The Effects of Imprisonment on Inmates' and their Families' Health and Wellbeing

prepared for

The National Health Committee

by

Dr Michael Roguski and Fleur Chauvel

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Level 6, Mibar Building
85 Victoria Street
PO Box 24181
Wellington
TEL +64 4 473 3883
FAX +64 4 473 3884
www.litmus.co.nz

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Summary

Background

As there is little New Zealand-focused information about prisoners' health-related prison experiences and continuity of care following release from prison, the National Health Committee developed a Health of Prisoners and their Families work programme.

The study aimed to explore the effects of incarceration on prisoners' and their families' health and wellbeing. Rather than a study that sought to generalise findings across prisoner and families, the study aimed to gather a selection of prisoners' and their families' in-depth lived experiences. Within this aim, the study was developed to address the following objectives:

1. Seek prisoners' views on the effects of imprisonment on their health and wellbeing one to two months before their scheduled release from prison and up to two months following their release.

2. Seek prisoners' views on health and disability services within prison and continuity of care upon release.

3. Seeks prisoners' views on how imprisonment may have impacted on their family's health and wellbeing.

4. Seek the views of one family member on the effects of imprisonment on the prisoner's health and wellbeing.

5. Seek the views of one family member on the effects of imprisonment on their family's health and wellbeing.

Approach

Sixty-three inmates participated in semi-structured interviews while incarcerated and, of these, 26 were interviewed six to eight weeks after their release from prison. Forty pre-release participants were men and 23 were women. The majority of participants identified as Māori. Ages ranged between 18 and 56 with a mean age of 34 years. Post-release participants comprised 17 men and nine women with a mean age of 29. Fourteen adolescent and adult family members participated in nine of the 26 post-release interviews. This resulted in a multi-generational account of the effects of imprisonment. Interviews ranged between 45 minutes and two hours.

Interviews were carried out in Arohata Women's Prison, Auckland Region Women's Corrections Facility, Rimutaka Prison, Waikeria Prison and Spring Hill Corrections Facility.

While conducting prison-based fieldwork, the researchers were invited by prison management to visit two medical units and to interview medical staff. In addition, some Corrections Officers who helped to facilitate interviews with prisoners also, upon learning more fully about the research, spontaneously provided their views on the impact of imprisonment on prisoner health and wellbeing, with a small number specifically requesting or inviting the researchers to conduct an interview. Informed consent procedures were fully utilised for all interviews undertaken.

Primary health care

While multiple examples of highly satisfactory medical provision were provided, these examples were generally restricted to emergencies and chronic condition management. In addition, satisfactory experiences with primary medical care occurred inconsistently, as participants commonly countered positive experiences with an equal or greater number of negative accounts.

Participants' satisfaction with primary medical care differed strongly across prisons and may be described as ad hoc.

Nurses were positioned as the prison medical system gatekeepers. In this role, the nurse is responsible for assessing the individual's medical needs and referring, where appropriate, to the prison doctor or directly sending the prisoner to hospital.

Prison's provision of primary health care was generally regarded as below the standard of "life outside the wire". Concern was raised in reference to continuity of care between public and prison services, difficulties accessing primary medical care and difficulties associated with treatment and inappropriate treatment.

A lack of continuity of care between public and prison services

Continuity of care arose in relation to previously diagnosed conditions requiring ongoing specialist medical intervention and/or monitoring by the prison doctor and discontinuation of medication upon entering prison resulting in distress and negative health outcomes.

Previously diagnosed conditions requiring ongoing specialist intervention

Of those with a pre-existing condition, continuity of care was more commonly reported as satisfactory by those with more obvious conditions (such as orthotics). Those with less satisfactory experiences attributed poor continuity of care to:

- appearing healthy
- being perceived by medical staff as malingering or as "frequent flyers"
- medical records not being thoroughly reviewed and medical staff erroneously citing that no condition had been noted by the "external" general practitioner and/or other prison staff
- negative perceptions of inmates
- prisoner transfers due to "muster blowouts", which countered any primary care-based relationships that may have been formed. Further, repeat "muster blowouts" acted to dissuade disclosure in an environment where disclosing one's medical history is embarrassing or simply frustrating when having to repeatedly do so
- a high rotation of nursing staff
- a reliance on nursing staff to assess the patient's condition and decide whether or not to authorise a referral to the medical provider.

Many inmates decided to "give up" seeking medical intervention as a result of these experiences.

Discontinuation of medication upon entering prison

Temporary and permanent discontinuation of medication occurs when prisoners are remanded, sentenced to prison and/or transferred between prisons. It was common for medications to be temporarily suspended until the prison doctor became available and was able to confirm medical and prescription histories with the prisoner's external provider. Permanent discontinuation appeared to be more geared towards medications with specific street values that risked the prisoner being threatened and forced to hand over their medication to other prisoners. Medications specifically mentioned by prisoners fell into benzodiazepine categories.

Inmates prevented from accessing medication experienced extreme anxiety. Some of this anxiety was attributed to concern over ensuring one's health care is maintained and the fact that discontinuation, even temporary, can be life threatening. Severe distress was reported by participants who had had their medications permanently discontinued. This was especially true in situations where inmates experienced a forced "cold turkey" withdrawal (i.e. no substitution or countdown). Most dramatic negative outcomes were reported by people who had a forced withdrawal from benzodiazepines and when psychiatric medication was not reinstated.

Difficulties accessing primary medical care

The majority of participants cited prolonged waiting times to see a doctor as a primary stressor and as having a major negative effect on their health outcomes. For those seen by a doctor, the average waiting time was generally seven days but ranged from the same day to five weeks; some medical complaints went unseen altogether. Waiting times differed by prison and by whether or not the situation was urgent. In urgent or emergency situations, inmates were more likely to report seeing a medical provider on the same day. However, a number of participants reported substantial delays in being seen by a doctor and receiving treatment and, in some cases, were never seen at all.

In response to prolonged waiting times, and especially when multiple requests had been made, participants commonly reported that they decided to stop seeking medical attention. These decisions were explained as a way of maintaining a sense of pride and control in an environment that had removed the individual's ability to have control over their health and wellbeing; otherwise no point was seen in trying to pursue the matter further.

Prolonged waiting times were attributed to:

- Medical request processes

  Prisoners were generally expected to make requests to see a medical provider by completing a request or "medical chit". Depending on the prison, this form is either given directly to the prison officer to pass on to medical or, in a minority of cases, placed in a box that is then collected by a nurse during their rounds. Medical requests are reviewed by a nurse and are prioritised and actioned as considered appropriate, with the nurse deciding whether or not to refer a prisoner to the doctor. It was common for multiple requests to be submitted. Participants reported feeling compelled to complete follow-up requests because:

  - presenting symptoms had worsened
  - pain and discomfort was persistent or escalating

- they had not been informed of the outcome of their initial request
- they assumed that their medical request had been ignored or lost.

