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Carswell, C., Noble, H., & Farrow, D. (2017). Barriers between offenders and primary health care after release from prison: A case study. *Practice Nursing*, 28(9), 386-389. Advance online publication. <https://doi.org/10.12968/pnur.2017.28.9.386>

**Published in:**  
Practice Nursing

**Document Version:**  
Peer reviewed version

**Queen's University Belfast - Research Portal:**  
[Link to publication record in Queen's University Belfast Research Portal](#)

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Barriers preventing offenders from accessing primary healthcare on release  
from prison: A Case Study

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## **Background**

The transition period from prison to the community is a high risk time for offenders, with post-release prisoners reporting a lack of support and increased levels of stress resulting from the process of reintegrating into the community (Binswanger et al., 2012; Vail et al., 2017). Mortality rates during the first two weeks following release can be as much as 12.5 times higher than the general population (Binswanger et al., 2012), and suicide peak one month after release from prison (Pratt et al., 2006). There is also a higher morbidity rate, with recently released prisoners being over-represented in emergency department attendance and admissions to hospital (Frank et al., 2013). Mental health is also a commonly identified problem, with 70% of sentenced prisoners in Northern Ireland having two or more mental health conditions (Northern Ireland Assembly, 2011), compared to 19% of the general population (Mental Health Foundation, 2017). This transition period is also a time where individuals with a history of substance misuse are vulnerable to relapse or overdose (Binswanger et al., 2013). Primary healthcare is a necessary support for post-release prisoners, and is the first step in accessing more specialised healthcare services – such as substance misuse programmes and mental health treatment (Lord Bradley, 2009; Kinner et al., 2015). Continuity of care can be particularly poor during high risk transition periods for offenders, such as the transition from prison to the community (Clinks, 2014; Vail, 2017).

The National Institute of Health Research published ‘Care for Offenders Continuity and Access’ (COCOA) in June 2012 (NIHR, 2012). This report explored health inequalities and the problems that prisoners in England and Wales experienced in the continuity of their healthcare. It was found that prisoners tended to suffer from at least one chronic health problem, and that 1/3 of offenders had longstanding physical conditions that required long term treatment. It also found that access to services was easier while in prison, and that there are substantial issues on continuing this care upon release into the community. Charitable services in the voluntary sector were also perceived as more accessible than statutory primary healthcare services, such as GPs.

Key barriers identified preventing access to statutory healthcare services include problems with registering with GPs, long waiting times for appointments, and an expectation of poor quality of service because of the negative perception of offenders (Binswanger et al., 2011; NIHR, 2012). There are also issues with healthcare access such as an inability to refill chronic medications, short-term courses of medication upon release from prison, and the feeling of not being supported by services, such as probation (Binswanger et al., 2011).

This case study presents a post-release prisoner’s experience of accessing primary health care services and the difficulties that they encountered. The individual in this study was a resident in probation approved accommodation in Northern Ireland and will be referred to by the pseudonym ‘John’, in order to maintain confidentiality.

## **Care Presentation: John**

Probation approved accommodation is a form of housing that provides support for post-release prisoners to help them develop skills to live independently, and manage risk in the

community (Mair and Rungay, 2014). Northern Ireland has seven approved premises which are monitored by the Criminal Justice Inspectorate Northern Ireland. Each is staffed 24 hours a day by social workers and support workers, who monitor license agreements and provide support for the residents. Community relationships with approved premises can be strained, and incidents of vandalism, verbal abuse, pickets and petitions asking for their removal have been recorded (CJINI, 2013)

John is a 48 year old man who was originally convicted of sexual offences against children, and was released from prison under Article 26 of the Criminal Justice (Northern Ireland) Order (1996). An Article 26 license is imposed by a court when a prisoner is granted parole, and imposes a requirement to be supervised by probation services and adhere to a number of conditions over a set period of time, otherwise the prisoner can be recalled to prison Probation Board Northern Ireland, 2006). John had a number of conditions on his license; these included adhering to morning, afternoon and evening curfews, restrictions on contact with children (such as being unable to live in a residence within a certain distance from schools and parks) and the requirement to live in probation approved accommodation.

