Healthcare inequality for people experiencing homelessness during and transitioning from prison

Crisis

#HealthNow

Acknowledgments

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Cover image: #Healthnow members gathering to rehearse at the Star and Shadow in Newcastle, preparing for the event to launch the research and to engage stakeholders in exploring change through creative tools.

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Foreword by peer researchers

"This research was much needed and a long time coming. People who are or have been to prison are often considered and treated like second class citizens. I fully understand why people are sent to jail but cannot for the life of me get my head around how basic human rights are being denied (withholding of medical attention, transfer of records, verbal abuse to name a few) to men and women being held in prison. Human rights are rights for all humans regardless of all other factors, criminal record included, and I think we have proved here that this situation has far reaching repercussions that can lead to ex-offenders ending up back in prison, homeless and very physically and mentally ill. This cannot be allowed to continue."

James, peer researcher.

"I didn't hear anything that surprised me from our participants as I'd been there and had similar experience of a broken system."

Jeff, peer researcher.

"My understanding of prison was that it was meant to "rehabilitate", but what our research made glaringly obvious was that this is very much not the case. It was difficult to listen to the interviews at times, what some of our participants have endured is a blatant infringement of basic human rights, further compounded by a woefully inadequate and fragmented process on re-entering society.

The inextricable link between health and homelessness is undisputed, our research continually highlighted and evidenced this link.

That an alleged democratic society deems this appalling treatment acceptable shocked me to the core, most of our interviewees simply wanted the chance to be a valid contributing member of society, a chance they had very clearly not been given."

Carol, peer researcher.

Executive summary

#HealthNow is a UK-wide campaign, working towards an inclusive health system where everyone has access to the healthcare they need and reducing their chances of homelessness.

#HealthNow is led by Groundswell and delivered in partnership with national charities Crisis and Shelter. In Newcastle, homelessness charity Crisis is responsible for delivering #HealthNow.

In Newcastle, from July 2021 to August 2022, three peer researchers put together and carried out a study that sought to better understand the experiences of healthcare for people in prison as they return into the community, and how this connects to homelessness.

29 semi-structured interviews with people recently or currently experiencing homelessness were carried out. The project was managed by an external project manager, who facilitated all elements of the project and offered assistance to peer researchers throughout. Additionally, the peer researchers were provided with support, both practically and emotionally, from Crisis Skylight and supported each other at all stages. They aimed to explore:

- healthcare inequality for people experiencing homelessness during and transitioning from prison
- people's experiences of healthcare inequality as they transition from prison into the community and into homelessness (including any form of temporary accommodation).

This peer-led study provides empirical evidence highlighting issues that people in prison face when trying to access healthcare, and problems faced with the transition of this into the community. It further illustrates that these issues have an impact on the suitability of temporary accommodation and later their longer-term housing. Additionally, when people are released without a fixed abode, the research shows how unaddressed health needs intersect with the challenges this poses. It places them in risky and dangerous situations and arguably makes accessing community healthcare even harder. The key themes identified in Newcastle were:

Healthcare before incarceration and during incarceration

Most participants had an extensive range of physical and psychological health issues, often intertwined with substance use of drugs and alcohol before going into prison. These healthcare issues continued and often escalated in prison due to a lack of adequate treatment and support. Some respondents developed healthcare issues while in prison, which is linked to the prison environment and poor conditions.

Healthcare in prison is poor

Overall waiting to see healthcare professionals, including seeing the dentist, was too long or did not occur. Serious conditions were often left untreated, whether this was through medication or holistic support or both. There were also issues with gaining medication and accessing the correct medication. The stories highlight the impact the inadequate system had on respondents and bring attention to an inconsistent system.

Acceptance of the inadequate system

Many respondents reported giving up on seeking healthcare support because they knew there was no point in trying to get medication or support. This led to some participants self-medicating or learning how to treat their own aliments. Their stories also highlight a lack of choice and control over how their health needs are responded to by healthcare staff and correctional officers.

Lack of training and attitudes of healthcare staff (in the community and in prison) and correctional officers' impact on responses and treatment

The treatment of individuals with mental health needs seems to be impacted by a lack of correctional staff training as they failed to provide an adequate or sympathetic response. Further, attitudes of healthcare staff in and out of prison are arguably grounded in discrimination. Participants felt stigmatised or labelled in relation to homelessness and past criminal behaviour. Some respondents felt healthcare staff abused their power and made decisions about who should get medication and support based on behaviour, favouritism, or a desire to dispense any medication with the aim of "keeping them quiet".

Communication and information issues

Issues with the passing of records from the community to prison, and prison back to community was identified by several participants. This impacted on gaining medication and treatment in prison and upon release.

Housing

Physical and mental health difficulties, which often intersected with substance use of drugs and alcohol, alongside broader social inequalities such as a lack of financial security, were not considered before respondents were "resettled" into the community. In turn, this impacted on their ability to engage with healthcare services and other key organisations. Some respondents were released with no fixed abode, which had serious implications including rape and assaults.

While participants acknowledged suitable housing was key to their ability to "resettle", many told us they needed support to rebuild their lives, which included accessing healthcare. The difference effective support made is well highlighted. The findings point towards the need for holistic, individual, and integrated responses.

Opposite image: Members of the #HealthNow and creative team filming a Newspaper Theatre piece about transfer of healthcare from prisons.

Wider issues

Data indicates that wider issues have arguably impacted on incarcerated people (IP) and previously incarcerated people (PIP). This includes poor conditions in prisons, cell sharing, professionals' attitudes in prisons and the community, a lack of training, silo working, and the transfer of records and communication issues.

These findings have been used to inform this report, which will be shared with stakeholders, decision-makers and the Crisis Skylight research and evaluation team. Additionally, an Arts Council grant has been secured to create theatrical pieces which aim to influence public policy. The findings and recommendations are likely to be presented to the wider public at conferences. They may also be published in an empirical journal.

1. Introduction to #HealthNow

#HealthNow is a UK-based campaign which aims to work towards an inclusive health system which provides everyone with the access they need and ultimately moving people out of homelessness.

#HealthNow is led by Groundswell and delivered in partnership with national charities Crisis and Shelter. Groundswell works with people who have experienced or are experiencing homelessness. They offer opportunities for them to be involved in key activities, such as being a Homeless Health Peer Advocate (HHPA) and Peer Research roles, which, in turn, helps promote their inclusion in society and aids others who are experiencing homelessness. The ultimate aim is to create solutions to end homelessness. In Newcastle, homelessness charity Crisis is delivering #HeathNow. This involves managing the local HHPA service and leading the local #HealthNow alliance across Newcastle.

The #HealthNow alliance brings together local people and organisations spanning the homelessness and health sectors and is led by local peers with experience of homelessness. This means peers set the agenda working with stakeholders to create solutions to key issues and can hold decision-makers accountable.

The #HealthNow alliance provides a way to explore and cultivate solutions to health inequalities for people experiencing homelessness locally and will co-produce an action plan based on the findings from this research. Moreover, the local activities, insight and changes will inform the national #HealthNow campaign leading to nationwide actions being adopted to improve the health of people experiencing homelessness.

