambiguous due to the use of the term "feedback", is experienced as a bureaucratic barrier, which not only delays complaints and the resolution thereof, but also discourages prisoners from making complaints, for instance about their healthcare. Participants perceived that the overall design of the complaints procedure made it appear that the NHS do not want any complaints to be made at all. A logical consequence of this deterrence is that the resulting absence of complaints can either be construed as a success in future evaluations of the healthcare services, and, in turn, that existing issues, which are not raised, will not be adequately addressed.

Participants' expressed that it was not clear which complaint procedure was to be used. Admittedly, this may have been as a result of the bedding in process when changes are put in place. However, they seemed to believe that the NHS complaints procedure was a waste of time anyway; needing a lawyer before their complaint was heeded. John gave an example:

John*. Can I give you an example?*

JF*. Please do.*

John*. There was this one guy. He was always off his face, failing drugs tests and one day we were out playing football and he hurt his foot. Went into a tackle, hurt his foot and he was taken back to the hall. He asked one of the officers if he could see a nurse. Nobody came and seen him for two days. This one nurse came and because they knew his history and that he was on drugs, they thought that he was just at it to get something…… Some pain killers from*

them. The next day a doctor came in, took one look at his foot, tane him tae Ninewells hospital and it ended up his foot was broke. So they left him for three days, thinking he's at it, he's wanting something from us.

JF*. So, you are saying that the attitude was that they thought he was at it and "drug seeking." They left him with a broken foot for three days before they took him to hospital where they presumably did whatever to fix it.*

JF*. What about how he felt afterwards.*

John*. He was not happy.*

JF*. What did he feel he could do about that?*

John*. You can go through a CP procedure, a complaints procedure but he just phoned or wrote his lawyer or solicitor to try and deal with it.*

JF*. Is that a strategy that lots of fellas use rather than using the complaints procedure?*

John. *Yeh, cause the lawyer seems to work more. If they get a letter from a lawyer saying that the healthcare has no been good then they're…it's gonna, they're gonna look at it more than just somebody writing.*

In John's account, he describes an incident that was quite serious involving a man suffering from a broken foot for three days before receiving the appropriate treatment, which had consequences on his ability to move around without pain and attend his work placement. It also had the potential to have more serious consequences for his long term health and

mobility if it had gone untreated. John observed that, it was quicker to get a lawyer to make a complaint than to go through the complaints procedure. As mentioned earlier, Todd's account demonstrates his belief that the SPS and NHS complaints procedures are designed to delay, discourage and prevent complaints. The SPS and NHS are thus exercising a power over prisoners and the bureaucratic structures and procedures appear to be used to affect prisoners exercising their right in complaining about anything, whether this is about general prison conditions or the healthcare services provided. However, it is interesting to note how a common knowledge develops to get around this.

5.5 Summary

This chapter has presented some of the differences and inconsistencies experienced by participants in relation to the SPS/NHS healthcare partnership. Some of their accounts present material that appears to illustrate the Care versus Custody dichotomy within the prison system.

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 handlings 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, 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.

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.

Chapter 6 will present part four of the results; the fourth major theme that highlights the vulnerability and hope of participants.

Chapter 6. Results – Part 4 – Vulnerability and hope

6.1 Introduction

All the participants stated that they did not enjoy prison life. It was something that they all had regrets about and they wished to break free of the continuous cyclical pattern of short-term readmissions to prison, known and referred to as the "Revolving Door." However, they face many problems when trying to break free from this. In recent years there has been a lot more investigation and study into desistance from crime and the long-term abstinence from criminal behaviour. There are several different theories that try to explain why offenders stop committing crimes and studies have looked at factors such as offender's age, gender, attitudes and motivation and how these play a part in offenders choosing to cease criminal behaviour. Although this study involved ex-prisoners, the focus of this study was on healthcare experiences and not desistance per se. However, while speaking to participants prior to the interviews, participants voiced healthcare experiences that had played a positive role in giving them a different focus on their lives after liberation. They spoke of the kindness of staff who had advocated on their behalf and arranged health services for them in the outside community. They were grateful for this and did not wish to let staff down by not attending the appointments arranged for them and expressed that they did not wish to let themselves down, nor return to their former routines and suffer deterioration in their health. This was because they believed that their health was a lot better than when they had first entered prison, which had provided them with a new positive focus to their lives.

It is not being argued that healthcare will definitely help all prisoners to desist from crime following their liberation. However, from the participants' accounts, it has become apparent that healthcare could contribute as an assisted desistance strategy in some cases. This

contributes to the debate about providing planned healthcare post liberation for prisoners, as this may promote good health for the individuals and contribute to better public health as well as help in abstaining from crime.

Participants mentioned a number of factors, which could help in providing a focus to life that would prevent them from engaging in criminal activities. Family and accommodation were claimed to be important, however, consistent, planned throughcare was also voiced as helpful.

6.2 Umwelt – Physical aspect

Prisoners are a vulnerable group. The term vulnerable is a broad term, yet it can generally be used to describe categories of people who are at risk. Applying this to the prison population, they are at risk of ill health and disabilities, have limited resources and as a result may face more risks to their health than the general population.

The NHS and various third sector organisations provide substance misuse services to help people with their drug and alcohol problems in order to maximise the health of the population, yet participants in this study were largely critical of those in the prison and the inconsistency of approach in the community.

6.2.1 Substance Misuse

Participants explained that illicit drug use was a major problem, not only in prison but also in the outside community. One participant explained that drugs can be viewed and treated as a form of escapism from the monotony of prison life, however also the challenges and

difficulties faced upon liberation. However, there are a number of different substance misuse services, each with different philosophies and aims of treatment. One issue that participants complained about in their dealings with these services, was the need for consistency in their approach. The main issues with this service was illustrated by Richard, when we were talking about obtaining his Methadone prescription in the community. He voiced the need for consistency in service provision. When we were discussing the service that he received from his current provider, he stated the following:

Richard. *Eh…. They don't provide any service at all there to you.*

JF. *Is that because of the people or is it because you think they are hard pushed for time or they are trying to deal with a load of people? Have you got any ideas about that?*

Richard. *No. No I don't think that there's no enough people. There's. you see lots of people there. They're always sitting about drinking cups of tea. They seem to have time to do that. Um. You go in "Eh right Richard we're here to see you today. We've got a fifteen-minute appointment. And I would like to make this fifteen-minute appointment as quick as we can. Right. How are you today Richard? I'm fine thanks Eh. Is there anything wrong with you? No. Nothing wrong with you. Right ok. We'll make up your next appointment for two weeks from now fine. Aye. Two weeks from now's fine Right ok. See you in two weeks".*

Richard was not impressed by the service he had received from the local health board's drug problem clinic and explained that he thought the staff were merely going through the motions with him. This was a recurrent theme when participants were talking about the

substance misuse services. When asked to elaborate on what he would expect to happen in a consultation, Richard replied:

Richard*. Um. I think they're meant to do in that fifteen minutes is uh. Find out how you're coping with your Methadone. Find out what drugs you've been taking. Find out um… what's going on in your family life. I know fifteen minutes is never been enough... a long enough time to get all the things done. But it's sure bound to be enough time to get a couple of they things done. each time.*

Richard*. – Eh I feel they're just going through the motions. I mean I'm no saying they're not interested. They must be interested to do the job but... I think they've just got into a routine of doing the same thing every day that they just keep doing it and doing it and doing it.*

A point to highlight is that Richard states that he thinks drug counsellors are going through the motions with him as well as his outlines of what he thinks they should have been asking him. However, although he demonstrated an understanding of their role and what should be discussed, he also explained that he does not tell them this. The questions that remain unanswered are why he does not tell them about his drug taking behaviours and family life, as well as what it is that is preventing him from initiating this discussion. His actions and words imply that he may have had information, which he would not wish to disclose about his behaviours. This experience exemplifies a common understanding of healthcare, which was revealed in the interviews to be held by the majority of the participants, which identified the prisoners as recipients of healthcare rather than active participants within it.

Richard implied that the staff treated him in a way that suggests they could possibly be suffering from "burn out". This is a situation when healthcare staff develop feelings of exhaustion and cynicism, which leads to inefficiency. Whether this was actually the case, is insignificant at this point. The important element, which needs highlighting, however, is the fact that he had received sub-optimal care due to the inefficiency of the healthcare staff members. I continued by asking him if he had come across similar attitudes in other health centres and he provided a contrasting example:

Richard. *Well I was working with the Nova Clinic.*[11] *And I thought the Nova Clinic* was a hundred times better. Because the guy I was working with. I don't know his name I can't remember his name. But um. He was giving me the help that I was needing... at the time.*

JF. *What was the help that you thought you were needing?*

Richard. *Well he talked to us about... um... what I'm wanting. thinking about wanting to do to come of my Methadone and em. Where do I feel that I am at the present? Do I feel that it's time to come down off it?*

It is notable, that In response to the question regarding the type of help he had felt he had needed, Richard states being asked the question of whether he felt it was time to come off the Methadone. His answer indicates the efforts from the staff in the clinic to consider his

[11] *The Nova Clinic is a fictitious name for a venue.*

views in relation to his recovery needs, as the help he thought he was needing. This suggests that there is a need for autonomy within the process of recovering from substance misuse.

Richard explained that he had noticed that staff were more focussed and attentive to his needs in this second centre. He was more satisfied with the service and gave the impression that his goals mattered and were being taken seriously by staff. However, although the clinic's staff had made a good first impression, he experienced that this had deteriorated over a period of time, due to a lack of continuity and consistency. He explained further:

Richard. *And when I got told when I first started this. I would be in three different groups. There'd be a cored. There'd be transaction. There'd be core treatment and there'd be maintain treatment... And I should have only been seeing like three different workers (slamming fist on table repeatedly). And in the time I've been there six. seven year I've seen possibly maybe fifteen... fifteen to twenty workers. There's not. For me to open up to one worker and then go in the next week and it's a different worker and have to open up to that different worker again... And then maybe get that worker for two weeks we're building a we're…. relationship there and then bang. there's another new worker that I've never met and time before "Oh Eddie[12] can't meet you. It's me today." It's just ongoing and ongoing, ongoing.*

[12] *Eddie is a pseudonym.*

In the above extract, Richard was becoming a little agitated and annoyed while remembering the inconsistent treatment he had experienced. Because of this emotion, he was struggling to remember the titles of the care programmes that had been offered to him, hence, he mentions cored and transaction before he then utters the terms core treatment and maintain treatment, which I took to mean maintenance treatment. However, I did not feel confident to question him about this at this point of the interview, as he was getting emotional and was slamming his fist repeatedly on the table.

Richard noticed that having to deal with a number of different key workers had led to a lack of continuity of care and therapeutic interpersonal relationships with staff. Because of this, he gave the impression that a consistent approach to his care had also been lacking. He explained that he believed that there was no point to try to build therapeutic relationships with key workers, and also that this situation had been brought about by the rate of change instigated by the service provider and the turnover of new staff.

Substance misuse services are provided in the prison and outside community, however, participants complained about the lack of consistency in service provision and the lack of motivation from staff.

6.3 Mitwelt – social aspects

Participants talked about social phenomena that contributed to their personal feelings of vulnerability and the risk of reoffending, especially when liberated. The metaphorical "revolving door" and their families were mentioned by several participants.

The phrase “revolving door”, in relation to prisons, is a phrase often used to describe the pattern of prisoners who have served short sentences and return back repeatedly with alternating periods of imprisonment and release.

The family was explained to be a valuable source of emotional and financial support, as well as also being able to provide accommodation and a permanent address in order to register for GP healthcare services and welfare benefit payments.

6.3.1 The Revolving Door

The “Revolving Door Syndrome” is a term used in the field of criminology to refer to recidivism, which is the act of a person repeating an undesirable behaviour after they have experienced negative consequences of that behaviour, for example reoffending. Some of the participants used this phrase when we were talking about prison life and how they had coped with it. In the course of conversation, David voiced an example of how someone he knew had been caught in the “Revolving Door”:

David. *I had a friend who served five years and after his five years, he was told, “tomorrow you are getting out, so pack your stuff up tonight”. Sixteen days later he was back in serving another five years. Now, the way I look at prisons and what not, it is just like a revolving door. They get so used to sitting about in their shorts and t-shirts doing nothing, watching the TV and all that crap. Unless you are working, keeping your mind open and also you are keeping your brain active. If you are not doing that then you are just gonna go into a slump and you’re just gonna……you know…. you’re eventually could build up to an addiction such*

as alcohol or you might get alcohol dependent when you are sitting about watching TV all day, if that is what you do.

It is notable how this discourse mirrors the academic accounts of "the revolving door." David gives a detailed account of a "friend" who was caught in the "revolving door." This was a feature of the interviews; that participants did not talk about their own crimes or sentences, but referred to those of a "friend" or "someone I know." Admittedly, I did not dwell on any details of their crimes or sentences other than to confirm that they were eligible to take part in the study. David explains that the prisoner in the tale was not at liberty for long before he ended up in prison again. He said that he believed that his illustrative account was an example of how some prisoners experience life in general. He explained that, due to the inactivity in prison and effects of institutionalisation, men become unable to cope with life at liberty in the community. He expressed that men are at risk of developing unhealthy alcohol/drug habits and implies that, while under the influence of these, may result in them committing crimes, which carry a punishment of imprisonment.

Participants explained that after the patterns of liberty and imprisonment have been repeated on multiple occasions, it can become difficult to escape from the attentions of the Police, courts and the prison service. They said they believed that there is a danger that this way of life can become normalised for the person. This pattern may have consequences upon the physical and mental health of prisoners as well as having implications regarding the continuity of care, especially for those with chronic conditions. While discussing the views and opinions that are held about prisoners, a participant voiced that those trapped in the "Revolving Door" did not expect anything else from life other than to be in prison:

JF. *Good. We have been talking a lot about you. Can I just talk a little in general terms? You said earlier, that society has a negative view about guys in prison.*

When you were in prison, do you feel that many others agreed with this public view of prisoners?