▪ Nurse referrals

In many situations, the nurse's role of assessment and referral to the prison medical doctor was reported as working well. However, prisoners considered poor referral decisions to be a result of nurses who were considered to:

- subscribe to negative attitudes towards prisoners
- possess insufficient knowledge to assess and refer when necessary
- give insufficient attention to the patients' medical history.

▪ Under-resourcing

Prisoners' access to medical staff was constrained by a lack of resourcing. Few of the prisons visited had a medical doctor working on the weekends and some prisons had a doctor on-site only part-time. For instance, in one prison, two doctors were employed on a part-time basis: one doctor works four hours on the Monday and a second works the remaining hours on a Friday.

▪ Systemic issues

The following systemic barriers to accessing primary health care were identified:

- Cost of care – health care provision was not free. For instance, flu vaccinations were available for a cost of $9.00 to the prisoner. While inmates with chronic conditions received the vaccine for no charge, prisoners viewed the cost as prohibitive.
- Continuity of care through dedicated nursing staff for each unit[1] – the need to dispense medication and uplift medical request forms generally means nurses, across prisons, visit units on a daily basis. A high degree of continuity of care was reported in prisons where nurses were exclusively dedicated to a unit. Continuity of care was more difficult when a nursing rotation system or "floating" nursing staff is employed. This was understood to occur because rotating systems make it difficult for nurses and prisoners to form relationships that facilitate the ongoing provision of care and/or monitoring of the individual's health status.
- Breaches to patient confidentiality – the medical request process acted as a barrier to accessing medical care because the request process risked the prisoner's confidentiality being breached. As a consequence, the medical request process was found to serve as a disincentive to participants to complete future requests.
- Below-functional literacy – participants with below-functional literacy said that the written medical request system often acted to compromise their access to primary health care because they were embarrassed about having to:

[1] Prisoners referred to "dedicated nurses", a term synonymous with "unit-based nursing".

    - rely on officers to complete the medical request
    - disclose their medical concerns to a third party (prison officers).

- Compromised safety accessing primary health care – participants reported that waiting in the medical clinic holding cell, with other inmates, posed a significant risk as it created an opportunity for violence.

Difficulties associated with treatment or inappropriate treatment

Treatment-related concerns were almost always restricted to nursing staff, with very few negative comments made with reference to prison doctors. Concern over treatment focused on the following:

- Dispensing – many participants with chronic conditions required medication to be dispensed at least daily. Concern was raised when medication was dispensed to the wrong person and when medication was not dispensed.
- A lack of communication and follow-up after a medical visit – one of the greatest complaints among participants was not having appropriate follow-up communications with medical staff after medical tests and/or procedures. This was reported as generating a high degree of frustration and anxiety that escalated with each unsuccessful attempt to secure information from the medical unit.

Mental health care

Participants consistently reported that mental health services were under-provided.

Prisoners who had accessed existing services generally reported a high degree of satisfaction. For some, this satisfaction was traced to receiving a diagnosis and treatment linked to their offending.

The majority of participants cited extreme concern over the lack of continuity of care between public mental health services and prison. This concern was expressed both by prisoners requiring continuity of mental health care and by prisoners in general. A major cause for this concern was the experience of medication being discontinued upon entering prison.

Severe distress and negative mental health outcomes were reported by participants who had had their medications permanently discontinued. This was especially true in situations where inmates experienced a forced "cold turkey" withdrawal (i.e. no substitution or countdown). Most dramatic negative outcomes were reported either by people who had a forced withdrawal from benzodiazepines or when other prescribed psychiatric medication was not reinstated.

Fear of being confined to the At Risk or Observation Unit dissuaded inmates from seeking mental health intervention.

The lack of mental health services and extended waiting times reportedly produced an environment in which many prisoners' mental health deteriorates.

Oral health care

Out of all prison health services, prisoners were most consistently dissatisfied with dental services.

Insufficient resourcing (too few dentists and a high demand for services) appears to be the main explanation for delays in accessing dental treatment. As a result, prisoners have to cope for days, weeks or even months with varying levels of dental pain. In addition, prisoner transfer and lost or misplaced records can significantly increase delays in accessing dental treatment and time spent with dental pain. Unfortunately, satisfaction with timely access to dental care is less common, and appears to be prison-specific and related to different prison population numbers.

Concerns surrounding poor standards of dental practice appear related to concerns of minimum standards of care due to restrictive eligibility criteria. Some prisoners are able to access dental treatment that would otherwise be beyond their reach on the outside and report satisfactory treatment, but there is limited control over and choice of types of dental treatment. Many prisoners are precluded from attaining a standard of dental care that they would expect or seek on the outside. Even where private payment may be an option, prisoner wages are disproportionate to enable prisoners to pay for most dental treatments.

Past experiences of dental care and treatment in prison have led many prisoners to "give up" or to avoid dental services while in prison, resulting in continued pain, drastic measures taken to alleviate pain, including self-extraction of teeth, and deteriorating oral health.

Impact on family

Both male and female participants commonly cited financial strain, the added strain on their partner due to a loss of parental and childcare support that they had previously provided and breakdown of relationships as impacts of their imprisonment on their families. Women were more likely to focus on child-related impacts.

Impact on children

The majority of participants had children under the age of 18 years. The most commonly reported impact of incarceration on children was anxiety and the child's sense of loss and responsibility for their parent's incarceration. These reactions were believed to be compounded by the visiting process, which portrayed their parents negatively and prevented them from showing affection.

The impact of imprisonment on children appeared to differ according to the age of the children. The table below summarises commonly identified impacts of parental incarceration on children and how they relate to children within different age groups.

Age of child	Impacts of incarceration
0–3 years	Low degree of attachment to incarcerated parent and loss of bond
	Separation anxiety
4–7 years	Separation anxiety
	Bedwetting
	Night terrors
	Aggression and violence
	Lack of engagement in school
8–10 years	Aggression and violence
	Depression
	Truancy
11–15 years	Violence
	Assuming the role of the absent parent or parenting the parent
	Truancy
	Decreased academic achievement

Incarceration continued to negatively affect parent–child relationships following the parent's release from prison. This was a stressful period of readjustment for both child and parent and sometimes resulted in parents and children withdrawing from one another. Parents sometimes experienced a loss of control and a sense of hopelessness in seeking to re-establish the relationship with their child or children. This was most notable for children aged five years and older. Generally, it stemmed from the child's resistance to the newly released parent imposing parental structure/rules on them.