2. Background

2.1 Homelessness, health and offending behaviour

Homelessness is the term used to describe people who are street homeless and those that have insecure accommodation. This includes people who are facing eviction, living in temporary accommodation (including hostels), squatting, are at risk of violence in their homes; those housed in unsuitable accommodation due to overcrowding and other factors which are potentially damaging to their health, people who are sofa surfing, and those who are at risk of homelessness because they are unable to afford their current accommodation.[1]

There is a well-established link between health and homelessness.[2] Health outcomes for those that experience homelessness are significantly worse than the general population.[3] This is due to practical, social, systemic, administrative and attitudinal barriers people experiencing homelessness frequently encounter when accessing and using health services.[4] It seems this can cause premature death. In 2020, the average age at death was 45.9 for men and 41.6 for women, which is more than 30 years lower than the average age at death of the general population of England and Wales.[5]

Furthermore, recent figures in the UK indicate that deaths among those experiencing homelessness rose by 80% in a three-year period, from 710 in 2019 to 1,286 in 2021.[6] The numbers include people sleeping rough, those placed in emergency accommodation and hostels, and those in insecure or dangerous accommodation run by unregulated landlords and funded by taxpayers. Both drug and alcohol abuse are particularly common causes of death, and people experiencing homelessness are nine times more likely to die of suicide.[7] Additionally, rates of diagnosed respiratory health conditions and lung disease are dramatically higher.[8]

People experiencing homelessness are also more at risk of long-term physical health problems (41% compared to 28%), and more likely to be diagnosed with a mental ill health (45% compared to 25%).[9]

Homelessness is a predictor for the onset and persistence of offending behaviour.[10] Spending time in prison increases the risk of homelessness, and then a lack of stable accommodation can increase the risk of (re) offending, which can lead to a negative cycle of repeated episodes of homelessness and imprisonment. Moreover, although health inequality is not the only factor contributing to offending behaviour, there is a recognised link between the two. Research examining offending behaviour and health mainly focuses on alcohol and substance use, and demonstrates these are contributory factors and in some cases determinants of an individual's propensity towards crime.[11] Further, while the relationship between mental health issues and offending is complex,[12] it has been found that levels of mental illness among those in the criminal justice system is higher than the general population.[13]

2.2 Health before incarceration and during incarceration

Incarcerated people (IP) suffer from worse health in comparison to the general population,[14] which includes chronic health conditions,[15] mental health disorders,[16] and nutritional deficiencies.[17] In the UK, chronic conditions for IP include musculoskeletal problems, diabetes, epilepsy, learning difficulties, hypertension, and gastrointestinal disorders.[18] It has been suggested that IP have worse health than the general population because they are largely drawn from marginalised segments of society, living in conditions (particularly homelessness) that foster poor physical and mental health outcomes.[19] Further, similarly to people who are homeless, IP health is compounded by unhealthy behaviours such as high sugar diets, smoking, alcohol use, substance use and poor engagement with routine oral healthcare services which leads to poorer general and oral health than age matched non-imprisoned people.[20] Consequently, it seems people who experience incarceration would have been in poor health irrespective, particularly if they were homeless, but emergent research consistently highlights that the experience of prison can act as a catalyst that accelerates worsening health[21] and increases the risk of homelessness.[22]

As the discipline, diet, labour requirements, accommodation and general living conditions of penal institutions remain sufficiently unpleasant,[23] the experience of incarceration and general prison environment is likely to impact on both physical and mental health.[24] Conditions are amplified due to overcrowding, limited access to basic healthcare services, living in confined spaces with limited options for exercise, and inhumane attitudes and practices of staff.[25] Moreover, despite increased healthcare needs of IP, there is a lack of discipline officers to escort IP to hospital appointments, which has led to an increase of the number of missed medical appointments.[26]

Furthermore, IP frequently report long delays in having their health concerns acted upon, which include worryingly symptoms not being responded to in a timely manner.[27]

The current restrictive prison regime caused by loss of prison staff has also meant that staff are less likely to identify prisoners with mental health issues, and on average 15% of medical appointments are missed largely because of a lack of staff to escort them.[28]

In parallel with staffing issues, evidence suggests that interactions with staff and healthcare professionals impact on IP health and wellbeing and can affect their access to healthcare. In a qualitative study carried out in the UK that interviewed 111 prisoners in 12 prisons, the importance of building "good rapport" with staff was seen as an important factor determining access to healthcare.[29] In another UK study that explored the Incentives and Earned Privileges (IEP) scheme, which incentivises IP to be more involved in their rehabilitation through rewards for behaving well, it was found that IPs that were able to subvert policy requirements that require engagement in purposeful activity and a commitment to rehabilitation and reducing risk of offending, through established relationships with staff, where they had built rapport.[30]

Although staffing issues and their attitudes cannot be overlooked, the fluctuations in accessing healthcare and treatment are potentially affected by the different systems that operate in prisons across the UK. Examining 12 prisons in England, it was found that when IP enter prison from court or as a transfer from another prison, in some prisons the nurse who oversaw their initial health assessment could start substitute medication immediately, while in others prisoners waited over a day to see a doctor who could prescribe substitute medication, which caused mental and physical distress.[31] It was further found that the overuse of paracetamol to treat conditions that required stronger medication was perceived as stemming from strict governor's rules about the types of medication that can be prescribed. For several IP this caused problems after being prescribed a drug at hospital, which could then no longer be given in prison.

The issues with gaining the correct medication and treatment in prison might also be compounded by issues with the transfer of information between healthcare and prisons. Due to these problems, assessments are duplicated which is time consuming and can lead to delays in timely interventions and treatment.[32]

While it can be argued that most IP experience the harmful effects of prison and have issues accessing healthcare, particular groups have been highlighted as being particularly exposed. Prison structures and practices fail to take account of certain groups such as women, and those that have disabilities, including physical, mental, and learning difficulties.

This makes daily prison life significantly harder to navigate, which can lead to increased negative health outcomes.[33] People with a learning disability are also significantly more likely to experience health inequalities and are less able to access healthcare services.[34] Moreover, accessing healthcare in prison for women is a long-standing issue, which is likely to be a symptom of wider issues around staff availability and resources.[35] Staff do not always communicate effectively which leaves women uncertain about when appointments will happen, in turn causing significant stress.

Issues with ensuring the health and wellbeing of prisoners and their access to healthcare was put under enhanced strain during the Covid-19 pandemic.[36] Before the pandemic, prisons were already under pressure due to budget cuts, lack of staff, overcrowding, and high levels of violence, suicide and self-harm.[37] The onset of Covid-19 added to these issues.[38]

Recent studies reveal lockdown in prisons had a negative effect on prisoners.[39] IP were often confined to their cells for 23 hours a day and largely unable to see or speak to family, friends, or support staff. In turn, this caused feelings of heightened isolation and detachment from family and friends and there were diminished opportunities for exercise, education, self-improvement and access to healthcare. Consequently, prisoners' quality of life deteriorated, a high proportion developed anxiety and/or depression, many put on weight, and some also experienced stress and/or worry.

2.3 The transition from prison to the community

The transition from prison back into the community is rife with challenges due to a complex mix of individual and systematic barriers. Previously incarcerated people (PIP) are likely to have lost their jobs, relationships with family and social support networks may have been harmed, and they may have no fixed abode to return to.[40] Additionally, PIP are at increased risk of poor oral health,[41] diabetes,[42] stress related disease,[43] and there is an increased risk of mortality immediately after and years after release.[44] As homelessness also increases the risk of mortality,[45] when homelessness intersects with previous incarceration, it can be inferred that the risk of death is heightened.