John. *Oh, definitely. It's a widely held view.*

JF. *Do you think that puts fellas like yourself at a disadvantage?*

John. *Yes.*

JF. *Your referral to the Drug Problem Clinic is working for you and you are feeling better. Do you think that it works like that for everybody?*

John. *No, I wouldnae think so.*

JF. *Any particular reasons for that, in your view?*

John. *You get the ones that dinna want help so….*

JF. *They don't want help….*

John. *They've been in and out of prison for that long so they just feel that, that is the way their life is going, that is the way it's gonnae be. They are just stuck in that revolving door.*

The exchanges in this extract are shorter than others in this thesis. They are more abstract in tone and less detailed than those accounts of, for example, times in which participants

had complained. John explained that some men become trapped in the revolving door and expect little else from life. He further stated that they did not want help, without providing any further elaborations or evidence for this view.

In conclusion, the "revolving door" is a phenomenon that participants experienced or witnessed to be a part of many prisoners lives. They also voiced that it was easy to become caught in the revolving door and that it was difficult to escape it.

6.3.2 Family

The accounts of some participants showed that the absence of family support or a home to go to could cause feelings of desperation and potential suicidal thoughts, in particular when faced with the further challenge of lacking support and money. It was also explained that this would often lead to the contemplation of committing a crime in order to get money or to achieve being sent back to prison. While discussing financial support, Richard explained the difficulties he was experiencing in relation to accessing benefits and how this was making him think about shoplifting to get money. The following extract includes the rational formulation he provided for these potential activities:

JF. *So when you were coming up for your lib date. When you are in the prison is there no –*

Richard. - *They start your claim for you. See before. You had to wait till you got out before you started your claim and it would take an extra five weeks. You would be five weeks without money. Whereas now you're only waiting. three weeks to get money.*

JF. *So they are starting it a couple of weeks before you get liberated.*

Richard. *Yeh.*

JF. *But you're still three weeks without money when you come out.*

Richard. *Yeh. And they tell you. you could put in for a.. Community... Payback grant. Now I've put in for this community payback grant... eh. First of all the... application went missing... Therefore, I phoned it back again and it takes forty-eight hours of your time to do this now. Phoned it back again. The lady said "There was no application ever made" the second time. Then I phoned it back a third time and she says "Uh. The application. Oh, we've just found the very first application now. Eh. Would you like us to put it in for you again?" I just ended up hanging the phone up on her. What am I meant to do of that (showed me his handful of loose change again)? I can't do anything.*

JF. *No I understand.*

Richard. *Would then you commit a crime?*

JF. *You're out here and from what you're saying I would think your backs against the wall.*

Richard. *I got up this morning thinking where am I going to make some money the day. That's what I did. And I thought "I'm going to go shoplifting" but if I get caught I'm going straight back to the jail then.*

Richard's account illustrates how difficult it can be for men, when they are newly liberated from prison and they do not have family to support them. The benefits system can be experienced as slow to process claims and, in Richard's experience, leave men with no

means to support themselves. Consequently, there is a temptation to return to crime to survive, despite is the known the risk of being caught and imprisoned again.

In contrast, Robert was able to rely on the support of his family following his liberation. He explained that this was very important for him upon liberation and alluded to this in the following extract:

JF. *You said you had a lot of support from your family and your friends.*

Robert. *I have. I have been lucky keen what I mean eh… If I never had that I'd be… sort of like eh…….. Well I would not have because I know that I have got family. I know I've got the people to go to ken what I mean. I'm eh… So I would always have some place to stay ken what I mean. It's just no like I've got to come out and I've got to go in a hostel or a dry house sort of whatever, ken what I mean. I. I really feel sorry for they guys, ken what I mean but…. I cannot sort of help them, ken what I mean.*

Robert explained that it was his belief that the family was a source of emotional support to help prevent a return to his former habit of misusing alcohol. He also stated that the role of the family as important in preventing the return to prison. This point was supported by Mark who explained:

Mark. *Yep… Same as a lot of guys that are coming from Perth... eh they're coming out... going into those units... eh with no. like. what like the home. to go to if they've no family*

they've to go to places like that and that's what they're taking is eh legal highs…. And going back to prison because they won't... they won't show up in the drug tests.

Mark comprehended that a precarious relationship appears to exist between family support, accommodation and recidivism. He gave the impression that if prisoners lack family support then their chances of breaking free of the revolving door and remaining at liberty are diminished.

In conclusion, participants voiced that it was difficult upon liberation if they did not have family to provide emotional, financial and accommodation support to help prevent a return to crime and, consequently, prison.

6.4 Eigenwelt – personal aspects

Participants had experienced a number of factors that, in their opinion had contributed to their health and vulnerable position. They talked about the importance of having accommodation when liberated, as this was a basic requirement for being able to access welfare benefits and GP healthcare services.

The importance of a job was highlighted, as this provided a purpose for their days and helped provide an income, as a lack thereof made them more vulnerable to accruing debts and being put in a position of having to sell/obtain medication in order to pay these off.

Participants voiced how planned throughcare could help them focus on their health and desist from criminal behaviour, especially considering that they may be faced with limited options following liberation.

Despite many participants having mentioned negative experiences of healthcare within the prison and community, another recurring theme throughout their interviews was the hope for a better life for themselves and future generations.

6.4.1 Accommodation

Participants expressed that if family support was not available, prisoners may try to relocate to a new town/village in order to break away from their past and begin a new way of life. The topic of relocation was raised by the participants in the interviews, which showed some of the difficulties prisoners face when trying to reintegrate back into society upon liberation. The following extract from Mark's interview illuminates the issue:

JF. *Interesting that you say about going to Perth to get away from things. Do a lot of boys do that?*

Mark. *I've heard a couple of people have done it yeh.*

JF. *Just to try and get away from…*

Mark. *Try and get away from abuse circles in Dundee eh.*

JF. *The circle that you are aware of and used in the past.*

Mark. *The revolving door. The revolving door.*

JF. *To try and break that circle... ok.*

Mark*. Well what I done actually was I says to... well what I done one time was I was finishing my sentence and I wrote to one of the Head Housing Officers in the Mary Slessor Centre*[13] *and I says to them... Look Bert*[14]*, Bert Wallace it was, I says Bert I'm fed up of being on this revolving door. Of coming out of prison. Being off all the drugs. coming into your homeless units. and being put in. like… in with people who with drug issues. are using drugs. have got alcohol issues. Eh, there is prostitution going on there as well... eh. I don't want to be in... one of those places for a long period of time. Is there any chance you can see about. speeding up the housing process for us and... when I got out three days later I got a house.*

JF*. Right. There is a place literally along the road, Brown Street*[15] *just beside the Dudhope roundabout. It is one of the places that there is quite a few…*

Mark*. That is a bad place that, oh yeh for drugs and that yeh.*

JF*. That's interesting.*

Mark*. I think it's only for a person who is fresh out of prison. Drug free. Into a place like that after his sentence, you are setting the guy up for failure.*

JF*. In what way?*

Mark*. Just eh the. the surroundings you are putting the guy in. You know what I mean. I mean I've tried it locking myself behind my door in places like that.*

[13] *A fictitious name for a venue to help protect Mark's identity*.

[14] *Bert Wallace is a pseudonym*.
[15]*A fictitious name for a venue.*

JF. *Is it just a room you get?*

Mark*. It's just a room. If you want to watch TV, you have to go down to the… social room there where everybody sits. If you go for your meals, you have to sit with everybody as well. So actually, to lock yourself away you've got to mix with these people sometime eh.*

In his account, Mark expresses the standard of accommodation available for those, liberated from prison, without any family support. It also illustrates the sense of isolation that he had experienced. He explained that it was his belief that this could be caused by a lack of family contact, but also because some prisoners disassociate themselves from former friends and acquaintances in an effort to erase the past, begin a new life and decrease the risks of being associated with those performing criminal behaviour.

Without accommodation, these men have no permanent address. Without an address they are disenfranchised, as they will not be entered on the Electoral roll, not be eligible for any welfare benefits or be able to register with a general practitioner. Consequently, the men will be unable to access primary care services, although they can attend Accident and Emergency departments for any serious conditions/injuries, these circumstances may contribute to their social isolation and vulnerability.

In conclusion, accommodation is a crucial issue for those men being liberated from prison that do not have the support of a family. Without accommodation, it places men in a vulnerable position whereby they will be unable to apply for welfare benefits or receive healthcare services.

6.4.2 The importance of a job

A job is considered important for health and healthcare for direct and indirect reasons. Directly, it provides physical exercise and mental stimulation. Indirectly, it provides an income, which allows them to purchase necessary items legitimately, without the need to resort to selling their prescribed medication for these purposes.

When discussing the prison routine, Charles highlighted that it was necessary to get a job in the prison in order to relieve the boredom and give some structure to the day.

Well yeh. It's boring if you've no job. No job then you're. locked up all the time basically or if you are opened up. like in C Hall you're opened up. Most of the day and you're just... mulling around.

The importance of a job was also highlighted by Mark when asked about his sentence. He immediately replied about a job; implying that it was extremely important:

JF. *Ok. When you were in prison, how did you find your time?*

Mark. *Well on remand you do not get a job.*

JF. *So for up to 140 days you have no job so you have no money.*

Mark. *And if you have no money either then you're left in the lurch.*

JF. *And if you don't have the family that's putting money in.*

Mark*. Which I... I never... when I was younger I had no one like my Mum was... Mum died and my Gran was... she was an old... she was 82 so I couldn't... I didn't have anybody like.. So what. What I used to do was the only way around that to get some money... on remand. Was to get yourself like a pass job... That's like being a trusted prisoner eh... so. go around cleaning and eh that was the only thing that saved me... eh... personally. in the past eh.*

JF*. So remand is quite a hard time?*

Mark*. Yeh.*

JF*. Even though it's limited and that you've got to be on trial within 140 days.*

Mark*. Yeh. I feel really sorry for some guys that are on remand and they have nothing eh.. really nothing and….*

JF*. How do you manage to get a pass job then?*

Mark*. Well if you got on well with the. some of the staff which I have done because I've been going for that many years when I was younger.. and eh.. I got to know them.. on a friends sort of thing.. more than just an officer.. eh. to me so. you end up getting a job all the time when you go in. So that saved me quite a lot.*

As Mark points out, jobs are at a premium and the priority is given to convicted prisoners for allocated workspaces. Under prison rules, all convicted prisoners must work. Remand prisoners can get access to work, however this is often limited. They can work in the Hall as pass men or pantry pass men. All prisoners also have access to education, physical training and a facility, where induction and educational programmes are conducted. Prisoners who

work are paid a wage ranging from £6.50 to £14.00 per week, depending on the tasks this work involves.

Jobs are also important, as they provide much needed income within the prison. Lack of jobs and the income this generates was stated to be a major problem within the prison population. As Mark put it "you're left in the lurch" without a job. In connection to this point, Thomas explained that the lack of money could lead to some prisoners selling their medication:

Well because….. they have to go on maybe.. say they're on medication or something they'll.. they'll go back to their medication for to try and sell it to get themselves tobacco. I've seen that… on numerous occasions.

It should be noted, that in Scotland, prescriptions are provided free to everyone in the outside community as well as in the prison, which contributes to the ability of prisoners to use their prescribed medication as a currency in order to obtain other goods, as they do not require money to obtain the medication, as witnessed by Thomas. In this example, he stated that tobacco is purchased with the proceeds of medication sales, which can lead to the deduction that a lack of money results in the free provision of necessary health promoting substances being sacrificed to maintain an addiction. .

In conclusion, participants voiced that having a job, especially in prison, was important to their health, as it provided physical exercise and a purpose to their day. It also provided

them with an income, which helped prevent them from having to sell their medication in exchange for other goods or to pay off debts.

6.4.3 Lack of income

The previous section highlighted the importance of a job as a source of income. Another source of income for prisoners is their Prisoners Personal Cash (PPC) account. The wages from a prison job are paid into this account, however, family members and friends can also deposit money in it. The spending power of each prisoner, however, is limited to fifty pounds per week. Items prisoners are able to purchase on their personal canteen orders include toiletries, sweets, biscuits, etc. However, only a limited number of prisoners within the SPS estates would have this level of financial support from families and friends to be subject to the weekly spending cap. A lack of income places prisoners in a potentially vulnerable position. As explained in his interview, Robert had observed that a lack of money could lead to large debts being accrued within the prison and prisoners asking to be placed on protection.

A prisoner can ask to be placed on protection within the prison, if he believes that he is at risk of assault/bodily injury from others. This process will involve him being placed in a hall, which is reserved for those on protection, and require him to wear a specific colour of polo-shirt to signify his protection status. In addition, prisoners on protection have access to other areas of the prison, such as the work sheds and healthcare at different times from the mainstream prison population.

Robert had this to say, while discussing the issue of protection for those in debt:

Robert*." They are going on protection because they are owe people money.. and they cannot pay it but there again, there is no many eh.. jobs for them".*

JF. *I suppose there are only so many people can work in a laundry at any one time.*

Robert*. It's a big laundry but. Yes but you have the wood sheds and eh.. everything like that. You've got the grounds. There is loads of work but what I'm trying to say is eh.. you've got eh.. sort of like eh…… these protection boys that ..that there's… they there's a sewing place that they can go in but there's…no many that it takes and then they.. to go down the route at a different time from the mainstream prisoners. And then… you get your mainstream sort of boys right and when they are getting visits they come in with us but like your protection people they are put in another room in case they get... into a visit with somebody that they owe money to and they get filled in there.*

However, he went on to explain that this compounds their problem with limited, lower paid jobs available to those on protection. With a limited income and by accruing high levels of interest, the levels of debt increase. They can become stuck in a vicious circle of poverty and debt with possible violent repercussions.