Younger children (under 12 years) reportedly tried to undermine the parent's attempt to impose boundaries and structure by enlisting their caregivers (e.g. the grandmother who had provided care while the parent was incarcerated). Children aged 13 years and older were more likely to actively defy the parent or to show resentment at having being abandoned by their parent (usually their mother), feeling that their parents now owed them for the time they had been away.

Parents with extreme drug and alcohol use histories reported incarceration having a positive effect on the family. They reported a lack of structure and routine in the home before the parent was incarcerated, which had had a detrimental effect on the children's school, nutrition and overall wellbeing.

Impact on partners, parents and other family members

Adopting a caregiver role, prison visiting, financial stress and stigma were predominantly identified as key pressures affecting prisoners' partners, parents and other family members. These pressures affected people differently, often depending on the extent of other support that could be accessed to ease these pressures. For most, it was a matter of significant adjustment. Impacts of such pressures included worry, anxiety, loneliness and isolation and sacrificing one's own wellbeing for the sake of other family members.

Adopting a caregiver role

Childcare more often than not became the responsibility of the female partners, mothers and sisters of incarcerated parents. For a prisoner's partner, incarceration meant that a key source of emotional and practical support was taken away. Partners had to adjust to an absence of childcare support and parenting assistance. Stress was further heightened if the partner had to care for older or unwell family members.

Of concern was the number of grandparents adopting these roles at an age or life-stage where they had expected their full-time care of young children to be over and where the physical and emotional toll of parenting was felt to be higher than it would have been in their younger years.

Caregivers related a heightened sense of isolation and a lack of support looking after children. The need for support included:

- respite from childcare – this was especially true for grandparents
- communicating the parent's imprisonment to children
- communicating the parent's imprisonment to non-family members (i.e. a child's school)
- knowing how to access support – participants commonly expressed a lack of knowledge about what support existed and how to access it
- counselling – for children distressed about being separated from parents and trauma associated with visiting parents in prison.

Financial stress

Significant financial pressures were commonly experienced by family members due to the imprisonment of their partner or family member. This commonly required the reallocation of finances, which potentially or actually affected health and wellbeing. Additional financial pressures and their resulting impact on health and wellbeing included:

- Increased financial responsibilities of childcare, compounded by delays of up to three months to access financial entitlements (i.e. where Work and Income may require a letter from the prison). These responsibilities include the added costs of children's schooling, food, medical, transport, clothing, bedding and personal needs, placing significant financial strain on families already living within tight budgets. Often, this meant that the primary caregiver had to "go without", including having less food, not visiting the doctor and scrimping on basic needs.
- Loss or reduction in household income – particularly for female partners of male prisoners who had been the main household earners. The impact of this was felt strongly by parents with children who now had to support themselves and their children on an individual benefit, as well as financially supporting their imprisoned partner. Predominantly, this resulted in the partner reducing their intake of food and no longer being able to afford anything beyond the very basics. In some cases, participants had to move accommodation or location due to being unable to keep up with rental or mortgage payments.

- Costs of maintaining contact with prisoners. The fact that a large number of incarcerated people and their family members were separated by distance and with limited financial means meant that family, partners and children were unable to visit their incarcerated family member or visits took place only infrequently. In addition, at a cost of $1 per minute for toll calls, partners and family members were financially stretched to provide money for phone cards to enable prisoners to maintain contact. Often, family members sacrificed basic necessities (such as food) to avoid compromising the frequency of visits, or to be able to provide prisoners with money for phone cards.

- Release from prison often means an additional financial stress to the household. In the majority of cases, participants related that they had intended to contribute to the household through a Work and Income benefit. However, the first three to five weeks were often very stressful as benefits were often delayed because of administrative errors, a lack of appropriate identification and not knowing how to navigate the welfare system.

Stigma

The degree to which the stigma of imprisonment impacted on families depended on:

- the type of crime – violent and sex crimes resulted in the highest degree of stigma

- whether or not the family had a history of incarceration – the more normalised imprisonment becomes for the family, the less the stigma

- the prisoner's neighbourhood or location – if a prisoner came from an area where it was not uncommon for residents to go to prison, imprisonment was not a shocking fact that would get others talking or casting judgement.

Stigma was identified as a potential barrier to securing employment. The partner of an inmate who struggled to find work after he moved to be close to the prison had wondered whether his lack of employment success was a result of his openness to prospective employers about his partner being inside. Similarly, several released prisoners spoke of their trepidation at having to disclose their convicted status at job interviews and the extent to which this would have an impact on their chances of employment success.

Continuity of care

Pre-release considerations

The first three to four weeks following release from prison were critical adjustment periods that risked ill-health, compromised wellbeing and re-offending.

Securing basic needs prior to release from prison was identified as a primary protective factor. The following basic needs were identified:

- prerequisites for the individual's release – securing appropriate identification and a bank account

- basic living needs – financial support (Work and Income application filed) and accommodation

- supportive travel arrangements from the prison to new accommodation
- continuity of care – the prison's provision of the inmate's medical record, prescriptions, referral and an appointment with an affordable medical provider in close proximity to their new accommodation.

Due to a lack of Reintegration Officers, the majority of inmates need to secure their own pre-release needs. The minority of participants who successfully managed to ensure that their basic needs were met attributed their success to supportive family members who were able to act as a liaison between the inmate and the relevant agency and/or a pre-existing relationship with a social service agency that was able to act as an advocate for the soon-to-be-released inmate.

The majority of participants did not have social support networks that could help them secure basic needs. As a consequence, participants reported extreme anxiety when attempting to gain an adequate understanding of requirements and processes. A failure to acquire pre-release basic needs directly affected continuity of care when participants were not able to secure:

- a copy of their medical record
- medications prior to their release
- prescriptions to be filled once released.

As a result, some participants reported leaving prison with only enough medication to last one week and/or without a prescription to be filled. This was not seen as realistic, given the amount of time it can take to receive a Work and Income benefit.

Post-release considerations

All participants reported feeling extremely vulnerable following their release from prison. Vulnerabilities were characterised by fear and uncertainty associated with:

- venturing out of their homes
- financial stressors
- drug and/or alcohol temptations
- social interactions
- re-learning how to make decisions
- deciding whether or not to tell people of one's incarceration history.

Vulnerabilities appear to have been more easily mitigated by those with strong social support networks, e.g. friends and family accompanying released inmates to help with their adjustment to open spaces. Also, when there were delays with Work and Income benefits, friends and family reportedly assisted the individual – either financially or in-kind.