Despite experiencing multiple disadvantages, on release PIP often have a long and intimidating list of appointments and activities to complete to obtain benefits, accommodation and medication.[46] This causes stress and often it is impossible to complete all the requirements in the time given, which is why support is required before release to arrange matters such securing housing and benefits. Without an adequate holistic support system to facilitate reintegration back into the community, PIP are less likely to gain employment, access proper healthcare, and foster healthy relationships.[47] In turn, this harms their overall health and wellbeing, which can lead to drug overdose and suicide. Further, the absence of protective factors such as good health, suitable accommodation, family support and employment can lead to reoffending.[48]

The issues PIP face when transitioning into the community are escalated when they have served a short sentence.[49] In these cases, people's needs are often not identified early enough to put support into place for their release. Additionally, poor coordination across services and an absence of sharing relevant information means PIP (irrespective of sentence length) do not always receive the holistic and joined up support they need. This can lead to prisoners being released street homeless or to unsafe, unsuitable or insecure accommodation. Although the experience of sleeping rough is awful for anyone, it can result in horrendous experiences for women, which often includes increased risk of sexual abuse and physical violence.[50] Moreover, a lack of contact details for those of no fixed abode often results in healthcare services failing to follow up on those newly released from prison.[51] Notwithstanding this, the issues of coordination between services and the lack of sharing information impacts on the continuity of care for all PIP with health needs.[52] A number of barriers to continuity of care have been highlighted in the UK, including a lack of two-way communication between the prison and community treatment providers, referrals not being received, release dates not being communicated, and attendance rates in the community following release being low with limited follow up.[53]

Health problems have a detrimental impact on attempts of PIPs to stabilise their lives. But when this is combined with homelessness, their disadvantaged position is escalated, effecting their ability to engage in a meaningful way with support services, including healthcare.[54] Both PIP and those experiencing homelessness are often stigmatised, which undermines autonomy and prevents them from seeking out services or fully engaging with them.[55] For instance, research in the UK with people experiencing homelessness has highlighted how they feel judged, stigmatised and dismissed by their GP.[56] In turn this prevented them from receiving adequate help and prevented others from going to their GP again to address ongoing heath issues, or to access medication to enable recovery from ill-health. Likewise, PIP have expressed concerns about being stigmatised or labelled as a criminal by GPs,[57] which could negatively impact on engagement. It can also increase psychological distress.[58]

Another significant factor contributing to a lack of engagement is the lack of flexibility within services to work around complex individual needs. Despite calls for holistic, individualised and integrated responses to address the overlapping needs of PIP, including ensuring their health and housing needs are met, such practices are rare.[59] In the current climate such approaches bring about significant challenges such as securing long-term funding and evidencing outcomes.[60] Consequently, many services face uncertain futures, whilst many prisons and communities have little or no provision at all.

However, a failure to work with the whole needs and strengths of PIP fails to help address their interconnected problems, including health and homelessness, or risk of it, and does not support desistance from crime.

Above image: Members of the #HealthNow team rehearsing 'Anna's Story', as part of the creative work to express the peer research members did about transfer of healthcare from prisons and issues associated with prison and homelessness.

1 Crisis (n.d)
2 Groundswell (2021)
3 Thomas (2011)
4 Groundswell (2021)
5 Office for National statistics (2021)
6 Museum of Homelessness (2022)
7 Thomas (2012)
8 Burrows (2016)
9 Homeless Link (2014)
10 Dore (2019) and Williams et al (2012)
11 Her Majesty's Inspectorate of Probation (HMIP) (2021); Keay (2014)
12 Peay (2010)
13 HMIP (2021b)
14 Binswanger et al (2009); and Wilper et al (2009)
15 Wang et al (2009)
16 Fazel and Baillargeon (2011); Royal College of Physicians (2018)
17 Nwosu et al (2014)
18 Heidari et al (2014); Payne-James et al (2010)
19 Royal College of Physicians (2018); Wakefield and Uggen (2010)
20 Burrows (2016); Thomas (2011); Heidari et al (2014); and Homeless Link (2014).
21 Brinkley-Rubinstein (2013); Massoglia (2008); Massoglia and Remster (2019); Schinittker and John (2007); Wildman and Wang (2017)
22 Dore (2019); and Williams et al (2012)
23 Garland, G. (2000); Novisky (2018)
24 Jewkes et al (2020); Massoglia (2008)
25 Biswas et al (2015); Condon (2006); Massoglia (2008); Massoglia and Pridemore (2015); Novisky et al (2021)
26 House of Commons (2018); and Ismail (2020)
27 House of Commons (2018)
28 House of Commons (2017)
29 Condon et al (2006)
30 Khan (2022)
31 Condon et al (2006)
32 Byng et al (2012)
33 Loucks (n.d)
34 NHS (2021)
35 Davies et al (2022)
36 User Voice (2022)
37 nstitute for Government (2020); MacDonald et al (2012)
38 Novisky et al (2021); User Voice (2022)
39 Maycock (2021); Suhomlinova et al (2022) and User Voice (2022)
40 Giordano and Copp (2015); Harding et al (2013); and Sheppard (2021)
41 Testa and Fahmy (2020)
42 Rolling et al (2019)
43 Massoglia (2008)
44 Spaulding et al (2011); and Wang (2009)
45 Thomas (2011)
46 Welford et (2021)
47 Brinkley-Rubinstein (2013)
48 Ministry of Justice (2019)
49 Welford et al (2021)
50 Bretherton and Pleace (2018); Menih (2020)
51 Public Health England (2018)
52 Byng et al (2012); Loucks (n.d)
53 Public Health England (2018)
54 Novisky et al (2021)
55 Corrigan et al (2014); Groundswell (2021); Marmot (2004)
56 Groundswell (2021)
57 Annison et al (2019)
58 Turney et al (2013)
59 Annison et al (2019); Welford et al (2021)
60 Ismail (2019)

3. Our aim

Two core aims underpinned this research. These were to explore:

- healthcare inequality for people experiencing homelessness during and transitioning from prison
- people's experiences of healthcare inequality as they transition from prison into the community and into homelessness (including any form of temporary accommodation).

A key element of the #HealthNow campaign is to conduct peer-lead research with the aim of better understanding the local barriers individuals face when accessing health services.

In May 2021 #HealthNow Crisis in partnership with Groundswell published research into health inequalities and homelessness.[61] During data collection, the peer researchers noticed that a significant number of participants spoke about their experiences of healthcare in prison and difficulties they experienced when released back into the community. Many reported that prison healthcare was of a poor standard which continued to impact upon them as they resettled into their community. The peer-researchers who have had similar experiences were thus inspired to investigate this area more. They had a keen desire to establish that there are health inequalities in prison which have negative long-term consequences. It is hoped that by sharing the findings from this current project there will be changes in the system. It is foreseen that progressive and initiative solutions would benefit incarcerated people and recently incarcerated people, alongside key services such as probation and healthcare providers.

61 Groundswell (2021)

4. What we did

From July 2021 to August 2022, three peer volunteer researchers designed and carried out an empirical study that aimed to gain a better understanding of the experiences of healthcare for people in prison and when they return into the community, and how this connects to homelessness (including any form of temporary accommodation).

29 face-to-face, semi-structured interviews were conducted with individuals who had been released from prison within the last four years and who had or were experiencing homelessness. Participants were recruited through gatekeepers which included approved premises, substance misuse organisations, and probation. Crisis members with recent experiences of incarceration were also approached. Each respondent was given a £20 voucher as a show of appreciation for their time. Interviews were carried out at various homelessness accommodation and support services across Newcastle. As interviews had the potential to cause distress, time was provided for emotional recovery during and after the interview, and welfare checks were conducted when necessary.