Prisoners on protection appear to be labelled. As the participant described:

All your sex offenders and that are basically…. at Glenochil and that. They used to have up at Perth in A Hall but... you had the... your overnights in there as well and then they used to

wear the sort of green… Joggy bottoms and green sweatshirts and when you see them you just class them as sort of beasts ken."

JF*. Really.*

Robert*. "Yes ken it's just because of the green eh and that's why the f'ing ken, they should have, sort of like… like jersey's with "P" on them like for "protection" or "S" on them for "sex offender", ken and…. Normal nothing on the other ones with the people that are just…….. Eh ken what I mean, just unlucky ken that they are there".*

There are implications for those on protection as they are at an increased risk of assault/bodily injury from the mainstream prison population. Although those on protection are segregated as much as possible, there are areas, such as the work sheds and healthcare, where the mainstream and protected populations interact. From Robert's account, anyone wearing a green prison uniform is classed as a "beast" and will be labelled as such by the mainstream prisoner population, as there is nothing to distinguish those placed on protection for sex crimes, and those seeking protection if they are in debt to another prisoner. Robert explains that he is aware of the distinction and suggests other means of labelling prisoners. In relation to the focus of this study, namely health and healthcare, these practices may have implications on access and efficiency of healthcare provisions, as the threat of being labelled due to the colour of one's clothing could arguably deter prisoners placed on protection from seeking healthcare services in order to avoid revealing their status to the mainstream prison population. Robert's account of the issues of labelling in relation to protection due to lack of funds and the resulting debt, demonstrates how the

priority of maintaining order and the lack of autonomy within the prison in relation to access to work can further limit access to healthcare.

In conclusion, lack of income and the accumulation of debt can have an impact upon a number of areas within the lives of prisoners, including their health and access to healthcare. Prisoners who are prescribed medication with a "currency value" may resort to trading these to offset their lack of income. Other prisoners, who are unable to generate some form of legitimate or illegitimate income may see no other option to borrow goods from other prisoners. Without the prospect of generating income, this leads to them becoming indebted. If their debts to other prisoners become unmanageable, they may request to be placed on protection within the prison, which compounds their debt problems by limiting their job opportunities within the prison, and leaves them more vulnerable to becoming targets due to labelling practices, which, in turn limits their access to healthcare

6.4.4 Planned throughcare

From the earlier extract in section 6.3.1, John had been given an opportunity to focus on something positive upon his liberation. He explained that it was his belief that this was partly due to the actions of healthcare staff who had arranged a clinic appointment close to his home address, that would help him deal with his substance misuse issues. He had stated earlier in his interview that some of the healthcare staff were friendly, approachable and treated him like a person not a prisoner. He gave the impression that this was important, as it gained his trust, which encouraged participation and made it easier for staff to assess his health needs, identify and prioritise his requirements, as well as set achievable goals for his

release. Although it does not constitute part of their daily practice to arrange appointments for NHS services, let alone third sector agencies, a member of nursing staff had arranged appointments for the participant to attend upon his liberation. He voiced that he was still at liberty, was feeling healthier than he had been for some time and had no inclination to return to any criminal behaviour that could result in his return to prison. He stated that these circumstances had brought about a change in his behaviour. Subsequently, he had attended the appointments because he was focussed on a healthier future that did not involve crime, and because he did not want to let himself or others who had helped him down.

At the core of John's account is the concept of care. Care as a concept is difficult to define, but in this context, it refers to a feeling of concern or interest. Thus, John stressed that the provision of what is necessary for his health, welfare, maintenance, and protection was carried out with genuine care in this scenario. The concept of care is arguably one of the core qualities of being a nurse, as the role requires the ability to value people, establish trust and form an interpersonal connection with them. John said that he was grateful that someone had cared about him and did not want to disappoint them. There are many possible reasons for this, however, the tone of his narration indicated that this was an exceptional situation. This fits with points previously raised in relation to staff attitudes, as discussed in section 4.3.2., which presented findings from the interviews of participants having experienced hardened attitudes of staff.

In conclusion, planned throughcare with the support of healthcare staff can play an important role in assisting some prisoners in their desistance from crime.

6.4.5 Access to healthcare upon liberation

Access to healthcare is limited upon liberation, especially if prisoners have no family support. Participants experienced a lack of planning by the SPS and NHS for healthcare provision following their liberation. For example, in relation to his health, Mark explained that no arrangements had been put in place for him to receive his prescriptions in the possible event that he got liberated following a court appearance:

The prison should be saying. Like to guys it should be automatic. This guy could potentially get out today, he's on Methadone, he's on Diazepam, he's on other tablets as well. So I had to go without my Methadone for five days... Five days until they sorted out a prescription.

It should be noted that it took five days for a nurse in the prison health centre to send a prescription to the local Drug Problem Centre that was continuing Mark's Methadone programme. The result was that Mark did not have access to his required medication for five days following liberation. The experience that Mark discusses revealed a loophole that appears to exist within the SPS/NHS communication system as regards the ordering and dispensing of prescribed medication for those attending court from prison. In his case, he explained that he had been on remand and faced the possibility of being liberated following the second hearing of his petition. Although no one can predict the outcomes of court hearings, it may have helped the continuity of this participant's healthcare if his needs had been communicated to the outside community care providers prior to, or immediately following, his liberation.

Participants expressed the lack of communication between healthcare providers when they were liberated. Mark reinforces this point in his account:

Mark*. A lack of communication yeh. You see that will be happening to a lot of guys who are coming from prison on remand. And they're getting... out because... they can get out... they get a community based disposal or something like that and then... they're not... their medical details are not being faxed on.*

This account reiterates the point regarding poor interagency communication of care arrangements. Mark explained that it was his belief that the lack of communication appeared to extend to the regular communication of results and healthcare reports between the NHS health centres in prison and community. An example, involving the communication of Hepatitis C blood results is given in his account:

Well I can pin point it to that or that. And another thing. Eh. Is eh. One time eh. I obviously contracted Hepatitis C ok and eh. I ended up in prison... eh so Helen Rae[16] obviously wanted to take a fresh set of bloods off me to see how the Hepatitis was... So. Eh, she took the bloods. Eh, the bloods got sent away. But during the time the bloods being sent away... I'd been to court and let out ok. And unbeknown to me when the blood results came back. They

[16] Helen Rae is a pseudonym.

came back negative for Hepatitis C. I had actually cleared it myself but this information wasn't forwarded on to my local GP outside. And I think that's a very serious one that.

When asked how he was informed of the results and how long this took he continued:

Mark*. I never got the results until I ended up back in prison and I'd reinfected myself.*

JF*. So you were clear.*

Mark*. Yep. I didn't know I was clear.*

JF*. So between being liberated at court and going back into prison, how long was that?*

Mark*. Oh, it was... I think it was about a year or something yeh.*

Arguably, it would have been good practice to ensure that Mark had been informed about his results by his GP as soon as practicable. However, on this occasion, for whatever reason, this did not happen. Instead, it took a year until he was informed of the results, and only because he was imprisoned again. During this year of liberty he states that he did not know that he was clear of Hepatitis C. However, he had not sought out his GP in order to obtain the results for himself. Despite not knowing whether he was infected or not, he admitted to have indulged in behaviours, which could have placed him and others at risk of the infection. The result of this was that he had been re-infected with Hepatitis C. He acknowledged that there may be difficulties with the communication procedures within the

NHS as an organisation. However, the participant explained that he did not believe that he should have had to take any responsibility in this situation. Instead, he blamed the apparent lack of communication between the prison and the outside community for the issues that had arisen in this case.

In conclusion, there are apparent hurdles to liberated prisoners access to healthcare, in particular due to communication issues. In this sense, poor interagency communication of care arrangements, reports and results between the SPS, NHS prison health centres and those in the outside community can contribute to vulnerability, which restricts not only initial access to healthcare provision, but also to the continuation thereof and effective treatment outcomes.

6.4.6 Hope

A powerful theme that persisted throughout the interviews was hope as the feeling that something desired may happen. The concept of hope can lead people to follow particular life goals and dream of different paths of life. Hope is be a positive concept, however, when hopes are dashed or thwarted, it can have profound negative effects on people's lives.

Participants' life situations varied significantly, as they were all highly complex individuals. Some had family support and others had none. All voiced the opinions that, despite being able to deal with prison life, they did not like it and had no desire to return to it. The element of hope was not restricted to the realm of healthcare, but covered many other general areas of life as well. Participants expressed hope for a better life and future, not only for themselves, but also for the younger generations following them. David voiced this sentiment in the following extract:

David. *I think that the healthcare system nowadays should be looked at. I mean, and you will see it yourself, em, a lot of young people now think it is cool to go to a young offenders.*

JF. *I have never been there but I accept what you are saying.*

David. *They think it is alright to go to a prison. You know, at the end of the day, when you speak about healthcare em… I think that the healthcare nowadays should be looked at and talked about. Something should be done about teaching our young people in society. The reason being is … a good majority of people, well, once they leave school they will just merge into the background. I think that we should be doing more about it em… so that our younger generation don't have to eh… do all the things that we used to do.*

JF. *So you are saying that more teaching is required….*

David. *It is not just educate but open more doors for…. Open doors for the younger generation.*

JF. *More opportunities to do things?*

David. *Basically doing this is cool and much cooler than going about a park… an empty park wi your mates kicking a ball about, drinking a bottle of cider or whatever. Because at the end of the day, doing all that is not cool anyway. It can destroy families, destroy homes also destroy yourself. If you're drinking so and so a day your liver… you know at the end of the day it's going to do some damage to your liver.*

David expresses his hope that future generations have a better life than he has had. He specifically talks about the social and health effects of drinking alcohol, but he is also alluding to a hope that more health education/promotion strategies might help future generations. He explained that it was his belief that this would help them experience a healthier life and also help prevent them ending up in prison due to crimes committed under the influence of alcohol and/or drugs.

In relation to hope and the healthcare provision in the prison, the interview, in particular, with John revealed the way this can also generate hope. As discussed in section 4.2.3., John explained that the healthcare provision, in particular health promotion and education in the prison, allowed him to improve his health in a way which gave him hope for better future prospects in life, due to his newly gained wellbeing, as well as the opportunity to use his experiences in this area to gain employment post liberation. However, accounts from participants, such as Mark, demonstrate how disruptions to healthcare provision post liberation, can contribute to these hopes being thwarted, and in some cases, like it was the case in his situation, result in further health issues as well as vulnerabilities which can result in reimprisonment. In this sense, as can be seen in section 6.4.5., Mark had overcome his drug addiction in prison, but his hopes of a smooth continuation of the Methadone programme were disrupted due to administrative issues. A year later, he returned to prison.

In conclusion, hope was voiced by many of the participants as a positive concept for themselves and future generations. In relation to healthcare provision and health, it has been found that healthcare provision can positively contribute to hope and, in turn, the successful reintegration into the outside community post liberation. However, when this is

not effectively provided, it can similarly contribute to unsuccessful reintegration into the outside community.

6.5 Summary

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 were also voiced as helpful, especially those from the third-party sector. These equipped participants with new knowledge and skills and allowed them to explore their lives and gave them confidence to make choices and move forward in a healthy manner. Finally, 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 which had resulted in their imprisonment, being repeated by the younger generations. Finally, it was found that effective healthcare provision can contribute to hope and the successful reintegration into the outside community post liberation.

Chapter seven will discuss the themes in greater detail and relate them to the literature. It will also discuss the limitations and contributions of the study and make recommendations for practise and future research.

Chapter 7. Discussion

7.1 Introduction

In this chapter, I discuss how the themes identified in the previous chapters compare with the extant literature. The contribution of the study to knowledge and practice, its strengths and weaknesses, implications for service provision and policy and improved protocols for future research are presented. Operational issues within the prison setting along with possible strategies to improve healthcare provision will be discussed. Most importantly, strategies and suggestions for the continuing care of offenders following their liberation from prison will be presented, as this is the area of care that is in most need of change.

Prisoner health has been studied by a number of researchers from diverse perspectives and using multiple methodologies. The literature has focussed on health issues such as offenders' attitudes towards health/illness and wellbeing, mental health, maintaining and improving health, family and supportive relationships, drug use/treatments and sexual behaviour whilst in the prison environment. The literature review highlighted that a number of health issues such as dental health, vaccinations, suicide and self-harm, alcohol, gambling, smoking, tattooing or body piercing did not appear to have been researched from the offenders' perspective. In this study, a number of participants have voiced that their experiences of dental care within the prison environment entails long waiting lists for an initial consultation and protracted treatment regimes.

I interviewed ex-prisoners to explore their personal accounts of healthcare experiences and what meanings these meant to them. The study reflects the experience of participants' healthcare and how it can differ greatly from the rhetoric of policy and procedures laid out by Government, health boards and the Scottish Prison Service. However, it would appear

that, from their perspective, planned and integrated through-care for prisoners, particularly upon their liberation, could play a part in their desistance from criminal behaviour.

To reiterate, the overarching research question for the study is:

"What are ex-prisoners' experiences of health and healthcare in prison and in the community?"

The discovery and interpretation of prisoners' healthcare experiences has remained the focus of this study since its inception and reflected within the literature review that prisoners' own voices have been notably silent in the legislative process.

The main finding of the study is that the ex-prisoners' experiential accounts raise themes which would appear to contradict the aims, policies and procedures of healthcare provision for this group of participants.

This thesis gives an account of the qualitative study performed to investigate ex-prisoners' experiences of healthcare within the prison and the community following the legislative changes that brought about a change in primary care responsibility for this group from the SPS to the NHS as referred to in the introduction. The study is situated within the tradition of phenomenological inquiry and aimed to understand participants' healthcare experiences through an analysis of their narrative accounts. Semi- structured interviews were utilised in order to allow participants to recount narratives that represented their experiences. This allowed for the recording of rich data in the accounts that represented the experiences of the group of participants. The individual accounts were united by shared experiences; aspects of experiencing healthcare within the prison and community environment. The literature review in Chapter one examined literature relating to prisoner/offender

healthcare and UK/Scotland health policy placing it within a wider public health context whilst acknowledging that little research had focused upon first hand experiences.