Those without strong networks were extremely vulnerable. In situations where basic needs were unmet, e.g. delays with Work and Income, participants reported:

- hunger and homelessness because of a lack of funds
- inability to pay for health and mental health care
- failure to fill prescriptions
- a lack of advocacy and having to attempt to rectify a situation without support.

Locating an affordable medical provider was extremely challenging. Cost ranged between $0 and $60 for the first doctor's visit. Higher costs reduced for subsequent visits but participants with multiple health care needs often had to go to their doctor once a week. In these cases, even a small fee was sometimes prohibitive.

When the costs of medical care were prohibitive, participants consistently chose to pay for food and accommodation over medical costs. In some situations, this placed participants at risk of exacerbating their mental health if not accessing medication or counselling appointments and due to worry associated with this. Others risked poor chronic care management (e.g. asthma and diabetes).

Experiences accessing a medical provider			
Recently released prisoner	**Cost of primary medical care**	**Affordable or not affordable**	**Impact of cost**
Joy	$15	Affordable	Continuity of care
Tipene	$10	Affordable	Continuity of care
Tamati	$0	Affordable	Continuity of care
Stuart	$60 first visit, $16 the following visit	Not affordable	Delayed going to doctor for five weeks
Mere	$35 (once a month)	Not affordable	Decreased amount eaten
Sue	$30 (three visits in one month)	Not affordable	Decreased amount eaten, delay in filling prescriptions
Miri	$60 first visit. Doesn't know if second visit cheaper	Not affordable	Will not go again unless in extreme pain
Helen	$60 first visit. Doesn't know if second visit cheaper	Not affordable	Will not go again unless in extreme pain
Leah	$60 first visit, $16 the following visit	Not affordable	Pregnant. Delayed seeing doctor because of cost
Pita	$25	Not affordable	Mother paid. Continuity of care
Heather	$60 first visit. Doesn't know if second visit cheaper	Not affordable	Mother paid. Continuity of care

1 Introduction

1.1 Background

Prisoners are typically an under-researched population. However, evidence strongly suggests that prisoners:

- often have high and complex health needs and/or co-morbidity[2]
- have poorer health overall than the general population
- are predominantly from communities with relatively poor access to health care and multiple risk factors
- have health outcomes that are directly affected by the prison environment
- experience a critical period for health, reintegration and mortality following release from prison.

Because there is little New Zealand-focused information about prisoners' health-related prison experiences and continuity of care following release from prison, the National Health Committee developed a Health of Prisoners and their Families work programme, including the commissioning of this research.

1.2 Project scope

The study aimed to explore the effects of incarceration on prisoners' and their families' health and wellbeing. Within this aim, the study was developed to address the following objectives:

1. Seek prisoners' views on the effects of imprisonment on their health and wellbeing one to two months before their scheduled release from prison and up to two months following their release.
2. Seek prisoners' views on health and disability services within prison and continuity of care upon release.
3. Seeks prisoners' views on how imprisonment may have impacted on their family's health and wellbeing.
4. Seek the views of one family member on the effects of imprisonment on the prisoner's health and wellbeing.
5. Seek the views of one family member on the effects of imprisonment on their family's health and wellbeing.

[2] *Review of Research on the Effects of Imprisonment on the Health of Inmates and their Families* www.nhc.health.govt.nz/moh.nsf/indexcm/nhc-prisoner-health-research-review-08?Open.

1.3 Key considerations

1.3.1 Voice of the prisoner

In developing the study's brief, the Committee placed the voice of the prisoner as a central consideration. This is a well-supported means for gathering vital information to support health policy and practice design[3] and prisoner involvement complements government health and disability strategies and dominant policy directions for Māori and Pacific peoples. As such, the research team adopted a phenomenological orientation to capture participants' lived experiences:

> *The goal in health research is often to gain insights into the lived experience of having a particular condition. The role of the health researcher is to provide a window into others' experiences.*[4]

1.3.2 Definition of health

The study adopted the following definition of health to reflect international best practice:

> *[Health can be defined as] a complete state of physical, mental and social well-being, and not merely the absence of disease or infirmity. (Constitution, World Health Organization, 1948)*

This definition was amended to reflect Māori worldviews by using Te Whare Tapa Whā as a means of ensuring elements contributing to this state of physical, mental and social wellbeing complement Māori experiences. Te Whare Tapa Whā considers health as comprising four dimensions:

- Taha whānau – the importance of wider social relations, particularly as they relate to family and the ability "to belong, to care and to share"
- Taha tinana – the capacity for physical growth and development
- Taha wairua – the spiritual capacity for faith and wider communion
- Taha hinengaro – the mental capacity to communicate, think and feel.

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[3] Even for groups presenting challenges for conventional research methods, such as youth offenders, valuable information can be derived from small qualitative research studies. See, for example, Counties Manukau DHB (2006) "Youth Health Team Evaluation: As told by the Young People of Korowai Manaaki".

[4] Dew, K. (2007). "A health researchers' guide to qualitative methodologies". *Australian and New Zealand Journal of Public Health*, 31:5, pp433–437.

2 Approach

The study used an adapted life history methodology to explore how imprisonment has affected prisoners' and their families' health and wellbeing. The majority of prisoners had been imprisoned in multiple prisons during their current sentence. During the interview, participants were asked to compare and contrast their experiences across prisons. This approach elicited rich descriptions of prisoners' health-related experiences.

The study aimed to explore the effects of incarceration on prisoners' and their families' health and wellbeing. Rather than a study that seeks to generalise findings across inmate populations, this qualitative study aims to gather a selection of prisoners' and their families' in-depth lived experiences.

2.1 Recruitment

A sampling frame was developed to guide the purposive sampling of participants according to gender, ethnicity and one of five prison locations. In practice, this involved recruiting on the basis of ethnicity (Māori, Pacific or other) and gender (men or women). Age was a variable of note but not of selection. Eligibility criteria included male and female prisoners who were:

- incarcerated for at least five months
- scheduled for release one to two months after the interview.

Best efforts were made to ensure that participation selection reflected a number of health-related diagnoses. This was monitored by interviewers keeping a rolling total of specific health conditions and addictions histories throughout the interview (see Appendix 1). When a pre-specified health issue did not naturally present during the interview process, the researchers purposely sampled according to that issue. For example, few participants presented with a mobility impairment and so prison officers were asked if they knew of prisoners who had an impairment and if they could bring them to the interview room where the researchers explained the nature of the study and asked if they would be interested in participating.