Informed consent was gained before each interview. Steps were taken to help ensure consent was informed. This included providing information in an accessible manner and highlighting the potential advantages and disadvantages of taking part, in particular the possible distress from recalling personal experiences, and right to withdraw.

To ensure we reflected the direct and in-depth narratives of respondent's experiences interviews were captured through audio recordings and transcribed verbatim. All data collected was treated in accordance with the General Data Protection Regulations (2018) and the Data Protection Act (2018). All participants were assigned a pseudonym of their choice to facilitate anonymity.

This research used a peer-led methodology that is set in an intersectional framework. Taking an intersectional stance allows us to emphasise the interactive and multiplicative nature of structural inequities.[62] Combining this with peer research helps to understand the challenges faced by people experiencing homelessness who also have experiences of incarceration.

Peer-led methodology and intersectionality recognises that those who have experiences of issues are best placed to conduct the research and shed light on the views of others who have shared similar issues.[63] It enables us to gain real stories, insights and experiences from the ground to better understand the challenges faced by people who have been incarcerated alongside experiencing homelessness and health issues. Giving peer researchers the power to shape the research process and listening to the voices of marginalised groups helps challenge the oppressive system and facilitates change.[64] This, in turn, promotes active involvement in the community that helps develop achievable, practical solutions based on the stories of those who have unique insight into how systems work and how and where they do not work.[65]

It can be used to challenge practices and policies which can relegate some groups to lower classes, where they are unable to access or benefit fully from opportunities afforded to those with greater social and cultural capital.[66] Peer researchers were involved in every stage of the research process which included:

- designing research tools including posters to advertise the research, and questions for participants
- reaching out to and responding to relevant organisations to secure interviews
- setting a proposed timeframe
- carrying out interviews with respondents
- supporting analysis of data by taking part in interactive group analysis sessions where common themes were identified and ideas on how findings should be presented in this report were agreed
- decisions regarding how the data, alongside this report, could be disseminated and involvement in putting these into action through arts-based pieces
- presenting the findings to the #HeatlhNow alliance and devising the next steps.

62 Healy (2022)
63 Groundswell (2022)
64 Healy
65 Groundswell (2022)
66 Potter (2013)

5. Who we heard from

Most participants were recruited through a range of means which included drug and alcohol support agencies, homeless hostels, an offending organisation and asking Crisis Skylight members to take part. Consequently, most people we heard from were engaging in some form of current support. This is a limitation because we have not heard from those who are currently disengaged from services or struggling to find and engage with services. All interviews were conducted face to face which helps mitigate issues for those who experience digital exclusion.

While it is recognised the research was limited to those that are to some extent engaging with services, a key aim was to reach out to include a wide variety of people experiencing different types of homelessness. We heard from people who had been street homeless, sofa surfing, stayed with friends or family, or staying in a hostel (including approved premises) or temporary accommodation when they were released. However, no one was currently street homeless, but some had been released with no fixed abode. The majority of participants were currently in temporary accommodation, which included hostels and approved premises.

All participants had been released from prison within the last four years, but some also reflected on past experiences of prison. When respondents reflected on past experiences, peer researchers sought clarification to ensure the analysis of data represented an accurate portrayal of issues as they are now, and past experiences. Past incidents were useful in shedding light on what if any improvements there have been overtime.

Some participants were currently in prison but also had past experiences of incarceration. The sample range thus allowed us to not only capture healthcare issues while in prison, but also the transitional period too. In the main, those we heard from told us about their experiences from prisons in the Northeast of England. However, stories also included prisons from locations outside of the Northeast, including the South and Scotland, which helped reveal differences in treatment in other geographical areas, albeit limited.

Out of the 29 respondents we spoke to, 21 identified as male, 7 identified as female and one identified as non-binary. 97 per cent said their gender identity was the same as it had been at birth. Sexuality was not disclosed or recorded in some instances, but most (eight) said they were heterosexual, with some identifying as bisexual (three). Despite valid efforts to reach out to a diverse range of communities, including asylum seekers, refugees and ethnic minorities, except for one participant, who told us they were White Scottish, and another who identified as White Irish, all respondents classified themselves as White British.

Age was not given by all respondents, but the age range for those that did disclose their age was between 26 and 58 years old. All disclosed having either physical or mental health needs. While all recognised that this impacted on their daily lives, not all identified as disabled and only a small proportion were in receipt of personal independence payments. 28 respondents were in receipt of Universal Credit, and one worked full-time.

6. What we heard

6.1 Health before incarceration and during incarceration

Similarly to past findings,[67] a wide range of physical and psychological health issues were disclosed by participants prior to incarceration, including chronic health conditions and mental health disorders.[68] Most respondents had more than one issue. Further, these were often intertwined with substance use before going into prison. Healthcare issues continued and often escalated in prison[69] due to a lack of adequate treatment and support.

For instance, Kevin told us that prior to incarceration he had an addiction to spice and was on mirtazapine to help him sleep. When he went into prison, there was no support to help him stop using, and he could not get any mirtazapine because they did not have his GP notes. This caused various issues. Commenting on these factors Kevin said:

> **"I went into prison with this horrible spice rattle. They said there is nothing we can give you for that. You are just going to have to get yourself well. So, they would lock us in a room, until I said I felt better. And probably came and checked on you every four to six hours and make sure I was breathing. I couldn't sleep. Had like really bad sweats. I had the shakes really bad, trembling. Really bad anxiety, having heart palpitations. I actually felt like my heart was going to pop, it was getting that bad. (…) I asked them if I could have something to help us sleep, because I was on mirtazapine on the outside. They said they didn't have the note from the doctor, and they couldn't give us it until they got it. They offered us some paracetamol. And I said what am I going to do with them. They said well, something is better than nothing. I was just losing weight rapidly. I didn't have no energy; I couldn't eat my dinner. Food was crap anyway. I went down to eight stone, and I was 25 years old, eight stone."**

The mental and physical distress this caused is apparent and corresponds with past research which shows the impact of waiting for substitution medication on IP.[70] However, this seems to have been exacerbated due to being locked in a room and isolated for hours, which can have negative impacts on psychological and physical health.[71] Further, in this respondent's situation, medication or a substitute medication were never given. It is possible that this is because the issuing of medication stems from strict governor's rules about the types of medication that can be prescribed.[72]

Some respondents developed healthcare issues while in prison. In Mandy's situation she developed healthcare issues which got left for years. She was eventually given ibuprofen, which did nothing to resolve her issues, and there was a failure to tell her it was essential to take these with food. Serious issues to her health were caused as a result. Commenting on this, she said:

> **"I have got a bad bunion and arthritis and that just got left for years and years. I asked for help, but they just not bothered, it never came to anything. Now its knacked, and it sometimes feels like the bone is trying to work its way out my skin. For a long time I was prescribed ibuprofen. (…) Because you get your meds before you eat. So, It's not like I had a full tummy. And moving on, two years later, when I ended up with colitis and I had a tube down my throat, they said I have got oesophagitis as well. So that is all corroded. And that is off the taking ibuprofen and not having the protection there from food."**

It is feasible that the initial extremely long wait, inadequate treatment and failure to advise on how to take medication are linked to the impacts of austerity on prisoner healthcare, issues with accessing basic healthcare services in prison, and attitudes and practices of staff.[73]

Kurt also developed health issues while in prison, but with his mobility:

> **"I used to walk about 10 miles a day. Then by the time I came out of prison this time, I could barely walk 100 yards".**

For Kurt, prison impaired his ability to make free choices for healthy eating which led to weight gain, the quality of the beds caused "terrible back pains" and living in a confined space with limited options for exercise stifled his ability to avoid a sedentary lifestyle. Issues are still not remedied and impact on his mobility. Thus, likewise, to past research and observations, he attributed his health issues to poor conditions and standards in prison.[74]

Covid impact

In a climate that was already struggling, it is not surprising that the impact of Covid-19 caused a dramatic impact on the health and wellbeing of IP.[75] In the present study, a few respondents reflected on their experiences of prisons during lockdown. For instance, Darren 1, who disclosed mental health issues and post traumatic stress disorder (PTSD) from "being locked in the room constantly from when I was a child", told us that him and his sister asked if he could work during the pandemic but was refused.