7.2 Discussion of Themes

The 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 participants gave their experiential accounts that raised the themes presented in chapters' three to six. These themes help to illuminate the way the participants experienced the healthcare system. What emerged from within these chapters are four themes that are intertwined and unite the participants' experiences. In the following section I discuss how the results from these themes compare them with the literature that was presented in chapter one.

A qualitative approach for this study was deemed most appropriate, as it was suited to exploring in depth participants' own subjective experiences.

The overriding conclusion to this study is that the participants' experiences of healthcare differ from the rhetoric of the UK and Scottish Governments, NHS and SPS policy with particular reference to the prisoners' accounts differing from policy with regard to equity of service provision and especially with regard to health promotion and education, prisoner involvement with their care, and additionally links with the community and public sector (see chapter 3).

Plugge et al. (2008) explored female prisoners' concepts of health and illness by conducting focus groups in two English prisons. They found that the women were enthusiastic about contributing to research but, similar to this study, it was discussed that

doubts are cast over the contributions of prisoners to research and policy development. Despite the differences in the participant sample and data collection method, the findings of this study are largely congruent with that of Plugge et al. (2008). What this study adds is that men were followed up in the community and included their experiences with community healthcare services in their accounts.

Plugge et al. concluded that the women in their study had a good understanding of the health issues surrounding women prisoners in the UK. The women had highlighted illegal drug use, mental illness, self-harm and sleeplessness as the main issues. The men in this study did not mention sleeplessness or self-harm but they did talk at length about the illegal drug use in prison and in the community, albeit no observable, comparison was made between incarceration and liberation regarding this issue. Mental illness was also voiced but as has been mentioned it was framed in terms of participants maintaining their personal safety from those who had a diagnostic label of mental illness. Physical conditions were given a greater priority over mental health and well-being by the participants in this study. Although there are many similarities in the results of the studies in the literature review, this study did not attempt to generalise the main health issues within the whole prison population but highlight those issues that participants chose to give priority to and focus on in their experiential accounts. The findings presented in chapter three are similar with a number of studies presented in chapter one. The lack of control, power and choice that participants voiced with regard to their ability to access and interact with healthcare staff, substance misuse services, health promotion and complaining is in keeping with the studies by Condon et al. (2007) and (2008). Conclusions reflected that a lack of prisoner autonomy and access to health promotion strategies were major barriers in ensuring that prisoners'

health needs were fully met and limited their ability to maintain or improve their health. Similar to the conclusions by Condon et al. (2008), participants in this study voiced that opportunities to make healthy choices varied between prisons, particularly in relation to diet and exercise. Thus, whilst imprisonment offers prisoners an opportunity to access health promotion services, in the priority areas identified in *Choosing Health*, prisoners are often prevented from making healthy choices by the prison setting. Barriers exist within the prison setting which limit the ability of prisoners to maintain and improve their health due to the points immediately outlined above.

Similarly, the sense of vulnerability and isolation brought about by those with a mental illness and the lack of social and/or family support are in keeping with the study by Samele and Keil (2009) that revealed that mental health issues for liberated females contributed to their sense of isolation and difficulty to cope in the community.

From the participants' accounts it would appear that healthcare workers in the prison did not plan, or were not involved in, their discharge from prison to community. Perhaps, unsurprisingly as a result they felt they had been left to care for themselves to a great extent. This is congruent with the research of Binswanger et al. (2011) in which former prisoners reported poor transitional preparation preceding release and inadequate or absent continuity of mental and physical health care. Binswanger suggested that improved release planning and greater communication between the health and criminal justice systems may help to reduce the risk of poor health outcomes for this population. This study also advocates this as well as other strategies that will be presented in the section "Implications for service provision and policy".

Participants in this study voiced that being prescribed certain medications made them feel vulnerable and open to bullying as medication was used as a currency. This occurred not only in prison but also in the community. The participants also talked about the problems of storing their medications within prison. This is congruent with the findings of Hassan et al. (2012) who explored prisoners' views of holding their own medication in prison and concluded that risk management needs development within the prison (see section 5.4.1 with regard to medication checks). I would also agree with their conclusion that there is still some way to go before in-possession medication policies are fully embraced in prisons. The critical issue here is one of balance between allowing the autonomy to manage their own medication and to maintain prison organisational protocols to deter bullying. Although some staff and prisoners recognise its benefits, some remain uneasy around the perceived risks.

Participants talked of feeling like "second class citizens" because they felt that they were labelled by healthcare workers for having been in prison. If they were observed associating with ex-prisoners in the community, for example, in pharmacies then this appeared to reinforce these feelings. Ex-prisoners also perceived that they were judged by healthcare personnel in the community especially when trying to register with a general practitioner. It is interesting that those working in GP practices and NHS establishments can now view computer records that will inform them if a person has been in prison whereas prior to November 2011 this was not possible. This means that those that have been in prison are potentially more prone to labelling, stigma and discrimination. This would appear to be contrary to the aims of the changes, which were to bring about equity of healthcare provision. Nurses control of healthcare and attitudes towards their patients were presented

in chapters four and five. Participants voiced how they felt that access to healthcare and prescribing of medication were heavily influenced by nurses and that this could be reflected by the nurse's attitudes and those of prison officers. As a result, participants voiced that they felt many nurses did not care and were only concerned with their career. Participants interviewed reflected that this led to a mistrust of nurses and doctors with some prisoners subsequently seeking alternative means of treatment by acquiring and using illicit drugs. This is in keeping with results found by Howerton et al. (2007) in which a lack of trust emerged as one of the most prominent themes in prisoners' not seeking help from healthcare workers.

As regards the waiting lists for healthcare services, it could be argued that participants should not expect anything more given that they have all transgressed against society by breaking the law. However, it is not the remit of healthcare services to worry about retribution. It is their job to provide healthcare within an ethical framework of beneficence, fairness and respect for autonomy. There is also the argument that in the community many have to wait for varying lengths of time to get an appointment to see their GP so why should prisoners receive any level of service that is better? However, the issue here is that in the community people have choices as to where they can access healthcare, whereas those in prison do not. For example, the public can change their GP, access accident and emergency departments and out of hours' services, access private healthcare companies, visit pharmacies and so forth, which prisoners cannot.

Participants in this study did not mention anything about staff training as mentioned in the studies by Howerton et al. (2007) and Burnett et al. (2009) but some did express their opinion as to the knowledge, skills, and abilities of healthcare staff. In keeping with a

conclusion by Burnett, a couple of participants in this study did state their observations of a proportion of the prison population who, from their experience, were not troubled by imprisonment and loss of liberty as prison provided for all of their needs.

I found that the participants' accounts were consistent with these views. This theme was congruent with the studies of Jordan (2012) and De Viggiani (2007). Jordan concluded that the prison milieu impacts upon prisoners' perspectives of their mental healthcare within prison. In this study, I argue that the themes are intertwined and that health is a complex concept that prisoners are constantly dealing with in the prison environment and in the community. In effect, it becomes "a world of health" and is a "cat and mouse game ". Over time, thus, with the routines and ambience of prison culture, health starts to take upon a different identity, which is related to the issues of custody. Compare the meaning of health in prison with that of the community, that is, the constant battle of risk assessment and taking by people whether this is alcohol, smoking, drugs, exercise, sugar, etc. How this manifests itself in this study is that the meaning and world of health that participants form inside the prison is carried over into the community upon liberation, thus the constant battle to try to initiate change in behaviours. Similarly, De Viggiani (2007) argued that the health of prisoners is integrated within the structure of the prison system through issues such as the prison regime, staff relations, attitudes and lack of opportunities for education and training. In addition to De Viggiani (2007) the participants' accounts from this study, provide evidence that the effects of the prison regime continue post liberation. These are all issues that participants in this study have stated as having an influence upon their healthcare.

Small (2006) in his case study of a prisoners experience with addiction services concluded that the services had failed the prisoner and prejudiced subsequent court proceedings. Although the participants in this study did not go as far as to say that healthcare had influenced any court proceedings they did outline that the attitudes that healthcare staff had influenced their care while in prison and could cause differences in the approach to care they experienced from different staff members. In this sense, it could be argued that healthcare services are failing to provide a consistent standard of care to this group.

Although participants talked about drug use in prison and the substance misuse services available, this study did not focus on any particular disease unlike many of the studies in the literature such as those by Lichtenstein (2000), Scheyett et al (2009), Small et al. (2005) and Small et al. (2009), but rather on their overall experience. However, the conclusion by Scheyett et al. (2009) that prisoners have difficulty in accessing support with treatment in the community is congruent with opinions expressed by participants in this study. Small et al's. (2009) study was based upon the experiences of a specific group of prisoners requiring treatment for HIV in Canada. The conclusion from Small et al's study was that there was a need for better coordination of healthcare services between the prison and community. This was reached as participants in the study were usually liberated with a supply of the HIV medications they would require to continue their treatment in the community. However, some participants reported that they received inadequate quantities of their HIV medications to bridge the period until they were able to access HIV care in the community. As a result, participants stated that the difficulties in obtaining care upon liberation could have a negative impact upon their adherence to HIV treatment. In addition, liberation back to the community could pose hazards for participants dealing with addictions, as drug use

upon liberation was noted to have a particularly negative effect on their ability to obtain care and treatment. Although this is based upon a specific group and condition in a country with a different healthcare service, the general conclusion is compatible with the opinions expressed by the participants in this study. Similarly, in the study by Small et al. (2005) the authors concluded that more harm reduction strategies were required in prison to prevent further health problems for the population. This is congruent with the participants in this study who stated that there were few health promotion/education strategies within the prison environment.

From the participants' accounts, my summation as a researcher was that they embraced planned, consistent throughcare along with health education/promotion and life skills training and opportunities. Whilst the participants may not have articulated policy style discourse, they nonetheless sought a focus upon liberation and beyond for a means to improve their lives, desist from crime and training opportunities especially those from the third party sector. The role that healthcare could potentially play in the desistance from crime was a major theme that no other studies in the literature review mentioned. This is a point that is worthy of further study and recommendations for this are presented later in this chapter.

Some of the findings of this study are in keeping with those found by Rae (2015) who performed a study in order to gain a greater understanding of the perspective of the homeless about their healthcare experiences. Although this study was not performed directly with offenders, it is highly relevant as many prisoners have been homeless before. The study was also an interpretive phenomenological inquiry in which interviews were semi-structured and recorded. Data analysis identified three major themes; expressed health

need, healthcare experiences and attitudes to healthcare. Some of the findings were similar in that participants reported difficulty in registering with a general practitioner, being treated with prejudice and receiving substandard care. Similarly, the author recommended that there is a need to address the apparent inconsistency of care and promote greater interdisciplinary communication from prisons to hospitals.

De Viggiani (2007) argued that the term "healthy prisons" was an oxymoron. However, some studies such as those by Burnett et al. (2009) and Yu et al. (2015) concluded that prisoners perceived their health as being better in prison. Three participants in this study concur with this conclusion and talked positively about being in a better state of health as a result of having been in prison. It was interesting that they talked of this in terms that gave the impression they viewed their health as a form of "social capital" i.e. it was a valuable commodity and being healthy made it easier to make new friends, relationships with the opposite sex and get a job. The participants felt that this was something that they wished to keep and it gave them a focus for their future lives and helped to prevent them from turning their attentions to criminal behaviours. This is congruent with one of the theory of desistance proposed by Laub and Sampson (2001) who highlighted a number of factors that are associated with desistance from crime. These included starting a family and gaining employment.

There is some similarity between this study and those by Nesset et al. (2011) and Bjorngaard et al. (2009) as they highlighted drug use in prison and some dissatisfaction with prison health services. However, both of these appear to have been conducted concurrently using the same samples of participants and quantitative data collection tool. As the penal and healthcare systems differ from those in Scotland, it is difficult to make direct

comparisons. The conclusions of the study by Nesset found that respondents reported many sleep problems and these were associated with high levels of healthcare use. Bjorngaard reported that there were high levels of dissatisfaction with the Norwegian prison health services and the accounts of participants in this study would appear to be congruent with that finding. If we look at the accounts given in this study, we can see that participants reported that some prisoners would feign illness in order to get prescription medications. Although sleep problems were not stated by the participants it is possible that this may be one of many problems presented to medics. The use of drugs reported by Nesset is congruent with the accounts given in this study.

The treatment or a provision for older age prisoners was not mentioned by any of the participants in this study[18] and therefore there are no similarities with the study by Jennings (2009). The exploration of the healthcare experiences of older age prisoners is one of the recommendations for further study presented later in this chapter. Likewise, for obvious reasons, the participants did not voice any issues that were similar to the study by Ruiz Garcia et al. (2014) which explored women's experiences in Spanish prison. However, this is an area that requires more study and is presented as one of the recommendations for future research.

The studies by Condon, Hek et al. (2007), Plugge, Douglas et al. (2008) and Jordan (2012) 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

[18] The study reflected rising numbers of prisoners over the age of 50 years within the SPS (Couper and Fraser 2014)

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; Samele and Keil (2009) looked at the resettlement needs of women offenders in the UK, Howerton et al. (2007) explored the help seeking behaviour in men in UK and Haley et al. (2014) studied the care given to those with HIV after liberation in the USA. 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.

7.3 Contributions to knowledge and practice

This study makes a contribution to the general debate of healthcare provision for offenders within not only the prison environment but also regarding the continuity of their care upon liberation based upon the voices of ex-prisoners themselves. There have been two community-based studies within the UK that have explored healthcare services for male offenders using their first hand experiences. This study aimed to draw deeper reflections specifically around health opinions upon recent experience inside prison and into the community. This gives those working with these men an insight into their experience. The literature review revealed a scarcity of studies that took prisoners accounts of their experience into consideration. This study therefore helps to address this gap in the literature. The findings of this study supports much of those that were found in the articles available and presented in Chapter one whilst I sought to gain fresh data as it arose from the blending of the NHS and SPS. However, it is the methodology utilised that makes the study findings significant. Using semi- structured interviews allowed the participants to talk about their healthcare experiences and give their accounts in a manner that they found comfortable. The interviews used to gather data, while focussing on healthcare, allowed the participants the freedom to select the issues that were important to them within the prison and community settings, although they were guided by my questions. These were highly personal and detailed accounts that gave an insight into how they experienced health within the prison and upon liberation.