2.2 Participants

In total, 63 participants were interviewed while incarcerated and, of these, 26 were interviewed six to eight weeks after their release from prison. Of the 63 pre-release participants, 40 were men and 23 were women. The majority of participants identified as Māori (n = 38). The next most prevalent ethnic group was Pākehā (n = 13). This was followed by Pacific peoples (n = 11) and one individual was classified as "other". Ages ranged from 18 to 56 years, with a mean age of 34.

Post-release participants comprised 17 men and nine women. The majority of the participants identified as Māori. Ages ranged from 21 to 54 years, with a mean age of 29.

Table 1: Participants by Ethnicity and Gender

	Pre-release participants		Post-release sample	
	Men	Women	Men	Women
Māori	22	16	7	4
Pacific People	9	2	7	1
Pākehā	8	5	3	4
Other	1	0	0	0
Subtotal	40	23	17	9

Fourteen adolescent and adult family members participated in nine of the 26 post-release interviews. This resulted in a multi-generational account of the effects of imprisonment.

2.3 Interviewing

Interviews were carried out in the following prisons:

- Arohata Women's Prison
- Auckland Region Women's Corrections Facility
- Rimutaka Prison
- Waikeria Prison
- Spring Hill Corrections Facility.

Pre-release interviews took place in a private interview room at each prison. In most cases, two researchers interviewed one prisoner. Interview times ranged from one to two hours. With the participant's permission, interviews were recorded. At the conclusion of the interview, participants were asked if they would like to participate in a post-release interview that, with their consent, could include a family member (see Appendix 2 for the pre-release interview schedule).

Post-release interviews generally occurred in participants' homes. On two occasions, interviews took place in a local café and seven interviews were conducted by telephone. Post-release interviews were recorded with participants' permission and interview times ranged from 45 minutes to 1.5 hours (see Appendix 3 for the post-release interview schedule).

2.4 Analysis

2.4.1 Content and thematic analysis

Qualitative data was analysed to locate patterns and themes relating to the research objectives and wider contextual issues.

This involved:

- reviewing interview notes and transcripts to identify common patterns in vocabulary, conversational topics, meanings, feelings, sayings and cultural codes and nuances
- combining related patterns into themes
- selecting quotes and case studies to illustrate themes and responses.

The quotes and case studies presented in the report have been anonymised to protect participants' identity. This includes changing names, gender, ethnicity and prison where this had no bearing on matters raised. We have also changed the specific details relating to medical conditions where this had the potential to identify participants.

2.4.2 Case studies

Case studies were compiled as a means of reflecting the various themes arising from the interviews in further depth and detail and providing greater context.[5]

Case studies were first compiled through an analysis of interview notes and transcripts. Next, the Department of Correction's medical database was accessed to triangulate participants' experiences and timeframes. The medical database was also reviewed where prisoners' accounts raised ethical and medical concerns.

2.5 Ethics

The research was approved by the Ministry of Health's Multi-Region Ethics Committee.

[5] Patton, M (2002). Qualitative Research and Evaluation Methods.

PRISON CULTURE

You can't tell officers. You'll be seen as a pussy and there will be a hit put out on you. (Rawiri, Māori man, 18–25 years)

3 Prison Culture

Prison culture was commonly referred to as a process in which inmates learn about their behaviour in relation to procedures, rules and interpersonal relationships at the level of the unit and the wider prison setting and in relation to particular roles (staff versus prisoners) and inmate groupings. Prison culture was discussed in terms of two dynamics:

- culture as defined and influenced by prison authorities
- culture as defined and influenced by prisoners.

The following discussion describes participants' experiences with each cultural form. These experiences are pertinent to a discussion of wellbeing as they were found to directly counter an individual's sense of self-worth and act contrary to rehabilitative efforts. This is reminiscent of Smith's finding that prison is an "intrinsically non-therapeutic environment"[6].

3.1 Culture as defined and influenced by prison authorities

Authority-led culture was generally discussed in terms of controls placed on prisoners that, in general, result in inmates being made amenable. Participants referred to this as a process of being domesticated or "tamed". Domestication was traced to the following processes:

- controlling inmates through language
- authoritative use of power – most notably through degradation and punishment.

3.1.1 Controlling inmates through language

Participants consistently related that they felt that the prison system treated them as second-class citizens and that their punishment extended beyond incarceration to include substandard conditions and treatment.

Punishment beyond imprisonment
You know I did my crime and I deserve to be in prison. But being in prison is my punishment. What people don't understand is that just because we're in prison doesn't give anyone the right to talk down to us. It doesn't give someone the right to treat us badly. Being treated badly is not part of being in prison. (Stuart, Pākehā man, 25–35 years)

Participants initially evidenced this by drawing attention to the way prison vernacular positions inmates as either animal-like and/or subhuman. For instance, the following animal-related terms and connotations of animal behaviour and treatment were offered to evidence inmates' second-class status:

- "Muster" was commonly used to refer to the number of prisoners in the unit or the prison as a whole.
- "Muster blowout" was used to denote when a prison's population has exceeded capacity. The term was generally used by inmates and/or officers in reference to reasons underlying why an inmate had to transfer between prisons.
- Strip searching was likened to being at a cattle market where one's teeth and genitalia are scrutinised.

[6] Smith (2000: cited in National Health Committee, 2008).

- Prisoners reported being likened to animals by being caged and herded. The example was given that, while at the medical clinic waiting for an appointment, inmates were herded into a holding cell with between 15 and 17 other prisoners.

- "Grading" was used in reference to the policy of assessing an inmate in terms of security classifications.

- Prisoners were consistently referred to by their surnames only, whereas they were required to address officers by their title – *The names, it's all Mr so and so can I have a toilet paper, Mr, Mrs, but when they yell it out to us it's like Smith, you got an interview, get up here now and then they ring it out again Smith you have an interview. (Maaka, Māori man, 30–40 years)*

- Prisoners commonly referred to being treated worse than an animal because they are required to eat, sleep and defecate in the same area.

- Lock-down, and being locked in one's cell, positioned inmates as unpredictable, untrustworthy and untamed animals that need to be locked up.

- Discursive reference to the inmates as animals was extended to rules governing access to medical care. In this regard, prisoners reported that, if one was polite and well-behaved, tamed or domesticated, one was rewarded with speedy access to medical services.

Conversely, prisoners interviewed in one Faith-Based Unit and one Māori-Focused Unit, consistently talked about the fact that officers addressed prisoners on a first-name basis and appeared to genuinely care about prisoner wellbeing. There was also a specific focus on personal wellbeing and development. This was regarded as making prisoners feel "human", part of a community, and encouraged the ability to succeed outside of prison and contributed to prosocial behaviour overall.