He explained how work would have helped him because he would have been out of his cell more. However, despite having additional needs, he was refused, even though some other prisoners were still working. Being locked in his cell 23 hours a day impacted on him while in prison and has caused ongoing health issues and a relapse:

> **"My sister said: 'can you not get him a job on the landing or something like that?' They were like no, but I was watching other people getting jobs, favourites. I was sat there 23 hours a day, for three months. So obviously I come out and was struggling. I was struggling walking and things. My legs had seized up. I think I walked from here probably a mile and then I had to sit down, I couldn't walk because my legs seized up. (…) When I come out it was a big shock to the system because I was on 23-hour lockdown, and I just hit the drink again."**

Similarly, but discussing the impact on mental health Lorraine said:

> **"(…) bad for your mental health as well. Being locked in that little room, 24/7 know what I mean? Your mind is ticking over cannot work or nowt. You are just tick, tick, ticking."**

Although the impact of Covid-19 was reflected on by some respondents, many of the experiences discussed occurred before the pandemic and thus it is evidential that the pandemic heightened issues, not caused them.

6.2 Healthcare in prison

The above stories highlight how gaining treatment for healthcare in prisons and the quality of healthcare in prisons is poor. This view was echoed by most respondents who described their healthcare in prisons as *"shit"* (Brian) and accessing healthcare as "null and void" (Alex). For some respondents the absence of support to address healthcare needs was experienced at different times in prison:

> **"I have basically been in prison all my life, through heroin. So, I went and got myself clean. But I then became a drinker, unfortunately like for the last six year. When I was in prison just got basically…left….to. Er…. … they didn't really help us in any way shape or form. There was no support, no one to talk to."**
>
> Debbie.

Tom also experienced a lack of treatment for alcohol misuse and told us about the serious impact on him:

> **"Come to my room every couple of hours. But them couple of hours I could have been dead really. There is more chance of a drinker dying than there is of a heroin or drug user, because they go into fits and stuff. In them couple of hours you know. Not given anything other than paracetamol. There wasn't even like a check your temperature. If you go into detox in hospital they come and check your blood temperature or and if it's through the roof, there is something happening. There's not like that in prison."**

Some respondents disclosed other health issues that were never resolved. For instance, Brian said:

> **"I have been asking to see a doctor since I have been in jail, I have got sciatica, am getting arthritis. But I never seen a doctor."**
>
> Brian.

Den received no response from healthcare staff despite having seizures:

> **"Didn't get any sort of response from them. They just told us to drink plenty of water, and they knew I was having seizures because I told the healthcare. That would have been on my doctors' records, because prior going into prison, I had been to the doctors about it."**

Den's story also possibly highlights issues with the transfer of medical records, which, as returned to later, was a common theme found throughout participants' narratives.

Accessing healthcare and waiting times

Many respondents told us that that accessing healthcare was now through an electronic app. The peer researchers explained that this is an interactive screen that is located on each wing and allows prisoners to apply for services (including healthcare) that were previously accessed by putting an application form in. For Unk this posed difficulties due to his learning difficulties:

> **"So, I would have to go on a screen and read, it is hard for me."**

Despite having diagnosed dyslexia, Unk received no assistance when trying to access healthcare. Thus, the normative system impacted on his ability to access healthcare services.[76]

Although it might be assumed that an electronic system would decrease waiting times, this did not seem to be the case:

> **"And when you go to healthcare, you would be in the queue waiting. And then it would come to time for movements, and you haven't seen the doctor yet. So, you have got to back and queue, so you reapply. And that could be another three months. So, it potentially be eight to nine months before you actually see a doctor."**

One respondent told us that he had *"something wrong with my bladder"* which had been going on for nine years without investigations, despite repeatedly telling prison healthcare about the issue:

> **"It's not an infection. I don't know what it is. I need investigations done. But it's been going on for the last nine years and for ages and ages I keep saying to them there is something wrong. I am going to the toilet five or six times a night which is causing us not to sleep and everything. On my last sentence, obviously Covid struck, and I am still waiting for an appointment now."**
>
> Don.

The issues with waiting times were also discussed in relation to seeing a dentist. For instance, Brian said he never saw a dentist despite needing his teeth "sorted" because the waiting lists were too long. Daniel 1 said he was told he would not see a dentist because he was due to be released in two months:

> **"I started to have toothache the first two days I was there. I asked about it, and they just said, 'well you are getting out in ...two months, we'll just leave it at that.' Didn't give me anything, not even paracetamol, just grin and bear it."**

Darren 1, whose tooth was "crumbling away", echoed a similar story telling us there was at least a six-month waiting list, and thus he had to access a dentist after release. This was despite arguably needing an appointment urgently because:

> **"Literally half my tooth fell out. And it was all down the nerve."**

Impact of lack of healthcare and poor-quality healthcare

Both the lack of healthcare and it's poor quality leads to issues because:

> **"If your healthcare is crap then everything else is a knock-on effect, it screws everything else up."**
>
> Peter.

Discussing the impacts of inadequate healthcare, Briain told us that an absence of treatment for mental health issues escalated his issues:

> **"It's worse. Aye. It's a lot worse. A hell of a lot worse."**

For some, the effect led to attempts to take their life:

> **"I took an overdose in (name of prison), because I was down in the dumps, and no one would listen to me."**
>
> Alan.

Alan's account provides further evidence that there is a high correlation between mental health issues in prisons and the risk of suicide.[77]

Some respondents disclosed that due a refusal to prescribe medication they had been taking prior to incarceration, they found alternative means. For example, Lee told us how he was misusing "codeine, morphine and all the opiate-based pain killers."

When he went into prison, he was told there was nothing they could do, so eventually he self-medicated with methadone:

> **"They just didn't bother, I said I need something, I need to see someone to give us advice on what to do because obviously now I am not using I don't know what to do, I have never been in this position. And I just heard absolutely nothing. And I was going to the hatch, the meds hatch, and they were saying there is nothing we can do. (...) The lad I was sharing the cell with, he started sharing his methadone with us. Which got me through it. Which is an awful thought, thinking back."**

Likewise, Ryan who disclosed he was an alcoholic before going into prison said he was given medication, but this was not enough. This led to mental health difficulties, and he started to make his own drink:

> **"Well, when I first went in, I was on stuff for help me stop ratting from the drink. But they weren't giving us enough. I took two seizures, I told them about it, and they just didn't take any notice. I ended up with mental health. (...) Because the meds they were given us wasn't helping us. So, I thought well why should I put up with making myself hard, risking anything, when I can just make my own drink. Know what I mean? It's not the way forward but... you have got to do what you have got to do; I am afraid."**

Rachel also started to look for something to 'numb' her because the medication prescribed for her mental health issues did not make her feel any different. Conversely, one participant who gained no medical advice or treatment for sciatica went to the library and learnt about it himself:

> **"I got more help getting books out the library than anything else."**
>
> **Anthony.**

While self-medication and self-help were utilised by a few respondents, other narratives indicate how some participants gave up seeking support because they accepted there was nothing else they could do.