This study makes a contribution to the debate about prisoner healthcare. It reflects an agency position whereby prisoners' accounts are not and have not been present and thus the objectification of their presumed experience is assumed by a more traditional medical model. As a matter of treating prisoners with humanity and decency, it is incumbent upon

the prison service to understand the voice of those who are in their charge/care. To do otherwise would reinforce the notion of a total institution and go against the very idea of rehabilitation. If we treat prisoners as 'cattle' to be herded and prodded then is it any wonder that they will either resist or kowtow.

Since the change of primary care responsibility occurred in November 2011, there has been no evaluation of the SPS/NHS healthcare partnership. Although this study is not an evaluation of this national partnership, it provides data that could be utilised in the evaluation process. It also provides data for third sector organisations involved in providing healthcare services and health education.

The ex-prisoners have given experiential accounts that raise the themes discussed in chapter's three to six. Many of the issues and points raised in these chapters agree with the literature. However, the main contribution from this study is that their accounts of how they have experienced 'health' in prison and on release differs from the rhetoric of Government, SPS and NHS policy. As a new policy initiative and with a significant organisational partnership between the NHS and the SPS unintended consequences flowed from the changes. Notwithstanding the limitation that this was a small-scale study, I would argue that the study's original contribution raises implications for operational as well as wider policy.

7.4 Strengths and limitations of the research

The main strengths of this study are that, firstly, it is one of a limited number of studies worldwide that have simultaneously explored prisoners' healthcare in the prison and community. Secondly, it is also the first study in Scotland, and one of the very few internationally, that has explored the healthcare experiences of ex-prisoners by involving them in the research process. Thirdly, the participants' accounts have raised themes, which tie in with the literature and healthcare policy. In addition, these accounts give an insight into how they have experienced health in prison/ liberty and how this differs from the rhetoric of policy. As a result, there are implications for considering operational and wider healthcare policy for this vulnerable group.

The methodology used for this study was similar to twenty-one of the papers in that it was a qualitative study exploring the healthcare experiences of prisoners using semi-structured interviews to collect data. However, these studies interviewed participants in the prison environment whereas I interviewed them in the community shortly after liberation from prison. This ensured that participants were able to fully consent to their participation without any institutional influences. It also ensured that they were able to speak freely without fear of retribution from others and helped to minimise the effects of "research fatigue" that can be experienced by participants/respondents within the prison environment (Ben-Nun 2008).

As with many research studies, this study has its limitations. One of the first limitations is that due to the small size, the study findings are not statistically generalisable. However whilst there no research study concern with the notion of representativeness of views, this research is based upon the notion that people have a set of views or attitudes that are

relatively fixed and can be accessed through, for example, a questionnaire. My study sought an insider perspective that offered the reader access to the participants' accounts of their experiences. Their accounts 'trouble' the official policy line. This was reflected by the theoretical perspective and research design. The study is about the healthcare experiences of ex-prisoners. Experience is the product of a person's beliefs, attitudes, knowledge and other personal variables that is interpreted by the individual, in order to make sense of the world and the situations that they find themselves in, and then expressed through their narratives. As a result, the same situation may be interpreted in many different ways by different people as they draw upon different experiences, beliefs, etc. In this study there are issues pertaining to the veracity of the accounts given by participants due to the credibility gap and stigma of having been in prison.

The findings of the study illustrate that although there were differences between the participants' experiences, there were similarities, which represent a common experience. As a result, it could be expected that their experiences have some similarities with those of other ex-prisoners. The voices of the study participants add an understanding and provide a counterweight to the official bureaucratic policy. This means that the results of this study can be used to inform those working within the NHS/SPS to the possible experiences of their patients' while acknowledging that they are not generalisable or rather there was less concern in the notion of representativeness of views. This is the case as this form of research is based upon the notion that people possess a particular set of views or attitudes that are relatively fixed and can be accessed through, for example, a questionnaire. This study sought an insider perspective that gives the reader access to the participants' experiences.

It is acknowledged that the interviews that yielded the narrative data for the study are socially and historically situated. As a result, the data was constructed within a social context between the participants and me at a certain time. This means that the data obtained in this study cannot be reproduced.

The findings of this study constitute a still frame of the participants' experiences of healthcare within the prison and the community. The significance of this data is not to try to represent the whole picture of their reality but to bring to light the issues that are presented within the participants' accounts of their experience.

A potential limitation to the study was the "Credibility gap". This is a journalistic term adopted in order to describe features of a story which lacks certain details often used, for example in the media or in responses offered by politicians. Thus, taking part in a research study raises the potential of a credibility gap in listening to participants' accounts as their experience of an event and the way in which they describe it may be quite different to the accounts others may offer surrounding the same experience. Participants in this study may be offering a truthful account but, given their past, will it be believed or merely condemned by others? This poses a question for the researcher: How to be sure that they have given a truthful account? In simple terms, one hundred per cent certainty that participants' accounts are truthful cannot be assured and the researcher can only deal with the accounts that have been given. It is not possible for others to gauge the veracity of the accounts given to them by others, whether they be from an ex-prisoner or not. This was a leading concern which was uppermost in my mind, while conducting the interviews, that of unintentional judgement. However, while conducting the interviews I became aware that the men were deferential towards me. This was clear from observable meek conduct and language of the

participant group. For example, Paul, Kenneth, Douglas and many others would use phrases such as “honest”, “I would swear on my mother’s life…",”in my humble opinion”, “not that my opinion matters”, “I could be wrong”, “You will understand it better than me” and repeat themselves even though I had acknowledged the point they had made. There are a number of possibilities for why this demeanour was present in their conduct. This factor may be relevant as some of the men may have been trying to overcome any credibility gap, which they themselves are conscious of; they have been called liars and had their accounts challenged by many, throughout their journey in the Criminal Justice System and prison. However, I made it clear to the men before commencing that I respected their experiences, what they had to say and that the exercise was not imposed and held no threat to their identity or future credibility. However, at times I felt that some participants were being careful in the way they were positioning themselves within the interview context. This could have influenced the way in which they told their stories as they may have felt that they had to make them credible and authentic to me.

It is also important to acknowledge the issue of reflexivity in this study because in my efforts to be empathetic to the participants during the interviews, it was easy to forget about my influences on the process. However, I acknowledge that my experiences of the NHS and SPS could have influenced decisions and interpretations during the study. Examples include the order and wording of questions before and during the interview and the issues that I emphasised in my interview notes and subsequent analysis of findings.

A crucial point to acknowledge in this study was the possibility that I could project my own feelings into the interview. In other words, I could imagine that is how I would feel if I were in the same situation as my participants. However, I understand that their experience of health and relationship with healthcare services will be unique, and very different to that of my own. I also acknowledge that my reactions to participant's answers may have influenced the way in which I asked the question and how they asked questions of me. This may have also influenced the answers that were given. My own feelings towards health and healthcare for prisoners could have influenced the analysis and findings of the study. I reflected upon these issues and their potential influence upon the study. Having recognised them, I made an effort to try to minimise their influence while conducting the interviews, and the study as a whole.

I utilised a number of practical techniques to address reflexivity in the study in relation to participant interviews. The first of these was that I allowed enough time between interviews in order that I could critically reflect upon them, discuss the content with other researchers and consider different perspectives. This was useful as it forced me to look at issues from different angles that I could have overlooked or dismissed without due consideration. Secondly, I kept a diary of how I was feeling while performing the study. This proved to be useful as it allowed me to reflect on my emotional state and other significant events on the days I performed the interviews. When it came to writing up the findings, I was able to refer back to the diary, which helped me make allowances for the way I was feeling. I found this to be particularly useful as I conducted the interviews on my own and sometimes had not been able to discuss them with a colleague. Thirdly, during the write up of the findings chapters of this thesis, I reflected on how I had interpreted what I heard during the

interviews and considered how my life experiences influenced the analysis of data. An example of this is I remember when I was writing this thesis, feeling real sorrow for a participant because of the poverty and life experiences they had described to me. Had I not reflected on how my relatively comfortable experience of life and my feelings towards this, I could have unintentionally stressed the powerlessness of the participant in the thesis. Lastly, prior to conducting the interviews I had practised my technique with a colleague in which we both made notes on how I had come across while conducting a mock interview. We took account of what I said, how I said it and what my body language and facial expressions were at the time. After the interview, we discussed the notes we had made which increased my self-awareness and allowed me to improve my interview technique. An example of how I utilised this was that I have a tendency to make many facial expressions that indicate approval when listening to accounts, which could be interpreted by a participant as encouragement to tell me more than they may have done otherwise. Had I not been made aware of my facial expressions I may have conducted an interview and thought that the participant was engrossed with the experience that they were giving when they had just been doing what they thought I wanted them to do.

7.5 Implications for service provision and policy

From the participants' experiences there would appear to be many strategies that could be tried, and evaluated, in order to improve the access and service provision for offenders within the prison and community. However, before I discuss these we should consider the purpose of prison, and what it is meant to achieve. First, it is meant to serve as a punishment with the loss of liberty. Secondly, it is meant to provide an opportunity for rehabilitation of the individual. It is debateable as to how this can be achieved but it is possible that healthcare could play a part. It could be argued that a stricter regime should be adopted by the SPS/NHS partnership with regard to the health of prisoners. For example, there should be no smoking, in prison and shorter methadone programmes with prisoners given more opportunities for exercise and less for entertainment by the provision of televisions, computer games consoles, etc. Put another way it could be argued these organisations should be more dictatorial in order to ensure that prisoners' health is not harmed and that they are not being done a disservice by a regime that is possibly "killing them with kindness". However, this needs to be debated further taking into account the right of Forfeiture, which is the legal principle that needs to be discussed. In other words, does the prisoner have the right to healthcare given that he has committed a crime against society? In addition, how serious a demeanour must be committed before the prisoner has forfeited the righted to healthcare? Interesting points that are debated in the legal field but possibly need to be debated by the SPS/NHS partnership.

The SPS and NHS are two large organisations that appear to have been operating as information silos. An information silo is an insular management system incapable of reciprocal operation with other, related information systems. Information silos occur whenever a data system is incompatible or not integrated with other data systems. This was

recognised in the document Better Health, Better Lives for prisoners (Brutus et al. 2012) as it was the case when the SPS and NHS integrated in November 2011 that information and data exchange was difficult due to the incompatibility of their computer systems. Given the rate of progress to the present situation it appears that healthcare provision for offenders is in a state of flux and may take years before they are fully integrated and the organisations have the capability to work fully as a partnership. In the interim, general healthcare is being delivered. However, the risk perceptions have changed. The SPS are no longer responsible for primary healthcare and as such appear to have taken a laissez faire attitude towards its provision by the NHS. In contrast, the NHS is adapting to providing their service in a new environment and appears to have become somewhat risk averse in their interactions with their new patient group.

Healthcare in the prison environment is all about structuring expectations, as people would expect to be informed about their care. At ground level between practitioners and their patients, this is still the case but at strategic levels within the NHS and SPS, communication to those at the ground level appears sporadic. When the NHS took over primary care, responsibility it would have been prudent to ensure that at local estate level within every prison they should have had a quality officer at SPS meetings. This would have ensured that the NHS would have gained a greater insight into the organisational governance of the SPS and the logistical problems that it faced in trying to ensure that the NHS as an organisation would be able to perform their role effectively. This was because the NHS was going to be in the position of delivering primary care in a secondary setting i.e. prison compared to a GP surgery or hospital. The NHS would have then been better informed and in a position to integrate its operations with that of the SPS. For example,

healthcare in prison relies on “runners”; prison officers that escort prisoners to the health centre. This is a logistical problem that may have been resolved had the NHS been more aware of the issues surrounding it in November 2011. If a prisoner has a scheduled appointment, then prisoner should attend this when requested by the “runner”. If the prisoner wishes to refuse treatment or no longer wishes to have the consultation, then he retains the right to this but must attend the appointment first and explain his refusal of treatment/consultation to healthcare staff. As it stands, the prisoner can simply refuse to go to the health centre and, in effect, he has had a day off work. This is seen as a way of subverting the system and causing work for officers. However, it is partly responsible for the long waiting lists experienced by prisoners to see healthcare workers.

In effect, the NHS is a primary employer operating within a secondary setting. This causes problems as it relies on the SPS in order to deliver its core business. An example of this was previously mentioned in the use of SPS officers escorting prisoners to the health-centre for appointments. As a result, the SPS actually control the access to the patients and therefore the delivery of care. One strategy that may help in this situation would be if the SPS took back some “ownership” of the clients’ healthcare and facilitated appointments. Ensuring that prisoners attend a prison health centre should be easier to facilitate than ensuring that a prisoner attends an outpatient appointment at a local hospital, as there is no need to coordinate the prisoner movements with an external contractor, that is, G4S Security Company. One strategy that could be looked at within closed prison estates would be that patients could be moved from the halls to the health centre in groups of 10/15 before the routine prison movements.

Medication is a problem as weekly medications are dispensed to prisoners on a Friday. This has colloquially become known as “Chemical Friday” due to the amount of trading and misuse of medications that will be seen in the prison at this time. The SPS following the change of responsibility appeared to take a view that it was no longer their responsibility to deal with medication or healthcare. This appeared to have a knock on effect to the NHS, which then became risk averse to the dispensing of medication. A suggestion would be to spread the dispensing of medication over the whole of the week rather than restrict it to one day.

Participants in this study voiced that being prescribed certain medications made them feel vulnerable and open to bullying as medication was used as a currency. This occurred not only in prison but also in the community. A way of avoiding this situation may be to place greater emphasis on drug treatment within prison and ensuring continuity of treatment upon liberation as found by Tompkins et al. (2007)[19].