Specialist units
It's an environment that's different from any other place in prison or in rehab. It's just an environment where people genuinely care for you. Like they call you by your first name. You get into a position where you really start to care for people. Like if you're a new guy the first thing that happens is pretty much most of the unit comes over and welcomes you here and things like that which you don't get anywhere else in prison. (Jonathan, Pākehā man, 18–25 years)

3.1.2 Prison authorities' use of discretionary power

While language framed the inmate as inferior, prisoners' subjected status was reflected in the dual use of degradation and punishment.

Degradation

Degradation through strip searching

According to prison policy, officers have the right to visually examine anal and genital areas (with no physical contact).[7] Male participants described being asked to retract their foreskins and lift their scrotum and then being asked to squat. Similarly, women were required to remove tampons in front of the officers, place these in a nearby rubbish bin (or toilet) and then

[7] The following notice was posted at one prison visited: *"As part of a strip search officers can conduct a visual examination of the anal and genital areas and can direct prisoners to lift or raise any part of their body (including rolls of fat, genitals and breasts)."*

squat in front of the officers. On some occasions, while the individual was squatting, a mirror was placed under the individual.

The practice was generally viewed as degrading and unnecessary because:

- strip searching was seen as unnecessary in environments with drug detection dogs and metal detectors – *I don't know if it is necessary though. 'Cause if it is about drugs then why have the drug dogs and the metal detectors? (Leah, Māori woman, 25–35 years)*
- non-invasive strip searching is an ineffective means of determining whether an individual has concealed contraband in an anal or vaginal cavity
- the combination of security cameras in visiting areas and prison overalls made passing drugs from visitors to inmates difficult – *Yeah like depending on the size of your stash and all that, like some people swallow it, some people cut a hole in their overalls to try and get it up their ass or whatever, yeah but I've been on the other side of the visit rooms where all the cameras are and there is like bloody 20 cameras or something so it's pretty hard to actually, if someone is monitoring the cameras it's hard to get it in cause they have got you know, at all times you've got at least two or three cameras on you from different angles, if someone is watching the screens they will see you. (Anaru, Māori man, 18–25 years)*
- the assertion that many of the drugs in prison are brought in by prison officers[8]
- if prison authorities were serious about removing drugs from prisons, then all staff and visitors would be screened by drug detection dogs upon entering and leaving prison.

Inherently, strip searching was regarded as a degrading practice that negatively affected the individual's wellbeing and sense of self-worth and was reported as deterring inmates from agreeing to visits.

Strip searching
I cancelled all my visits. Cause I don't want them to be looking at my ball sack and my anus. After seeing your kids they take you out the back and they tell you to squat, I am not into that, I ain't no homo. Do I look like a homo? It's just degrading. (Mika, Pacific man, 30–40 years)
There are ladies that refuse to have their visits here. Some of it is about strip searching but it's also about ladies getting their periods. They [officers] make them take their tampon out, put it in the bin and then they're given a new one you know. Yeah and I've had that done and that's why I can say this. I've had that done and I've had to pull my knickers down to my ankles and then you do the squat to the front and to the back squat but because I had my period I had to pull that out first hold it out show them, then drop it in the toilet. That's your wairua. That's everyone that goes there [inmates going to visitation]. If you got your period you take those things off [tampon] and then you get given a new one [tampon] to put back on. So it's not only another humiliating thing to people who are vulnerable, it makes people refuse visits. People need visits to maintain whānau. (Tui, Māori woman, 30–40 years)
Yeah we get stripped searched. We have to bend down, knickers to the knees, bend down in front of them and show them, you know. It's humiliating you know I think that's wrong I think that's very wrong and I think that's a broken code of privacy and tikanga. As women, because like us wahine we're sacred because we carry the babies and like yeah it's just humiliating having to do that and like when I was in low one [low security unit] we had a couple of knives went missing. So they stripped us down one at a time they locked up our cells and we had to go into the bathroom and strip in front of the officers [female officers] there even though they're women but who cares you know. That's our body and I didn't like that and I still don't like it. Also, they make us do it when we have our period. It's very, very… it's embarrassing because when you have your period, your monthly, you've still got to pull it out and throw it on the floor. I think the officers they actually need to learn a lot more about the tikanga because like here

[8] "Drug ring accused prison officer in court: Senior Rimutaka Prison manager Jeffery Reid has appeared in court over an alleged prison cannabis ring", http://home.nzcity.co.nz/news/article.aspx?id=102631&fm=newsmain,nup (downloaded 20 August 2009).

it's a Pākehā system they don't seem to give a damn about the Māori side of things. Especially with tikanga and that because like stepping over somebody that's tapu to us but not to the officers they don't understand that. And I think that they need to learn about tikanga yeah it's just very degrading it's horrible. You mention rehabilitation earlier, strip searching doesn't rehabilitate people. It makes people angry, hurt, lose self-respect. I mean it's dumb it's bad tikanga it's not treating people with respect. (Aroha, Māori woman, 40–50 years)
*I said, "Oh Mister when I was young I was sexually abused by an older man and I don't feel comfortable with people looking at my genitals". And he goes, "I don't give a f*** if you were f***ing abused you got to turn around". You know even if you try to make a statement like that they still don't care. (Anaru, Māori man, 18–25 years)*

Degradation through poor treatment of prisoners

Participants commonly discussed prison officers in terms of "good officers" and "bad officers". Officers who were positively regarded were reported as:

- maintaining clear boundaries between officers and prisoners
- treating inmates respectfully
- actively trying to assist prisoners should a particular need arise, such as following up with medical if a medical issue was not assessed or treated.

"Bad officers" reflected the opposite qualities and were commonly described as degrading prisoners by treating prisoners as inferior beings. Specifically, participants cited:

- staff's negative attitudes and comments about prisoners
- sexual harassment of inmates.