6.3 Acceptance of the inadequate system

The stories highlight a lack of choice and control over decisions around healthcare and how ongoing treatment is considered when entering prison. When commenting on accessing healthcare and waiting times in prison Geoff said: "it's just how it is", thus arguably indicating a sense of how IP accept issues because they feel they have no choice and lack power to raise challenges. Acceptance led to some respondents just giving up. For instance, Briain, who told us about difficulties gaining his medication and seeing a doctor, said:

> **"What was the point asking a nurse, because nine times out of 10 she would just pass you. So, I just didn't ask. Because I am not going to get anywhere."**

Similarly, Rachel told us:

> **"I got to a point where I didn't even ask. You just get knocked back anyway. Unless you did something seriously wrong."**

Additionally, a few respondents arguably expressed how they had no choice but to accept methadone instead of medication they were prescribed prior to incarceration. For instance, Mark said he had jumped off a bridge and "smashed all my legs and back and head and stuff like that." He was given medication, but this was refused in prison because it was assumed he would sell it. He thus accepted the prescription for methadone:

> **"(...) on a lot of medication. Morphine tablets, pregabalin, Zopiclone, I was a few different kinds of antibiotics and stuff like that. (...) – soon as I went into prison and I saw the doctor, doctor took us off all the medication. They just took us off it. Because of the tablets I was on, they should have been took down slowly and said that in was on a lot of types of medication that you don't get in this prison. I ended up going onto methadone, basically the doctor said to us either do the rattle off the medication you have been on or...because of your past and you have a lot of addictions, and we don't want you buying drugs on the wings...go on methadone...**

They took us off them because – and I know why it was, they know that they can sell it in prison, and its high value. So, they wouldn't want people like me to sell them drugs in here. Which is ridiculous really because…but, once you go into that prison and you are behind that wall, they can do anything they want."

His story reinforces previous contentions that the issuing of medication in prisons is possibly based on strict governor's rules about the types of medication that can be prescribed.[78] It also draws attention to how healthcare staff possibly judge prisoners and stigmatise them, which was a reoccurring underlying theme in the data. The last sentence also highlights another underlying theme of the nature of power which will be returned to later.

Other respondents told us how they had no choice but to accept a double cell, which can have a negative impact on wellbeing, coping, and negatively impact sleep quality.[79] These respondents had health needs that prison officers were aware of, but no account was taken of these. They all described the impact of being placed in a shared cell. For instance, Peter disclosed PTSD due to childhood abuse. He would wake in the night and hear someone in the room and relive his memories. One night he nearly smashed a kettle on the head of his cell mate until waking fully and realising what he was about to do. He was moved to a single cell, not to help support him with PTSD, but to prevent him from hurting another prisoner. Darren 1, who also disclosed PTSD, shared his experience:

"When I was younger, I used to get locked in a room all the time, I have PTSD now. So, obviously when you are put in a cell, I had problems. I told them. It was mainly like the officers basically said tough. So, I ended up losing my temper once, and I lost my temper with a screw. I should have been put in by myself. The time before that, I explained when I was in (name of prison) a few years earlier, and I got my own cell."

This quote additionally highlights variations in treatment from prison to prison, and other narratives show that treatment can alter over time or be impacted by attitudes of professionals. In turn, the stories show the lack of consistency in the system.

6.4 Lack of training and attitudes of healthcare staff (in the community and prison) and correctional officers' impact on responses/ treatment

The lack of training staff receive has been identified as impacting on how IP are treated, particularly those who experience mental health difficulties.[80] Peter's narrative highlights the lack of ability to effectively deal with mental health issues. He told us that he tried to hang himself when he was in one prison and was told that if he did this again, he would suffer consequences:

"When I was in (name of prison), I tried hanging myself. (…) A screw told me if he ever caught me doing anything like that again, he would take me outside and beat the shit out of me."

While it may be understandable that a lack of training leads to an ineffective response, this shows the unacceptable extent this stretches to. In stark contrast to this, Peter also told us about his experiences of a prison in the South of England where he received excellent support for his mental health:

"The jail downs South were fantastic. Not up here in the Northeast. The jail down South I had a counsellor there, saw her every couple of days, she was on the phone. If you wanted to talk to her all I had to do was go into the office and ring her number and she would be down to the wing and talk to me. Brilliant, absolutely fantastic".

Rachel also told us that she received treatment for mental health difficulties almost immediately, but was not consulted with and did not feel the medication prescribed was suitable, highlighting previous observations that IP have no choice and control over their healthcare:

"I don't think citalopram is good. I think…I don't think it's a good antidepressant at all, (…) especially when you want to come off it. …Never given the chance to talk to anyone, they just assume that you want to get high if you wanted valium or something, so they give you something that won't affect you in that kind of way."

While geographical location may make a difference, it seems negative and poor treatment is also grounded in healthcare staff's attitudes, as Daniel said:

> **"Well, when you are in prisons, all the civilian staff…they kind of treat you almost like you are a second-class citizen. But it's… it's kind of unsaid. It's not in what they say, it's the way that they go on."**

Likewise, Kurt, who was given no medication to help relieve pain caused by sleeping in a poor-quality bed in prison, said that correctional officers:

> **"Didn't care at all. (…) some staff, if your face fit, they would give you some paracetamol or sometimes ibuprofen."**

Similarly, to other respondents Kurt believed this was because healthcare staff and correctional officers abuse their power and decide who should gain support and/or medication based on favouritism. Further, Peter, Kurt and Rachel all made comments that indicate that sometimes unsuitable medication is given with the aim of keeping prisoners quiet. Arguably the influence of power can be identified from Mark's earlier narrative which may also be influenced by a desire to "keep them quiet." As a result, only certain medications are administered despite needing alternatives. This included the overuse of paracetamol,[81] or as Peter and Kurt called it "the wonder drug". The attitudes of healthcare professionals were also apparent once released, with Mark telling us about his experiences when trying to access his GP:

> **"Discrimination again they have against people from that hostel is ridiculous. And you are just treated totally different. They judge you massively. Because they know I am from the hostel, so they know that I have come out of prison and I am on a script, so its automatically judged."**

6.5 Communication and information issues

Transfer of records

The transfer of medical records was highlighted as a key issue by respondents. For instance, Alex said that he injured his knee and two days before his release, results showed he needed an operation. Within a week he was recalled and was told there was no record of this, and he could not receive any medication. Commenting on this:

> **"I know that is bullshit because the same prison took me to the hospital, and it was in my prison records, but they just shoved me off and I was left with no operation, nothing, not even pain killers."**

Also telling us about issues with medical records, Peter said:

> **"It's an absolute nightmare. I don't think my records have ever come from (name of prison). I am not sure that all my records came from (name of another prison). Various doctors (…) over the last few years have had snippets of my files, but not all of it. I asked my newest one only recently if they got all my records and they haven't."**