Attitudes of healthcare staff are very important and they should see the individual prisoner as a patient first. Staff labelling prisoner’s as “druggies”, “drug seeking” or simply that they do not hold them in regard are not conducive to good interpersonal relationships with their client group and may influence the quality of care given. There also needs to be a culture where doctors prescribe what is needed by patient and not have to be overly concerned about the “currency” value of what they are prescribing. Operational SPS staff need to be concerned about drugs as “currency” not NHS staff. The patient needs to feel “he is being treated” fairly and in accordance with policies, protocols and guidelines that would be used in the public domain. In this respect, patients need to be prescribed the most

[19] It is noteworthy that in prison as medication operates as a form of currency, information as to who possess ‘currency’- medication. Additionally, others may be bullied by inmates into gaining that medication through prescription in feigning illness.

appropriate treatment if they have a legitimate condition. Subsequently, if this causes operational issues within the prison then the operational SPS staff needs to deal with that, not abdicate responsibility to the NHS. This just perpetuates "them and us" divisions and prevents collaborative working in partnership.

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 (TSO) are a new initiative which can provide valuable support for accommodation, continuity of healthcare upon liberation e.g. hospital and social work appointments. As discussed previously, planned throughcare upon liberation may play a part in the desistance of crime. There is a need to link healthcare with social care to ensure a more holistic approach to care for the marginalised and disenfranchised. This is possible as in the prison there is an opportunity to do something different compared to the general community.

Six participants mentioned that their care plans, which had been developed in one prison, were sometimes not followed when they had been transferred to a different prison. This

had caused problems especially when they had built up therapeutic relationships with health care staff, which were then discontinued when they were transferred. In addition, these 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.

There are cultural barriers and attitudes to efficient healthcare delivery. The NHS needs to experiment with different strategies to empower patients and allow them to make choices and not in a paternalistic manner. The NHS has traditionally not been good at this as it has been very prescriptive with care and its power base centres round that of the health care professional "knows better", (Robertson et al. 2011). The NHS also needs to listen to, and inform, patients more regarding their personal care and the quality of service provision. This may have a positive effect upon the level of complaints made by prisoners about their care.

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. This was discussed in sections 5.4.2. 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.

One subject that was raised by participants was that they had been de-registered by their community GP while in prison. This meant that upon liberation they had to re-register with a GP, which could be a difficult process particularly as some people leaving prison often do not have a home address, which is needed by the GP to register. Indeed some participants reported that some GPs were unwilling to register people who had been in prison. Being unable to register with a GP also has implications for those being liberated that need to apply for disability allowance as this requires a GP to assess them as being unfit to work. Any delays in registering with a GP can cause long delays in accessing benefits, which can cause hardship and tempt many to committing crimes in order to live. This implies that a mechanism needs to be developed to help assist men register with community GP's prior to liberation and that the prison Doctor should be able to assess a person's fitness to work in order to help prevent delays with benefit claims. These initiatives may help liberated prisoners in the transition period from prison to community.

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 SPS and NHS should meet regularly within the prison estates and at National level to review and evaluate the service provision and outcomes and aid collaboration in the change process. This may have a positive effect upon service improvement and development.

Although this was an exploratory study of male ex-prisoners' experiences of health and healthcare in prison and the community specifically since the responsibility for providing primary health care within the SPS was transferred to the NHS, the accounts from participants have raised the importance of looking at health's role in the wider context of justice and reoffending. The implications of this are that there needs to be an effort by the justice authorities to look at earlier opportunities for intervention to help avoid people going into prison. There are a number of partnerships with justice in which health could play a more important role. These include Community Justice Authorities, Community Planning Partnerships and the greater involvement of third sector organisations in Public Social Partnerships.

7.6 Future research recommendations

This study has highlighted a number of issues that participants experienced with their healthcare. The issues surrounding the participants' desistance from crime requires to be investigated further, from the offender and healthcare providers perspectives, as it is possibly one of the most interesting and useful issues to society as a whole. To what extent can healthcare services play a part in helping offenders desist from crime?

In order to establish a clearer picture on a national scale it is proposed that a larger scale quantitative study be performed. This would not only help to clarify the main issues that offenders encounter with healthcare but also help in evaluating the national prisoner healthcare framework. A study designed to investigate the major issues in further detail may help determine their significance within the whole of the offender population. The views and opinions of offenders should be sought by health boards and trusts in the evaluation of their services. This would help in the design and delivery of services and ensure that the needs of offenders were fully met.

The literature review has also highlighted that a number of health issues such as dental health, vaccinations, suicide and self-harm, alcohol, gambling, smoking, tattooing or body piercing do not appear to have been researched from the offenders' perspective. Research is required to explore how much these issues impact upon the health of offenders.

There is also a need for the healthcare experiences of women and the older age in prison to be explored further. The integration of services between prison, community and third party sectors requires a review to ensure that communications, policies and procedures are aligned to ensure the smooth delivery of care for offenders entering prison and when liberated.

Throughcare planning and provision needs further research in order to evaluate the part that it may play as an assisted desistance strategy that could be utilised by the Criminal Justice System.

The partnership between the SPS and NHS is still relatively new, and has involved many changes, within the two organisations, in order to deliver primary healthcare for prisoners. There is a need for a study that focusses on the integration of the two systems/institutions. This could look at how this integration has been achieved, how it is currently working and where there is a need to improve efforts in fulfilling the remit and responsibilities of the institutions, which were drawn up in the document, National memorandum of understanding between the Scottish Ministers, acting through the Scottish Prison Service and NHS Scotland (Scottish Government 2011).

The new initiative introduced by the SPS, of the Throughcare Support Officer warrants further research in order to assess its efficiency in providing valuable support to prisoners with securing accommodation, continuity of healthcare upon liberation e.g. hospital and social work appointments. The study could also explore whether the role could be expanded to include any other forms of support to liberated prisoners.

There is also a need for a study to explore the culture and systems of healthcare performance management within the SPS/NHS partnership with reference to the quality of healthcare and service improvement, through enhanced communication, periodic reviews and audits. This is required in order to ensure that healthcare is adequately monitored and policies and initiatives intended to improve the health of prisoners are actually achieving their goals.

7.7 Knowledge dissemination plan

It is crucial that researchers disseminate the knowledge from their study to the appropriate audiences. In this instance there are several audiences; the prison population, SPS and NHS Staff. In order to disseminate the findings of this study to these groups it is anticipated that a number of publications will be prepared.

Academic dissemination of findings

The findings of the study will be submitted as a large empirical qualitative research article to respected peer reviewed journals (e.g., Advanced Journal of Nursing). A number of other separate articles will also be submitted to relative journals that will focus on the methods, results or implications of the study. In addition to journal articles, findings will be reported at a national conference (e.g., Prison Health Symposium) which will also provide other valuable opportunities via networking with others in this field.

Non-academic dissemination of findings

A short article summarising the main findings of the study will be submitted to the national newspaper for prisoners, “Inside Time”. In order to disseminate the findings to SPS staff an article will be submitted to the SPS online e-magazine, “Together” which reports on the work happening across all the prison estates in Scotland.

Findings have also been disseminated to the prison population in HMP Barlinnie via the in house radio station, “Barbed Wireless”. This project has been running now for a while with prisoners learning all aspects of creating and producing radio programmes. Not only has the

radio station has been set up as an education class but also as a means of communicating information to as many prisoners as possible. Letting them know what is going in the establishment and the opportunities available to them through education, courses, visits, addictions, health issues and much more.

Collaboration development

There is also an opportunity to disseminate findings by working with the local SPS establishments and NHS primary care trust to promote the role that healthcare can play in helping prisoners desist from crime upon liberty.

Healthcare, including that for prisoners, could be taught along with offending and crime prevention measures within secondary schools and further education establishments. This was suggested by David in his interview when talking about hope for the future with particular reference to reducing offending within the younger generation and improving healthcare. David voiced his idea regarding teaching young people as follows:

They think it is all right to go to a prison. You know, at the end of the day, when you speak about healthcare em… I think that the healthcare nowadays should be looked at and talked about. Something should be done about teaching our young people in society. The reason being is … a good majority of people, well, once they leave school they will just merge into the background. I think that we should be doing more about it em… so that our younger generation don't have to eh… do all the things that we used to do.

7.8 Summary

The criminal justice systems are politically sensitive places and this can be challenging for the prison staff. The public views on the people found in prisons and the experience of imprisonment can be misrepresented in the media (Jewkes 2007) which tends to concentrate on notorious prisoners, stories of prisoners receiving undue privileges, and sentences deemed too lenient. As a consequence of this, health initiatives in prison run the risk of being perceived as too good for prisoners, who are portrayed as undeserving.

This study has found that participants found it difficult to access healthcare services. They expressed problems with their self- esteem and self- worth due to their experiences of stigma that to which they ascribed their low expectations of healthcare and dissatisfaction with life in general. Although the participants in this research were all liberated men who did not foresee themselves ever returning to the prison environment, they had experience of many men who saw prison as a way of life that provided them with all that they required and were caught up in “the revolving door” of prison and liberation

In prison healthcare, the relationship with the nurses was central to accessing and receiving care, as they were perceived to be the major gatekeepers. However, although it might be expected that they would experience this relationship as being helpful, many found that many nurses did not appear to care and their autonomy was influenced by the interventions and actions of prison officers. Participants expected that nurses would be aware of their vulnerabilities and help ensure their safety, advocate for them and their care but often found that this was not the case and that a punitive attitude was displayed towards them. When these expectations were not met, for whatever reason, participants felt that nurses did not care and were merely doing a job. This resulted in disappointment

and frustration towards individuals but also the healthcare system as a whole, which resulted in complaints.

Structural issues such as the prison routine, staff attitudes and nurses control of the prison healthcare system made it difficult to access healthcare services. Participants also voiced that there were limited opportunities to take part in health promotion/education initiatives to help them improve their health. Issues such as medication and a lack of money could also make them vulnerable to bullying and lead to them accumulating large debts.

Participants had little expectations of the healthcare system catering for their needs. However, they voiced hope for the future. Healthcare was voiced as having helped three of the twenty-nine participants break free of “the revolving door” of prison and liberation. This is an aspect of healthcare that requires further research and evaluation as it may be of great benefit to society as a whole.

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Appendices

Appendix A. Literature Sources Accessed by this Study via Summon

Literature Sources Accessed by this Study via Summon search engine database.

Abertay Print Journals
ACM Digital Library (Association for Computing Machinery)
American Chemical Society
Annual Reviews (Back Files)
Applied Social Sciences Index & Abstracts (not full text)
ASME Journals & Conference Proceedings (American Society of Mechanical Engineers)
Environmental Science (Backfile)
Immunology & Microbiology (Backfile)
Psychology (Backfile)
BioMed Central Open Access
BioLine International
BioOne Open Access
BMJ Journals – Subscribed only (British Journal of Sports Medicine, Evidence-based Mental Health and Evidence-based Nursing)
Brill Journals
Business Source Premier
Cairo Scholarship Online
California Scholarship Online
Cambridge University Press Journals
Cell Press (Free Archive)
Chicago Scholarship Online
Co-Action Open Access
Direct Access Journals
Edinburgh Scholarship Online
Emerald
Florida Scholarship Online
Fordham Scholarship Online
Gale Newsvault
Highwire Press (Free Journals)
IAMCR Open Access Journals
ICE Journals (Civil Engineering)
IEEE/IET
IngentaConnect
Intellect Journals
Mark Allen Nursing titles – subscription only (British Journal of Mental Health Nursing & British Journal of Nursing)
IOP Journals
Journals @ OVID
JSTOR

Karger Online
Manchester Scholarship Online
Medknow Open Access Medical Journals
MIT Scholarship Online
Oxford Journals
Oxford Liverpool Scholarship Online
OUP Scholarship Online
Policy Press Scholarship Online
Project Gutenberg Online Catalogue
ProQuest Central
PsycARTICLES
Psychology & Behavioural Sciences Collection
SAGE Journals
Science Classic Archive
Science Direct
SPORTDiscus
SpringerLINK Journals
Springer Open Access Journals
Taylor & Francis Online Library
University of Adelaide Press (Open Access)
Web of Science
Wiley Online Library
Yale Scholarship Online

Additional databases searched via ESBCOhost

CINAHL

Embase

Medline

PsychINFO

Sources for grey literature

UK Government website – https://www.gov.uk/

Scottish Government - http://www.gov.scot/

Scottish Prison Service - http://www.sps.gov.uk/

The Knowledge Network Scotland - http://www.knowledge.scot.nhs.uk/home.aspx

WHO Health in Prisons Programme (HIPP) via http://www.euro.who.int/en/health-topics/health-determinants/prisons-and-health/who-health-in-prisons-programme-hipp

Appendix B. List of search terms used in Summon

List of search terms used in Summon.

Research
Prisoners
Prisons
Scottish prisons
Offenders
Community
Health
Epidemiology
Prison population
Medicine
Public health
Psychiatry
Environmental health studies/care
Occupational health studies/care
Health aspects
Health concepts
Health policy
Health services
Social sciences
Biomedical sciences/services
Health care sciences/services
Care and treatment
Sociology
Inmates
Hospitals
Health care industry
Philosophy
Social aspects of health
Social issues
Nursing
Healthcare
Public health studies/care
Psychology
Clinical research
Medical research
Behaviour
Penology
Criminology
Criminal Justice
Recidivism
Young offender
aged prisoners
old prisoners

alcohol & drugs
Older prisoners
blood borne virus infection
prison health
prisoner health
prison palliative care
dental health in prison
elderly prisoners
prisoner demographics
Prisoner health complaints
equity
equality
equitable healthcare
prisoner self-harm and suicide
prisoner welfare
prisoner's mental health
sexual health in prisons
imprisoned patients
inmate

Search Terms used for EBSCOhost databases (CINAHL, Embase, Medline and PsychINFO).