Negative views towards prisoners
The way they talk to you and look down at you, they really do let you know that you are just an inmate, like you know it's quite degrading really. Like, you know I have always really looked after myself, you know always had really nice clothes and had my hair done, my nails done, everything like that and to come in and be treated like scumbag it was quite hard. You know they can kind of make you feel like that after a while cause you know it's not good. But the guards down here, they are all lovely, they are all really nice, especially in the DTU [Drug Treatment Unit] they actually genuinely care about the girls. They are like mums. (Annette, Māori woman, 30–40 years)
*Now it's just the way that they speak to you and you know like we're meant to respect them but it's hard to give them respect when they don't respect you back and I am a big thing on treat people how they want to be treated. Like if we answer back we can get charged and I did a couple of times. It's the way they spoke to me. So I just said, "F*** you" you know, it's hard not to say, it's hard to hold it in when they just treat you like shit. And like I might have worked all day, get home, when they do the cell search and that and they come in and throw everything around. Everything is thrown everything right across the room, pictures ripped, photos ripped, just assholes. (Annette, Māori, 30–40 years)*
Some of them are alright. You know a good officer treats you with respect. They treat you like a human being. A crap officer is someone that punishes you twice. You know, you've done a crime, you come to jail, so you don't need to be punished anymore. But then they keep punishing you, like I don't know, treating you like crap, you know, talking down to you, treating you like you are a criminal. Not just someone that has made a mistake and ended up in jail. (Joy, Pākehā woman, 20–30 years)
Sexualising prisoners/sexual harassment
*For every 10 good male screws [prison officers] you have got three or four bad ones and they ask you questions like, "Do you miss sex Miss?" "I beg your pardon Mister what did you just say?" "How much do you miss sex when you in here aye?" "You f*** don't even speak to me like that you fool". "Oh sorry, oh sorry hehe". You know big joke. Like one day we were sitting out in the yard and this guy had been*

*playing, he was playing volleyball with us in the gym just before we got back to the yard, he had been playing volleyball and he was hitting it and then we would hit it back and he would go "Harder Miss. Harder. It's better when it's harder Miss". You know just being a f***ing egg and then we got back to the wing and we were all sitting out in the yard and he is just sitting there looking at us like this you know and I just said to him "What you f***ing looking at?" And he goes, "Yeah you." I could have done a B10 [complaint form], I felt like doing a B10, he was just being a filthy pervert. (Heather, Pākeha woman, 30–40 years)*
On two occasions, participants discussed having sexual relationships with prison officers. On each occasion, participants described being in love and feeling extremely happy and well treated by the officer. In addition, participants related a sense of relief as they had felt extremely vulnerable, lonely and depressed in prison. Each relationship lasted for less than three months and ended abruptly when the officers became concerned that the relationship would be discovered. Out of a sense of protection, neither inmate told anyone about the relationship and in the words of one woman: *"I suffered in silence. I just cried myself to sleep. At one point I couldn't see a way out and all I wanted to do was die. It's been two years now. It's really hard when I see him… you know he treats me like I don't exist. I feel really led on… you know abused. It shouldn't be allowed. I know now that it is an abuse of power." (Miri, Pacific woman,18–25 years)*

Participants related that it became increasingly difficult to maintain prosocial attitudes and behaviours when authority figures engaged in objectifying behaviours. This difficulty was compounded by being in an environment where protest, albeit prosocially assertive or antisocial, risks punishments such as the loss of privileges and/or reports that can negatively affect the inmate's chances at a parole hearing. As a consequence many participants related having internalised their frustrations and had become withdrawn and/or depressed.

Punishment

Punishment through "muster blowout"

As previously discussed, "muster blowout" refers to the transfer of inmates between prisons when one prison's capacity has been exceeded (blown out). On one level, "muster blowout" serves a function to ensure appropriate distribution of inmates. However, on another level, "muster blowout" was commonly regarded as a form of punishment.

Fear of "muster blowout"
I don't go on the committees any more [unit committees].[9] It's too much of a head spin aye mate. 'Cause if you do play up too much with authority, and knowing too much, they just put you on a bus and you're off to Invercargill. They don't call it a punishment, and you can't prove that, they just say "Muster blowout", you're on a bus, see you later. (Gary, Pākehā man, 50–60 years)

Inmates were concerned about transfers because they highly valued a sense of permanence. Longevity within a unit often resulted in supportive social networks that provide:

- camaraderie and emotional support
- information about how to navigate the prison (and parole) system
- protection against violence
- continuity of health care, as the prisoner develops a relationship with medical staff.

[9] Some low security prison units have prisoner-based unit committees. The role of prison committees differs across prisons and units. The unit committee in question was generally concerned with event planning (such as family days).

The impact of muster transfers was most acutely felt by inmates:

- taken considerable distances away from their families, which meant families could no longer visit the prisoner
- with a history of victimisation and stand-over tactics and who were less well equipped to protect themselves
- who are members of a less dominant gang than the one residing at the new prison
- whose ethnicity is not widely represented in the prison they are transferred to
- not fluent in English and "muster blowout" results in them being taken away from people of their own culture and language.

Impact of "muster blowout"
Well, it really plays with the mind. You're getting taken away from your family, from the top of the North Island to the bottom of the North Island. Down here I haven't had no visits, no nothing, it's not very healthy. You have to deal within yourself and pick yourself up and stay motivated. (Te Māia, Māori man, 18–25 years)
I wanted to stay in Mt Eden prison because of the high number of Pacific Islanders. We sang, we cooked together, we talked. In Springhill I'm just an ESOL [English as a Second Language]. I feel very isolated. (Fale Lima, Pacific man, 40–50 years)

Punishment through At Risk confinement

Participants identified the At Risk Unit as a second form of punishment. At Risk units are small, bare one-person cells with 24-hour surveillance. Individuals are placed in At Risk because of a concern that the individual might harm themselves. Throughout the confinement period, officers regularly observe the prisoner to ensure that they have remained safe.

At Risk Unit
You're in 23 hour lock down in a white room. There's a concrete slab with a thin mattress, a stainless steel toilet with a sink attached and a wee table attached to the walls. That's it. You are not allowed to wear any underwear or clothing all you're wearing is basically a nightie, a denim nightie and they say it's for your safety but it's actually just degrading. It's supposed to be for our safety because you are on 15 minute obs, you're observed through a little wee glass slot in the door every 15 minutes to make sure we haven't hung ourselves or hurt ourselves. (Helen, Pākehā woman, 30–40 years)

Participants commonly talked about At Risk as a form of punishment. It was generally felt that officers, and some medical staff, automatically channelled prisoners into At Risk, or left them there for inappropriate amounts of time, due to a lack of sufficient training and a limited availability of medical professionals to appropriately deal with possible mental health crises. As a result, participants related that if prisoners appeared to be emotional and possibly at risk of hurting themselves, then they would be placed in an At Risk cell.

Being placed in At Risk has cultural relevance because participants related that exposure, including vicarious exposure, to At Risk resulted in decisions to avoid At Risk at all costs. Reasons for this included:

- the lack of stimulus and solitary nature of At Risk, which caused prisoners to despair
- being stripped to a nightie and left without underclothes

- constantly being watched
- potentially being left in At Risk for indeterminate and significant periods of time
- privileges being removed.

As such, one aspect associated with learning about life in prison is remaining silent about your emotional distress or psychological issues.