Peter believes his records have either been "lost, thrown away, forgotten about", and blames this on how prison staff do not care because they are only responsible for the time you are there:

> **"It is more like total apathy; they just don't give a shit… I think they just bin them almost – oh he is not with us anymore…bins. I was once told by a doctor in the community who dealt with people on probation regularly that she rarely got records from anyone that had been in prison."**

A few stories also show the impact the loss of medical records can have. For instance, Geoff said it has profoundly affected his mental wellbeing:

> **"I went to the surgery and they says 'oh, they have disappeared (…)' Then I am worried, because there is a lot of confidential information in there. All my psychiatrist stuff… And I don't want that in the hands of strangers."**

Also discussing impacts, Kurt told us that it took three years to gain an appointment with a therapist because his records had not been transferred, by which time:

> **"I was taking drugs again, I was self-medicating and ended up going back to prison."**

Kurt's story, along with comments made by other participants such as Debbie, Claire and Brian also indicate that if healthcare needs are not addressed this can contribute to reoffending.

Mark told us that the loss of his medical records affected gaining appointments after his release and impacted on his wellbeing:

> **"(..) the prison say all the records, everything has been sent, but they were saying we can't find it. So, I was supposed to get, when I got out, I was supposed to go back to my pain specialist, but I am still waiting. (…) Mine seem to get lost in translation, I still haven't got my biopsy results. They can't find a lot of my history and stuff like that, that needs to be done for a lot of tests and I am still waiting for quite a lot of things.**

> **I am wating for the neurologist appointment, waiting for the pain specialist. And I live by myself, and I am worried about the biopsies and stuff, which is frightening, because I am starting to get lumps. (…) disgusting."**

While there were many instances where there had been issues with the transfer of records and the continuity of care from prison to the community, Daniel 1 told us that when he was released from prison he went straight to his doctors and got his medication the same day. He explained that:

> **"I have already got a doctors. So, I just went to my previous GPs. And I said I have just got out of prison, can I – because they are quite important to have. So, they look at that and they think right ok, we are going to send a prescription over."**

In Daniel 1's situation it seems the difference was attributed to ongoing registration with his GP, moving back to the area he lived in prior to release and thus maintaining continuity. This thus suggests that PIP are more likely to be able to receive their medication on release if they housed in the area they lived in previous to release, and are still registered with their doctor, when compared to those released in different areas or are required to register with new surgeries.

Communication and silo working

Tom's story highlights a lack of communication between prison staff and healthcare professionals operating in the community. He told us how he has slipped on some moss, and shortly after he was recalled to prison. He then noticed his leg was swelling which later transpired to be due to septicaemia. He was sent to hospital and given antibiotics which he was on when he was discharged. After he had finished the course, he was still in pain and unable to walk, but when he asked for more treatment, he was refused any more antibiotics. This was despite the hospital telling him he may require a second dose and to gain a follow up check with the prison nurse. However, he explained how staff were not communicating with the hospital:

> **"Once you finish the dose get to healthcare and check to see if you are thingy but…. when I asked for more thingy and they went no. They wasn't communicating with the hospital (…) so they went no, you left with antibiotics. But I said but what they say is see you, to check up and stuff. It spread so much like up my knee and its back part of my knee, and the muscle. So that as a couple of year. And then if I was keeping on deteriorating, I think we will have to put a plastic kneecap in, because it attacked, it ate all around it."**

The communication issues are brought into sharp focus when placed in a gendered context. A female respondent told us they were informed they had been given an appointment for their mental health difficulties. However, when she arrived, it became apparent it was for a smear test. Reflecting on this Julie said:

> **"Well, I went to see…. I thought I was going to see a psychiatrist. And when they tell us to take your knickers down, I nearly shit myself. I say's my crusties down? Why would I need to take my crusties down? I am here to see a psychiatrist. You are not, you are here for a smear test. I went…a smear test? I was told I was coming for me mental health."**

When asked if she refused, Julie told us:

"No, I got my crusties down and let him do his smear test."

6.6 Housing

Released with no fixed abode

A few respondents (Tom, Don, Unk, Den, Debbie and Claire) said that they had been released with no fixed abode. This impacted on their ability to access healthcare and in some instances (Debbie and Claire) contributed to reoffending.

The impact of being released with no accommodation is well highlighted by Debbie's story. Debbie, who disclosed mental health needs, told us that when she was released, she had no housing put into place and was street homeless and sofa surfing for approximately eight years. During this time, she said she got herself into some very vulnerable situations but did not expand on this. However, she further disclosed that at one point when she was homeless, she "ended up with a very violent man" and was "badly assaulted off my partner".

Debbie felt that if she had been given support with her mental health in the first place, and housed after her release from prison, she would not have been in any of these vulnerable and risky situations in the first place and would not have later reoffended. Likewise, Claire, who received no support for her mental health issues when in prison, also shared her story of being homeless on release and being in extremely risky and vulnerable situations as a result. She told us that, due to having mental health difficulties and being homeless, she used to get abused by men, get into risky situations and was raped for years and abused:

"Well getting used and abused off men. And getting yourself into extremes and weird and hard predicaments. Like with groups of people. And I got raped for years and used and abused."

Likewise, to Debbie, when asked what kind of support might have helped her, she said "my own flat". Claire also told us about previous times in prison where she received no support for her mental health issues and then, when she was released, was put into unsuitable accommodation. In her view this led to her reoffending "all the time". Many other respondents told us about their experiences of being placed in unsuitable accommodation following release.

Placed in unsuitable accommodation upon release

A common theme identified was respondents being placed in unsuitable housing after release. Many such as Darren 1 and Ryan, who had previous substance use issues, were placed in hostels where drugs and alcohol were being "pushed" on them. Darren 1 told us he ended up back on drugs. Ryan said there was no chance of remaining abstinent if he continued to stay there for too long:

"No chance, no chance. I need to get out of there as soon as possible".

In Mark's and Kurt's situations they were both temporarily housed in flats. However, due to mobility issues and other intersecting health needs, the accommodation was not suitable. For instance, Kurt said:

"(...) when I moved in, my back was hurting, my legs were really sore. I could barely bend over, my back was bad. That is what I said – I need a flat with a shower because I just find it really hard to climb out of a bath at the minute. So, I got a flat with a bath and no shower, I said I wanted something where maybe I could get a pet, because I don't leave the house, it's nice to have the company. So, in a tower block you are not allowed pets. I wanted to be somewhere it was as far away from drug communities as I could – it's sort of drug haven. So, it's not really ideal for me."

Nonetheless, both respondents accepted this housing because they felt they had no choice, and it was better than being placed in a hostel:

"Well, I have got to climb the stairs which is not ideal but it's different to like the hostel because it's my flat."

Mark.

Both participants had also been temporarily housed "miles" away from town and told us about the difficulties with affording public transport so that they could access healthcare and attend other essential appointments such as housing and benefit appointments. It also restricted their ability to build pro-social networks:

"The flat I have been put in is miles away. So everywhere is like £8 taxi fare. So, I need to live some... when I am finally...

allowed to move on, I have to live somewhere sort of… try and find somewhere central. I will have to find somewhere without many stairs. With sort of because I have got all these physical health issues now that I didn't have. And a lot of mental health issues, it would be nice to be nearer Crisis, maybe nearer the drugs and alcohol agencies. Just er… even for a social life in this next phase. Because where I am now, if any of my friends want to come and see me, it will cost them a fortune and it will take them two hours on the bus. It will cost a fortune in taxi so…"

Kurt.