John had a number of chronic health conditions. These included a diagnosis of ischaemic heart disease and peripheral arterial disease. John was prescribed low-dose aspirin, a statin to reduce his levels of low-density lipoprotein cholesterol and an anti-hypertensive. He was also on a waiting list to receive surgery to treat his peripheral vascular disease, which is only indicated in the most severe cases (NICE, 2012). A study conducted by Howell et al. (2016) found a significant relationship between incarceration, hypertension and cardiovascular disease. Uncontrolled blood pressure was found to worsen during the transition period from prison to the community. While this case study focuses on one individual the health problems presented are common in post-release prisoners in general (Howell et al., 2016).

### **Management and Outcome**

On arrival at the hostel each resident undergoes an induction and is allocated a keyworker; a member of staff who is responsible for monitoring their risks, maintaining close contact with their probation officer and provides support to help them live independently. On release from prison John had a two day supply of his medication and was not registered with a GP, which is a common issue experienced by post-release prisoners in Northern Ireland (CJINI, 2013). This meant that John needed to register with a GP in order to receive another prescription and collect a new supply of medication. John brought this issue to the attention of staff the day after arrival, meaning that by this point John only possessed a one day supply of medication and was in urgent need of a new prescription. Staff informed John that to access his Medication he would need to register with a GP in the local catchment area. His allocated keyworker then contacted the local GP practices to see whether they had capacity for another patient.

Due to the criminal history of the residents at the hostel there is a poor relationship between the hostel and the community. This has taken the form of regular vandalism, public protests and verbal abuse towards staff. This poor relationship applies to local GP practices as well.

The manager reports that on one occasion he had received a letter from a practice requesting that they no longer send residents to register with them, despite them still having capacity for patients. COCOA (NIHR, 2012) reported that stigma contributes to post-release prisoners' difficulty accessing healthcare services. The keyworker was informed by the local GP practices that they were at capacity, and one, which had capacity, refused to register John without photographic identification. Lack of photographic identification on release from prison is a common problem faced by post-release prisoners (CJINI, 2013). Application and collection for photographic ID would take an additional amount of time, and John was in immediate need of his medication. The staff therefore decided to contact the citizen's advice bureau in order to assess their options.

The citizen's advice bureau informed John's keyworker that, according to NHS guidelines, photographic identification is not a requirement for registration and that having a policy that requires photographic ID for registration is discriminatory as it prevents certain people from accessing healthcare - this includes not only post-release prisoners but also asylum seekers and homeless people (NHS, 2015). Staff were informed that if the GP practice had a policy that required some form of documentation for registration, then a letter confirming John's residence at the hostel from the manager should be sufficient to act as proof of address. They were also informed that any refusal should be provided in writing. John's keyworker once again made contact with a local GP surgery that finally agreed to register John, however he was informed there would be a wait of two weeks before John would be able to see the doctor.

While long waiting times are common in the community and are not specific to post-release offenders, it is the fact that prisons do not provide enough medication on discharge to cover this waiting time that further compounds the health inequalities in this population. Despite the fact that John was successfully registered with a GP, he was still unable to access his prescription as he had to wait for an appointment to be assessed. The General Medical Council guidelines (2013) on prescribing state that a prescription should only be made if the doctor has adequate knowledge of the patient and their needs. John's new GP did not have his medical records and he was completely new to their service, meaning that an assessment would need to be made before a prescription could safely be issued.

To resolve this John's keyworker contacted the prison where had John had previously been incarcerated and explained the situation, citing John's health problems, his prescribed medications and the issue with accessing primary care services. John's previous doctor agreed to issue a one-off repeat prescription that would last him until he was able to access his GP, and John was able to collect this prescription from a local pharmacy. This is not standard practice, and was the result of the physical nature and severity of John's conditions.

### **Discussion**

This case study highlights three main issues that post-release prisoners encounter when trying to access primary healthcare services in the community, following release from prison. These are:

- The short supply of medication provided to individuals on release;
- The long waiting time for an initial GP appointment in the community;
- The poor relationships between criminal justice services and local primary care practices.