A number of search terms were used using truncation and wildcard symbols (ending with * and/or including ?) to ensure that all permutations of the terms were included.

health*
healthcare*
experience
view
perspective
opinion
explanation
?prison*
?offender*
community*

Appendix C. Attributes of included studies

Table 4. Attributes of included studies

Study	Purpose/Aims	Sample	Country	Setting	Design/Data Collection	Findings
Plugge et al (2008)	Women prisoners experiences of primary care in prison	37	UK	Prison	Qualitative	Gap between patient experience and policy.
Jordan (2012)	Patients perspectives of NHS mental healthcar in HMP	4	UK	Prison	Qualitative	Prison milieu impacts mental healthcare
Condon et al (2007)	Users views of prison health services	111	UK	Prison	Qualitative	Lack of autonomy is major obstacle.
Samele and Keil (2009)	The resettlement needs of female prisoners.	27 and 8	UK	Prison/community	Qualitative	Mental health, drugs & accommodation issues on liberation
Nesset et al (2011)	Health care help seeking behaviour among prisoners in Norway.	1454	Norway	Prison	Quantitative	Sleep problems and drug misuse reported
Hassan et al (2012)	Prisoners views of holding their own medication in prison	24 Interviev	UK	Prison	Mixed methods	Risk management needs development in prison
Bjorngaard et al (2009)	Prisoner health services satisfaction survey	1150	Norway	Prison	Quantitative	Dissatisfaction at high levels with prison health services
Condon et al (2008)	Prisoners views on making healthy choices in prison.	111	UK	Prison	Qualitative	Barriers limit prisoners ability to maintain/ improve their health
Plugge et al (2008)	Imprisoned women's concepts of health and illness.	37	UK	Prison	Qualitative	Good understanding of health. Similar to public.
Burnett et al (2009)	What 'Revolving Door' prisoners think of their prospects	35	UK	Prison	Qualitative	Positive thinking about imprisonment. Distrust of health staff.
Scheyett et al (2009)	Assessing the role of social support in release planning for HIV prisoners	23	USA	Prison	Qualitative	Difficulties in accessing support
Binswanger et al (2011)	Health experiences of recently released inmates.	29	USA	Community	Qualitative	Poor preparation for release and continuity
Small et al (2005)	Inmates experiences injecting drugs in prison.	26	Canada	Prison	Qualitative	More harm reduction required in prison
De Viggiani (2007)	Exploring structural determinants of prison health.	35	UK	Prison	Qualitative	Health inequalities are emeshed within prison
Howerton et al (2007)	Understanding help seeking behaviour among male offenders.	35	UK	Prison/community	Qualitative	Distrust of health staff. Staff training required
Jennings (2009)	An exploration of elder inmate health and healthcare	16	USA	Prison	Qualitative	Recommendations for elderly care in prison
Ruiz-Garcia et al (2014)	Experences of women in Spanish prisons	69	Spain	Prison	Qualitative	Experiences of prison including healthcare
Tompkins et al (2007)	Experiences of prison among injecting drug users	51	UK	Prison	Qualitative	Experiences and opportunities for care
Haley et al (2014)	HIV care after prison	24 prison 13 community	USA	Prison/community	Qualitative	Need for interventions to prepare for transition from prison to comm.
Small (2006)	Patient, prisoner or person?	1	USA	Prison	Qualitative	Negative experiences with addiction services
Small (2009)	Effect of prison upon HIV treatment	12	Canada	Prison	Qualitative	Need for better coordination between prison/community

Rae (2015)	Perceptions and experiences of healthcare in the homeless.	14	UK	Community	Qualitative	Greater interdisciplinary communication required
Lichtenstein (2000)	HIV risk and healthcare attitudes	Focus Grou	USA	Prison	Qualitative	Negative experiences of healthcare staff. Lack/ avoidance of access. These increased risk of STD's.
Yu et al (2015)	Self-Perceived Health Improvements Among Prison Inmates	136	USA	Prison	Qualitative	Prisoners perceived improvements in health due to prison.

Appendix D. Process of coding

In order to illustrate the process of coding and organisation into themes; two short extracts help to illustrate how this process was performed. In the first extract the participant is talking about the dental services within the prison:-

Data Extract	Code	Sub theme/Theme
203. Michael. Yeh. You have got to remember that like there is maybe like 700. 800 people right in the dentist right	Dental service numbers.	Waiting lists/ Structure
204. So the list is. Like he will maybe see maybe about ten people one week. Another ten the next week and it goes on and on.	Limited dental service.	Access to service/ Structure
205. And you just have to wait until you are on the list. And it could be three. four months.	Dental waiting list.	Low expectations/ Agency
206. Can you imagine having a toothache for three four months?	Effect of waiting list.	Agency
207. JF. Well.	Acknowledging question/contemplating answer.	

208. Michael. It makes you. makes you ratty. It makes you like like you cannae think of anything else. You are unapproachable and it makes me ratty.	Not coping, feelings "ratty" and unapproachable.	Agency

In this second example the participant is talking about the process of accessing the mental health team.

Data Extract	Code	Sub theme/Theme
212. Michael. Aye, yeh you could access the mental health team.	Confirming access to MHT	Accessing healthcare/ Structure
213. JF. Is that quite easy?	Question	--------
214. Michael. Yeh.	Thinks it is easy to access MHT	As above
215. JF. So, if you say to an officer I need to see somebody...	Clarifying question	---------
216. Michael. Naw. I think you would just go down sick and explain on the thing. There is different bits on the form.	Explanation of access process. Form required.	Accessing healthcare/Structure
217. Like chiropodist, dentist, mental health, nurse. Nothing for a Doctor.	Different services accessed via same form but not Doctor.	Different services/ Structure
218. JF. Right.	Acknowledging answer	----------
219. Michael. You need to see a nurse first and they will put the cause down on it.	Nurse is gatekeeper to Doctor. Makes initial diagnosis.	Nurses control/ Structure

220. JF. Ok, so you always got to go through a nurse first.	Clarifying question	----------
221. Michael. Yeh.	Confirming answer	As above

Appendix E. Abertay SHS Ethics Committee approval letter

Abertay SHS Ethics Committee approval letter

RL/CR/SHS/P/12/007

6th December 2012

James Fraser
****
****
****

Dear James

This is to notify you that **conditional approval** has been granted for you to collect data for your project entitled '*Male ex-prisoners experiences of health and healthcare in prison and in the community*', but is subject to the following conditions:

You must remain in regular contact with your project supervisor

Your supervisor must see a copy of all research tools and your procedure *prior to commencing data collection.*

If you make any substantive changes to your project plan you must submit a new ethical approval application to the committee. Application forms and the accompanying explanatory document are on the Intranet. Completed forms should be handed in to the School Office, School of Social and Health Sciences, Level 5, Kydd Building.

The proposal states that you will conduct unstructured interviews. While it is appreciated you do not have a list of specific questions you must submit a short list of the general themes or areas your interview is likely to cover. This must be submitted to the School Research Ethics Committee before starting data collection.

A separate risk assessment form must be completed for all projects. In principle it appears that there are likely to be few issues with this project. However, the School Research Ethics Committee must see this information prior to data collection

I would be grateful if you could contact Mrs Carol Ramsey in the School Office on c.ramsey@abertay.ac.uk as soon as possible to advise that you accept the conditions stated. Should you have any queries please contact your supervisor.

Yours sincerely

School Ethics Committee
School of Social and Health Sciences

Appendix F. East of Scotland Research Ethics Service approval letter

East of Scotland Research Ethics Service approval letter

EoSRES

NHS SCOTLAND
Research Ethics Service

East of Scotland Research Ethics Service (EoSRES) REC 1
Tayside Medical Sciences Centre (TASC)
Residency Block C, Level 3
Ninewells Hospital & Medical School
George Pirie Way
Dundee DD1 9SY

Mr James I Fraser
PhD Student
School of Health and Social Sciences
Division of Nursing
University of Abertay,
Bell Street
Dundee
DD1 1HG

Date: 07 December 2012
Your Ref:
Our Ref: LR/12/ES/0103
Enquiries to: Mrs Lorraine Reilly
Extension: Ninewells extension: 83878
Direct Line: 01382 383878
Email: eosres.tayside@nhs.net

Dear Mr Fraser

Study title: **Male ex-prisoners experiences of health and healthcare in prison and the community.**
REC reference: **12/ES/0103**
IRAS project ID: **121087**

The Proportionate Review Sub-committee of the East of Scotland Research Ethics Service REC 1 reviewed the above application on 07 December 2012.

We plan to publish your research summary wording for the above study on the NRES website, together with your contact details, unless you expressly withhold permission to do so. Publication will be no earlier than three months from the date of this favourable opinion letter. Should you wish to provide a substitute contact point, require further information, or wish to withhold permission to publish, please contact the Co-ordinator Mrs Lorraine Reilly, lorraine.reilly@nhs.net.

Ethical opinion

On behalf of the Committee, the sub-committee gave a favourable ethical opinion of the above research on the basis described in the application form, protocol and supporting documentation, subject to the conditions specified below.

The following points require to be addressed by letter and submission of revised documentation where requested. **Please note that there is no requirement to amend your application form.**

1. Regarding the application form:

   - A23 had been ticked 'No' - the Committee felt that some of the topics discussed could be sensitive or embarrassing and therefore 'Yes' should have been ticked.
   - A24 the Committee noted that stimulating further research would not be beneficial to participants it would be beneficial to researchers.

2. Regarding Participant Information Sheet (PIS):

- Please clarify where the digital recordings would be stored and how they would be carried from place of storage.

Please submit a revised PIS and Consent form, which should include a new version number and new full date.

Ethical review of research sites

The favourable opinion applies to all NHS sites taking part in the study, subject to management permission being obtained from the NHS/HSC R&D office prior to the start of the study (see "Conditions of the favourable opinion" below).

Conditions of the favourable opinion

The favourable opinion is subject to the following conditions being met prior to the start of the study.

Management permission or approval must be obtained from each host organisation prior to the start of the study at the site concerned.

Management permission ("R&D approval") should be sought from all NHS organisations involved in the study in accordance with NHS research governance arrangements.

Guidance on applying for NHS permission for research is available in the Integrated Research Application System or at http://www.rdforum.nhs.uk.

Where a NHS organisation's role in the study is limited to identifying and referring potential participants to research sites ("participant identification centre"), guidance should be sought from the R&D office on the information it requires to give permission for this activity.

For non-NHS sites, site management permission should be obtained in accordance with the procedures of the relevant host organisation.

Sponsors are not required to notify the Committee of approvals from host organisations.

It is the responsibility of the sponsor to ensure that all the conditions are complied with before the start of the study or its initiation at a particular site (as applicable).

You should notify the REC in writing once all conditions have been met (except for site approvals from host organisations) and provide copies of any revised documentation with updated version numbers. The REC will acknowledge receipt and provide a final list of the approved documentation for the study, which can be made available to host organisations to facilitate their permission for the study. Failure to provide the final versions to the REC may cause delay in obtaining permissions.

Approved documents

The documents reviewed and approved were:

Document	Version	Date
Covering Letter		30 November 2012
Evidence of insurance or indemnity		17 September 2012
Interview Schedules/Topic Guides	1	29 November 2012

Investigator CV		30 November 2012
Letter of invitation to participant	1	29 November 2012
Other: CV - Dr Rosie Stenhouse.		
Other: CV - Dr Anne Wilson		
Other: Copy of Letter from Gareth Balmer		21 November 2012
Participant Consent Form	1	29 November 2012
Participant Information Sheet	1	29 November 2012
Protocol	1	29 November 2012
REC application	121087/389 602/1/875	30 November 2012
Summary/Synopsis	1	29 November 2012

Membership of the Proportionate Review Sub-Committee

The members of the Sub-Committee who took part in the review are listed on the attached sheet.

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

After ethical review

Reporting requirements

The attached document "After ethical review – guidance for researchers" gives detailed guidance on reporting requirements for studies with a favourable opinion, including:

- Notifying substantial amendments
- Adding new sites and investigators
- Notification of serious breaches of the protocol
- Progress and safety reports
- Notifying the end of the study

The NRES website also provides guidance on these topics, which is updated in the light of changes in reporting requirements or procedures.

Feedback

You are invited to give your view of the service that you have received from the National Research Ethics Service and the application procedure. If you wish to make your views known please use the feedback form available on the website.
information is available at National Research Ethics Service website > After Review

12/ES/0098	Please quote this number on all correspondence

We are pleased to welcome researchers and R & D staff at our NRES committee members' training days – see details at http://www.hra.nhs.uk/hra-training/

Yours sincerely

[redacted]

Dr Carol Macmillan
Chair

Email: eosres.tayside@nhs.net

Enclosures: List of names and professions of members who were present at the meeting and those who submitted written comments

"After ethical review – guidance for researchers"

Copy to: NHS Tayside R&D office
Dr Rosie Stenhouse, Supervisor
Dr Ann Wilson, Supervisor

Appendix G. Participant Information Sheet

Participant Information Sheet.

UNIVERSITY of ABERTAY DUNDEE

Participant Information Sheet

"A qualitative study of male ex-prisoners' experiences of health and healthcare in prison and in the community in Scotland"

A research study to find out about people's experiences of health and healthcare in the prison and community.

I am James Fraser, a postgraduate student at the University of Abertay. I would like to invite you to take part in this research study. Before you decide if you want to take part it is important for you to understand the purpose of the research study and what it will involve. Please take time to read the information carefully and discuss it with others if you want. You can ask me any questions you have about the information, or if you need to know more.

What is the purpose of the research study?
The study aims to understand what it is like to be an ex\prisoner trying to stay healthy in Scotland. Men who have been in prison in Scotland will be asked to talk about their experience, because their views are important. The information from the research can help service providers to design services that fit the needs of people who use them.