Wider support

While participants acknowledged suitable housing was key to their ability to resettle, many told us that they needed support to assist them to rebuild their lives and access healthcare. For instance, Emma told us that she did not wait "too" long to be registered with a GP when she was released from prison because she had a support worker. When asked if she thought this support was helpful and if she could have managed by herself, she said it was helpful to have somebody and that she could not have done it by herself:

"I wasn't in the right frame of mind. I need a little push sometimes."

Emma's account shows the difference support can make, which was a reoccurring theme. Alan, who gained support from the homelessness charity Crisis, said:

"Since I have been out here, since the Crisis team you help me a lot, you support me the best ways you can. (…) Now I can deal with my problems. I can deal with my temper; I can deal with my anger. Now I am calmed down, I am a lot better now. And it's like when you go inside you get pushed to one pillar. You do not get taken care of. So basically, when you come outside, and people like you who help people like us try and get back on right track, to get a job, to get a little accommodation for yourself, that is the kind of support you actually need inside, as well as outside. So, when people come out, they have got a better feeling."

Alongside providing support to resettle into the community, it was evident from some accounts that support workers, to be effective, also had to care. For example, when asked if he had a key worker at his temporary accommodation, Darryl said:

"Aye support worker. But no, no good. Not compared to you guys at Crisis. Totally different kettle of fish. Because you care."

These stories indicate the importance of being housed after release. They also draw attention to the importance of housing being suitable for individuals' physical and mental health needs. In addition, it is essential to ensure vital services can be accessed to address health needs and facilitate successful resettlement. The findings therefore point towards the need for holistic, individual, and integrated responses. However, wider issues seemingly need to be addressed to enable services to operate in this way[82].

6.7 Wider issues

Throughout the data presented so far, links have been made to wider systemic issues, including poor conditions in prisons, cell sharing, staff attitudes, a lack of training and silo working, the transfer of records and communication issues. These wider issues were expressed or implied by some respondents' accounts. As noted earlier, Tom arguably recognised the broader issue of silo working and a lack of communication between prison staff and healthcare professionals operating in the community. It seems other respondents acknowledged some of the systematic issues that are currently impacting on the prison system. For instance, when asked what needed to be changed to improve healthcare in prisons, Darren 1 said:

"It's probably all down to the money and funding and stuff like that. Or lack of knowledge."

Lorraine not only drew attention to the difficulties she suffered because she did not receive any support for her mental health needs, but also the challenges correctional officers may face, which is arguably due to staff shortages and/or an absence of training:

"That's it. You just got to deal with it. Depressed (…) going to feel loads of emotions, you are stopping the drugs at the same time, you're missing your family. So, it's like your head is all over. So, it must be hard on officers as well. They think there is loads of people with mental health, dealing in there like that. What can they do to stop it? Everybody deals with emotions in a different way…

Some people can deal with it by being quiet in their room. Some people deal with it by smashing their room up."

Debbie, who also did not gain any support for her mental health issues, said that accessing healthcare in prison was worse now because of how many people are incarcerated:

"Totally different ball game altogether. Aye, because 20 years ago there wasn't as many women in prison as there is now".

Reflecting on communication issues and issues with joined up working, Kurt said:

"It is all data protection. And the prison won't want to share with the hostel, the hostel won't want to share with the doctors. So, you are constantly explaining yourself again and again. And if you have had trauma in your life…like I was diagnosed with PTSD, and if you are talking about something like abuse, having to go and sit and explain again and again and talk about why you need therapy or help… it's…that's abusive in itself."

Kurt additionally draws attention to how having to repeat stories of abuse causes significant distress, to the extent it seen as "abusive". This arguably gives rise to arguments that all services should be trauma informed by acknowledging the impact of trauma and actively avoiding retraumatisation[83]. Further, given that re-entering the community after prison is particularly challenging for those with multiple and complex needs, it is also essential for services to understand how needs such as substance abuse and mental health issues can interconnect with disability, class, gender, sexuality, age, and other social identities which produce unique experiences of disadvantage and marginalisation[84].

Nevertheless, for services to be able to offer a trauma informed and intersectional approach, it is essential they have a complete picture of a patient's life situation, past and present[85]. This cannot be achieved without an integrated system that cuts across organisational boundaries and provides joined-up approaches between staff in criminal justice and health agencies, with a clear commitment and aim to deliver holistic and tailored support.[86] However, in the current climate, provisions in prison and the transfer of IP into the community is unlikely to improve sufficiently.[87]

67 Wang et al (2009)
68 Royal College of Physicians (2018)
69 Heidari et al (2014)
70 Condon et al (2006)
71 Shalev and Edgar (2010)
72 Condon et al (2006)
73 Biswas et al (2015); Condon (2006); Ismail (2019); Massoglia (2018) Massoglia and Pridmore (2015)); Novisky et al (2021)
74 Biswas et al (2015); Ismail (2019); Novisky (2018)
75 Maycock (2021); Novisky et al (2021); Suhomlinova (2022); User Voice (2022)
76 NHS (2021); Loucks (n.d)
77 Durcan (2021)
78 Condon et al (2006)
79 Deva (2019); Favril et al (2017); Muirhead (2019)
80 House of Commons (2017)
81 Condon et al (2006)
82 Ismail (2020)
83 Centre for Health Care Strategies (2021)
84 Bunn (2019)
85 Centre for Health Care Strategies (2021)
86 Annison (2019); Bernard (2020)
87 Ismail (2019)

7. What's next

This peer-led research provides empirical evidence which illustrates the key issues people experiencing homelessness face with their healthcare when in prison and transitioning into the community. These findings will be used to inform local and national strategies with the aim of influencing positive changes within various relevant agencies.

Recommendations for practice and policy

- A timely improvement in the transfer of records from the community to prison and prison to community. Records should be transferred immediately to avoid breakdown in ongoing healthcare.
- Improved healthcare in prisons that takes account of complex needs and is based on these needs alone. A trauma informed approach is needed that also promotes choice and control for IP.
- Suitable housing and wrap around support to be arranged and put into place prior to release. This should take an intersectional and trauma informed stance and be reassessed at regular intervals to ensure individuals can achieve and maintain successful resettlement. This process should ensure maximum choice and control for those involved.
- Training put in place to improve the response by healthcare staff to avoid judgment and stigmatisation, particularly frontline staff.
- Policies and training put into place to ensure the day-to-day running of the prison regime is conducted by correctional officers only, and healthcare is ran by healthcare providers.

Recommendations for future research

- The lack of representation of asylum seekers, refugees and ethnic minorities is recognised as a key limitation. Their experiences could have revealed how key intersecting inequalities, at an individual and societal level impact on experiences. We thus recommend that future attempts are made to include these groups in the research process and listen to their stories of prison, health issues and homelessness.
- While our aim was to examine issues in the local community (Newcastle), the data does not provide a thorough picture of issues at a national basis. We thus recommend that consideration is given to a co-produced project that seeks to include other geographical locations. In doing so, this may also help increase the diversity of participants from minority groups.

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Opposite image: #HealthNow members talked about what people lose when they go into prison and/or become homeless. The silhouette is a symbol they used to express this, and which we use in our creative work on the issues.

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