It is the combination of these three factors that have the potential to contribute to the health inequalities of post-release prisoners. Long waiting times in the community are a common experience due to pressures on the NHS (YouGov, 2013), however prisoners are not provided with a medication supply that takes this into account, and do not always have access to avenues to obtain repeat prescriptions (CJINI, 2013).

While some research has found health benefits of incarceration, with improvements in mental and physical health while in prison because of improved access to services while incarcerated (Shaw, 2011), there is a dramatic decline in health following release from prison, making post-release prisoners a higher risk population than currently incarcerated offenders (Kinner et al., 2015). As a result of this decline in health, and the high mortality and suicide rates post-release from prison (Binswanger et al., 2012; Vail et al., 2017) it is essential that this transition period is made as smooth as possible.

There are a number of potential changes that can be made to address the identified issues. Discharge planning is an area that has been repeatedly identified as unsatisfactory (Shaw, 2011; Binswanger et al., 2013; Lloyd et al., 2015). Haley et al. (2014) found that HIV positive post-release prisoners experienced a period of non-adherence to anti-retroviral medication because of a delay in the initiation of care. The short supply of medication provided to prisoners on release from prison has been identified previously as a significant barrier to continuity of care, and is thought to place additional pressure on post-release prisoners during this highly stressful transition period (Lloyd et al., 2015). A simple solution to this issue would be providing prisoners with an adequate supply of medication on discharge, which takes into account the waiting times for GP appointments in the community. (NIHR, 2012; CJINI, 2013)

There is a need to formalise primary care pathways for prisoners being released into the community in Northern Ireland (CJINI, 2016). The COCOA report (NIHR, 2012) recommended that transfer of medical records be improved, and that community primary care be arranged prior to release from prison. While a significant amount of practices require registration in person, it would be worth establishing communication between prison services and primary care practices in order to find ways to make this transition of care (Lloyd et al., 2015). If an individual in the community is discharged from hospital they are provided with a GP letter and discharge summary, ensuring they can access a repeat prescription of medication if needed (Care Quality Commission, 2009). GP registration prior to release from prison, and provision of discharge summary, would ensure that post-release prisoners could access the medication they need while awaiting GP appointments.

There is also a need for further research in this area; the literature has shown that post-release prisoner's experience of stigma can result in an entrenched avoidance and mistrust of the system, leading to failure to engage with services. One potential area for exploration is looking at the difficulties that primary care practitioners face when providing care for post-release prisoners. Due to the high morbidity rate, the high prevalence of psychiatric disorders and substance misuse disorders in this population they may represent a substantial burden to primary care practices. Research could also be conducted comparing access of post-release prisoners to other vulnerable groups, such as the homeless, and look at the interface between these vulnerabilities – 30% of prisoners are homeless when they enter the criminal justice system (NIHR, 2012). The majority of research in this area has also been qualitative, so further research looking into the quantitative difference between the general population and post-release offenders in terms of engagement in healthcare services could be useful to highlight any inequalities.

In conclusion, there are significant risks associated with the transition from prison to the community, and post-release prisoners are a vulnerable population with a range of complex health conditions (Binswanger et al., 2013). There are a variety of barriers affecting post-release prisoners from accessing primary healthcare, ranging from planning for discharge while they are in prison, to the stigma they experience within the community setting (Binswanger et al., 2011; Kinner et al., 2015). This case study illustrates how an inadequate supply of essential medication, poor relationships between approved accommodation and primary care practices, and long waiting times for appointments made it difficult for John to access the healthcare he required. These problems are consistent with previous literature on the subject and recent reports by regulatory bodies and health agencies (Binswanger et al., 2011; NIHR, 2012; CJINI, 2016). While this case was successfully resolved by hostel staff advocating for John, it is likely to have caused additional stress to a vulnerable individual during a particularly difficult time. It could have had a particularly detrimental effect on John's health if he had conditions where medication administration is time sensitive, such as in Parkinson's disease (Nutt et al., 1984) or insulin dependent diabetes mellitus (Dimitriadis and Gerich, 1983). It is therefore imperative that primary care services and criminal justice services work together to identify and develop good practice to promote the continuity of safe care to this vulnerable population.

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