Who can take part?
If you are a male, over 18, been in prison for more than 3 months and have been given this information by your healthcare worker you can volunteer to take part in the study. Participation is voluntary and participants can withdraw from it at any time and is confidential.

What will taking part involve?
You will be invited for an interview at which I will ask you to tell me about you're your experiences of good/bad health and of the healthcare organisations and professionals that you have encountered. The interview will last around about 1 to 1 1/2 hours. If required, and with your consent, we may arrange for a second interview. I will ask you to sign a consent form at the beginning of the interview.

What happens to what I tell?
Interviews will be recorded on a digital recorder.
The digital recordings will be stored on a password protected hard drive in a personal computer within a locked office in the University of Abertay Dundee.
Only the researcher will know the password to the computer.
The recordings will not be taken out of the office.
All recordings will be stored separately from any information which would identify you, **and will be destroyed following completion of the study**.

UNIVERSITY of ABERTAY DUNDEE

What are the possible disadvantages or risks of taking part?
People might worry that what they say about their experiences of healthcare organisations might affect the care they get if they need to visit them again. All steps will be taken to hide people's identities so that nobody can be recognised in the report.

What are the possible advantages of taking part?
The information from the research might help improve healthcare for prisoners and ex-prisoners.

Will my taking part in the study be confidential?
Nobody will be informed about your participation.

What will happen to the findings of the study?
To protect your identity a pseudonym, instead of your real name will be used in reports, articles and presentations that are made about the study. I will also change some of the personal information about you so that you are not recognised, for example, age, town or area where you stay. I will also write a summary report that I will send to everyone who took part, and anyone else who is interested.

Who has reviewed this study?
As a Ph.D. student I have two supervisors at the University of Abertay, Dundee who are experienced researchers. The role of these supervisors is to make sure that the study is well designed and that I carry it out in a way that is respectful to participants. The University of Abertay and local NHS Research Ethics Committee's have reviewed the research proposal and given permission for the study to go ahead. 'The East of Scotland Research Ethics Committee REC 1, which has responsibility for scrutinising all proposals for medical research on humans in Tayside, has examined the proposal and has raised no objections from the point of view of medical ethics. It is a requirement that your records in this research, together with any relevant records, be made available for scrutiny by monitors from the University of Abertay and NHS Tayside, whose role is to check that research is properly conducted and the interests of those taking part are adequately protected.'

What if I have a complaint about the research?
If you wish to make a complaint about the research you can make a complaint to my supervisors at the University of Abertay or through the usual NHS complaints procedure.

UNIVERSITY of ABERTAY DUNDEE

Contacts for further information:

For further information about the study, or if you decide you want to take part, you can contact me, James Fraser on telephone number 01382 302007.

You can also contact my supervisors by telephone:

Dr Rosie Stenhouse 01382 308508

Dr Ann Wilson 01382 308717

To talk to someone who is independent about any worries you have about participating in the research study you can speak to Dundee Independent Advocacy Support, 6a Meadow Mill, West Henderson's Wynd, Dundee. They can be contacted between the hours of 9am and 5pm, Monday to Friday or can be called on 01382 205515.

For those living in the Perth and Kinross area they can contact Independent Advocacy Perth and Kinross, 90 Tay Street, Perth PH2 8NP. They can be contacted between the hours of 9am and 5pm, Monday to Friday or can be called on 01738 587887.

Thank you for taking the time to read this.

Appendix H. Participant Consent Form

Participant Consent Form.

UNIVERSITY OF ABERTAY DUNDEE

CONSENT FORM

Title of Project:

Male ex-prisoners experiences of health and healthcare in prison and in the community.

Name of Researcher: James Fraser

Please initial box

1. I confirm that I have read and understood the information sheet dated 14/12/2012 (version 2) for the above study. The research study has been explained to me and I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily. ☐
2. I have been given a copy of the information sheet and I understand what is involved in taking part in the research study. ☐
3. I agree to the interview being recorded and understand that the recordings will be held confidentially, stored securely and destroyed following completion of the study. ☐
4. I agree to the quotation of material from the interviews in any subsequent reports and understand that all attempts will be made to hide my identity through the use of pseudonyms and changing of other identifying information. ☐
5. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without any medical care or legal rights being affected. ☐
6. I understand that taking part in the research does not affect my treatment or rights in relation to health services. ☐
7. I agree to take part in the above study. ☐

Name of participant	Date	Signature
Name of person taking consent	Date	Signature

When complete, 1 for participant and original for researcher site file

Participant Consent Form.
Version 2. 14/12/2012.

Appendix I. Interview schedule

Interview schedule.

UNIVERSITY OF ABERTAY DUNDEE

Interview Schedule

The purpose of the interviews is to gather stories about participants' experiences of health and healthcare in prison and the community. Therefore, much of the input from the interviewer will be in the form of probing and reflective questions based upon the participants story. These will be used for clarification and to increase the depth of data.

The questions that the interviewer anticipates asking are:-

1. What do you consider to be good health?
2. How would you describe your own health?
3. What healthcare professionals have you dealt with in the community?
4. What were your experiences with these people?
5. What experiences had the biggest affect on you?
6. When you were in prison what experiences did you have with the healthcare within it?
7. When you were released form prison what was your experience of getting access to healthcare services, for example, registering with a GP?

Interview Schedule.
Version 1. 29/11/2012.

Appendix J. Healthcare referral form

Healthcare referral form.

NHS
SCOTLAND

HEALTH CENTRE, HMP
APPOINTMENT REFERRAL FORM

NAME: ..... SPIN NUMBER: ..... LOCATION: .....

DATE: ..... Home/Leave ..... (Please enter at least 2 dates of home leave)

PLACEMENT Y/N .....

CONFIDENTIAL APPOINTMENT – Tick as appropriate

CLINIC	TICK	PROBLEM	OUTCOME
ROUTINE NURSE			
MENTAL HEALTH			
ADDICTIONS			
BLOOD BORNE VIRUS			
SEXUAL HEALTH			
DENTIST			
OPTICIAN			
PHARMACIST			
VACCINATIONS			

Any other comments: PLEASE ADVISE DATES WHICH ARE NOT SUITABLE FOR APPOINTMENTS

Date Received: ..... Date of Reply: .....

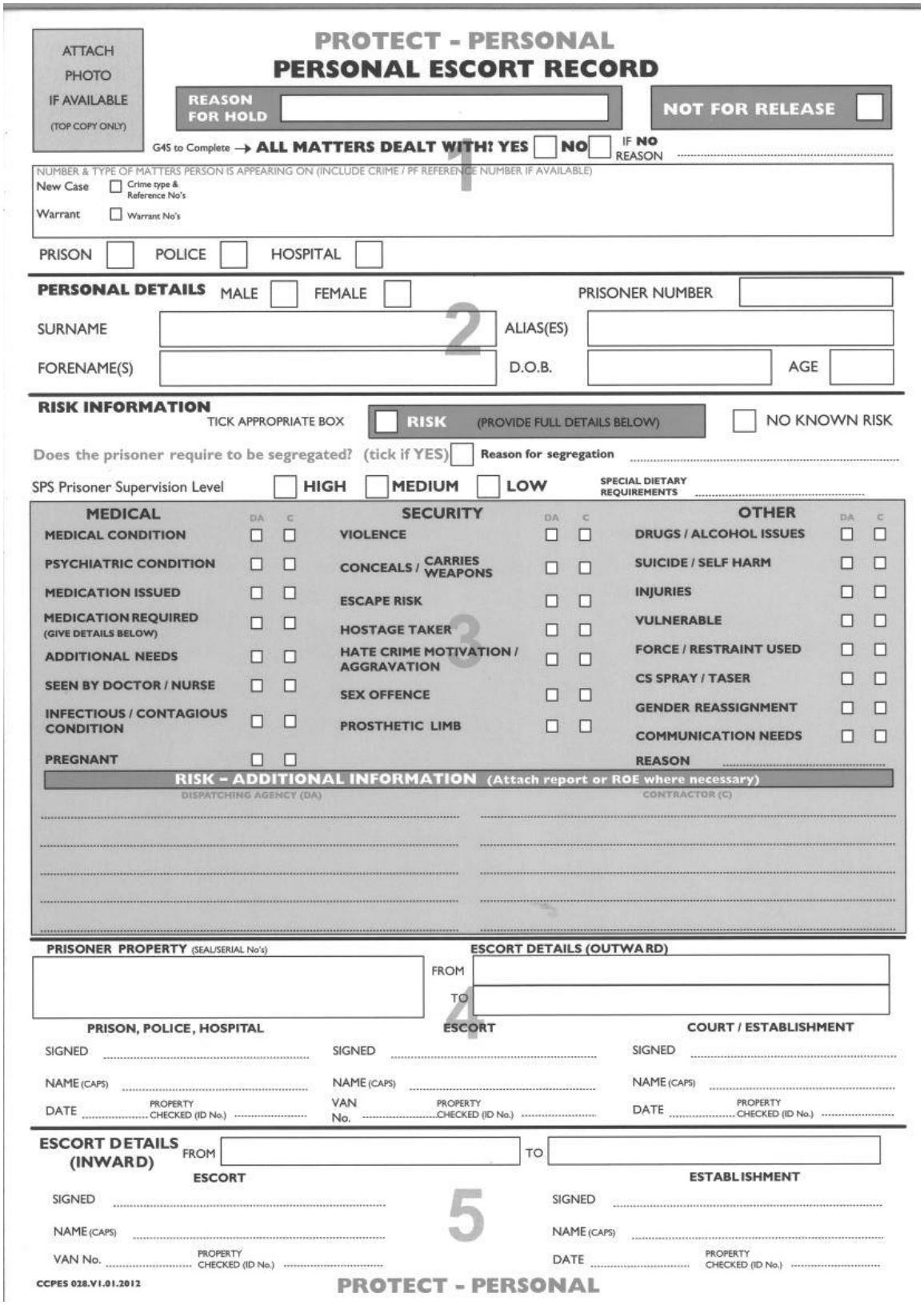
Nurse/Admin Signature: .....

This referral form will be returned to you with an appointment date or advising that you have been added to the appropriate waiting list.

Failure to complete all parts of this form will result in no appointment being made.

Appendix K. Personal Escort Record

Personal Escort Record.



PROTECT - PERSONAL

PERSONAL ESCORT RECORD

ATTACH PHOTO IF AVAILABLE (TOP COPY ONLY)

REASON FOR HOLD

NOT FOR RELEASE

G4S to Complete → ALL MATTERS DEALT WITH? YES NO IF NO REASON

1

NUMBER & TYPE OF MATTERS PERSON IS APPEARING ON (INCLUDE CRIME / PF REFERENCE NUMBER IF AVAILABLE)

New Case Crime type & Reference No's

Warrant Warrant No's

PRISON POLICE HOSPITAL

PERSONAL DETAILS MALE FEMALE PRISONER NUMBER

2

SURNAME ALIAS(ES)

FORENAME(S) D.O.B. AGE

RISK INFORMATION TICK APPROPRIATE BOX RISK (PROVIDE FULL DETAILS BELOW) NO KNOWN RISK

Does the prisoner require to be segregated? (tick if YES) Reason for segregation

SPS Prisoner Supervision Level HIGH MEDIUM LOW SPECIAL DIETARY REQUIREMENTS

3

MEDICAL	DA	C	SECURITY	DA	C	OTHER	DA	C
MEDICAL CONDITION			VIOLENCE			DRUGS / ALCOHOL ISSUES		
PSYCHIATRIC CONDITION			CONCEALS / CARRIES WEAPONS			SUICIDE / SELF HARM		
MEDICATION ISSUED			ESCAPE RISK			INJURIES		
MEDICATION REQUIRED (GIVE DETAILS BELOW)			HOSTAGE TAKER			VULNERABLE		
ADDITIONAL NEEDS			HATE CRIME MOTIVATION / AGGRAVATION			FORCE / RESTRAINT USED		
SEEN BY DOCTOR / NURSE			SEX OFFENCE			CS SPRAY / TASER		
INFECTIOUS / CONTAGIOUS CONDITION			PROSTHETIC LIMB			GENDER REASSIGNMENT		
PREGNANT						COMMUNICATION NEEDS		
						REASON		

RISK - ADDITIONAL INFORMATION (Attach report or ROE where necessary)

DISPATCHING AGENCY (DA) CONTRACTOR (C)

PRISONER PROPERTY (SEAL/SERIAL No's)

ESCORT DETAILS (OUTWARD)

FROM

TO

4

PRISON, POLICE, HOSPITAL ESCORT COURT / ESTABLISHMENT

SIGNED SIGNED SIGNED

NAME (CAPS) NAME (CAPS) NAME (CAPS)

DATE PROPERTY CHECKED (ID No.) VAN No. PROPERTY CHECKED (ID No.) DATE PROPERTY CHECKED (ID No.)

ESCORT DETAILS (INWARD) FROM TO

ESCORT ESTABLISHMENT

5

SIGNED SIGNED

NAME (CAPS) NAME (CAPS)

VAN No. PROPERTY CHECKED (ID No.) DATE PROPERTY CHECKED (ID No.)

CCPES 028.V1.01.2012

PROTECT - PERSONAL

Appendix L. Poland's notation for transcribers

Poland's notation for transcribers.

Pauses.

Denote short pauses during talking by a series of dots (…), the length of which depends on the amount of time elapsed (e.g. two dots for less than half a second, three dots for one second, four dots for one and half seconds). Denote longer pauses with the word pause in parentheses. Use '(pause)' for two- to three-second breaks and '(long pause)' to indicate pauses of four or more seconds.

Laughing, coughing, etc.

Indicate in parentheses; for example, '(coughs)', '(sigh)', '(sneeze)'. Use '(laughing)' to denote one person, '(laughter)' to denote several laughing.

Interruptions.

Indicate when someone's speech is broken off mid-sentence by including a hyphen (-) at the point where the interruption occurs (e.g. 'What do you- ')

Emphasis.

Use caps to denote strong emphasis, for example 'He did WHAT?'

From Poland (2002, p.641).