At Risk – a process of being socialised into being silent
The worst thing you could do to me is to put me At Risk, I do not like At Risk, time drags, nothing to do. Like I am a worker you know, I am very active, I like to be doing something all the time and if I am not at work I am at home writing letters or reading books, you know, to sit in a cell day-after-day with nothing to do it just drives me insane. (Heather, Pākehā woman, 30–40 years)
When I first came they put me in At Risk. I was sentenced for three years. When I come from the court house it was about close to midnight 'cause I was waiting all day for a verdict then I come in, got strip searched and everything, sweet as and then they go to me are you alright? "Yeah I am alright." I had a bit of a tear because I was thinking about my kids; just a little bit of a tear in the eye. Then they go, "How about we just put you on observations for the night?" Next minute they march me all the way to At Risk and I was like, "What the hell am I doing here; I didn't ask to come to At Risk?" They were like, "Oh you will just be here for the night until we sort it out, oh yeah sweet as". One night turned into like three weeks and I told them every day, "Mister can I go back to remand? I am real good." "Oh yeah, yeah hang on we'll sort it out." And the next day, the next day, next minute three weeks later I was still At Risk. Like straight up I was going nuts. (Anaru, Māori man, 18–25 years)

For some participants, this socialisation process resulted in individuals "feigning smiles". Others discussed feeling as though they could not remain in their cells when they wanted to for some "time out" for fear of being viewed as depressed. More disturbing were participants who were experiencing depression and suicidal ideation deciding not to seek intervention for fear of being placed in the At Risk unit.

3.2 Culture as defined and influenced by prisoners

A number of prisoner-defined cultural dimensions were described as negatively affecting health and wellbeing. Most significant was the incidence of violence and extortion in prison. In addition, tensions between ethnic groups often defined cultural divides. However, where previous research has understood gang conflict as a driving antisocial force, the majority of participants positioned inactivity and boredom as the primary antisocial influence; citing inactivity as an antecedent to violence, drug use, gambling and general "mischief". While still relevant, gangs were more commonly classed as an aggravating influence; not the driving force.

Violence
There's so much violence and the ridiculous thing about the violence in prison is that it's senseless, absolutely senseless and what happens, well what happened to me and I can only assume it happened to other inmates, is that over the years you become desensitised to it, like yeah just all the blood and muck, I have seen so much of that crap, yeah it's just absolutely senseless. Violence becomes the norm. (Siaki, Pacific man, 20–30 years)
I was in the high/medium unit and there was a lot of violence in that unit, that was unpleasant 'cause you always had to watch your back. The staff would never patrol the wings, they were just back at the guard room and you had 40, 40 or so inmates, just hazard really, staff just didn't patrol the wings. I wouldn't want to patrol the wings if there was 40 inmates in there and I was in there by myself. (Meki, Pacific man, 20–30 years)

Extortion
*Some people do stand over. You know they'll take your canteen [recently purchased supplies], they'll take your smokes, you know they could take your lunch. But they'll make you pay rent as far as they're concerned this is their f***ing home mate this is jail pay us half a 30 gram [tobacco] every week and if you don't we're going to kick your head in as simple as that. And I suppose me I'd get kicked and a lot of people do 'cause they've just got that attitude that's just how it is. You can go in segregation but then again a lot of times they run the segregation units because their presidents or captains tell them you go over on segregation you run that unit you make money over there for us. It's just how it is you know so they turn around and fill out a form wanting to go on segs [segregation] saying they're going to get their head kicked in whatever and next minute they're running the Segregation Unit. (Pita, Māori man, 30–40).*
Drugs
I spent 10 months in DTU [Drug Treatment Unit]. It was fantastic and then I get out and I'm back in mainstream and the temptation. I mean it is just so hard sometimes – there are drugs everywhere. I want to stay straight but prison is the last place you go if you want to clean up. (Atārangi, Māori woman, 20–25 years)
Gang culture
When I first came in what stressed me out were gang members and stuff like that in prison. I mean they throw you out in a mainstream yard and people try the stand over tactics and stuff like that and at the end of the day there's no real option for you. Its either go hard [try and protect one's self] like she's all over but they'll kick your head in anyway it's as simple as that. They've actually got no places for normal nice citizens who are non gang members in jail they basically throw you in with the rest of them and that's it. That was probably the only stress thing in all I'd say when I first came in. (Langi, Pacific man, 18–25 years)
Gambling
Most of the time gambling is about passing the time, like say seven days in a week, five days, I would gamble every day but most of the time we would gamble all day, one game and at the end of the day sweet as, you don't owe me, you don't owe me and it's all over. But you know once somebody puts say some smokes or some munchies on the table and say, "Have a game?" "Oh yeah sweet, I'll go grab something". So he will grab something and then at least you know there it's cash up so whoever wins takes it away. But there are a few days of the week where nobody has got nothing. "Oh yeah payday I will put up a packet of smokes" and next minute they owe 10 packets of smokes when you can only buy like two or three packets a week so you are just sinking yourself deeper in debt. But most of those games, those tick-up games are like at the end of the day you know, "Sweet it's over, everyone is square". No one hardly ever holds you to your debt. *I was addicted hard, like I gave up for like a whole six months. If somebody asked me for a game I just turned it away cause I got to a point where I owed thousands of dollars and it just got to the point you know there is no way you can pay that, you know you're in jail, the most you can spend a week is $60 or $70, then I ended up just keep gambling until I had chopped the bill down and paid off the rest yeah, it just hit me hard, like f*** how the hell am I going to get $20,000?* *It can create real problems. Like recently, we've had a few people run away to another unit cause they owed bills, so trying to hide away somewhere else where they don't have to pay it. A lot of carry on. At the end of the day you put your families through a lot of stress you know, them having to send you money. Yeah and plus you know amongst the unit it will stir up shit in the unit too cause he owes him but he can't pay up so they're going to go take his stuff off him and all that and then at the end of the day if the staff see what's happening then they just take our privileges away. (Anaru, Māori man 18–25 years)*

Those who failed to adapt to prison life reported heightened states of anxiety over prolonged periods of time, numerous accounts of assault on the person, the loss of property (through stand-over tactics) and one's family being extorted to provide funds to protect the individual.

Those at greatest risk of these vulnerabilities were:

- first-time offenders
- offenders without any social support networks in prison

- those with mental health conditions
- those perceived to be wealthy
- child sex offenders.

Protective factors included:

- previous incarcerations
- gang membership – *You get a lot of respect from a lot of the things that you do like get a lot of guys who played basketball and touch and all that, if you get in to that and you're good at it or whatever you get a lot of respect from the rest of them from doing thing … carving and sport lot of respect. (Langi, Pacific man, 20–30 years)*
- an ability to physically protect one's self
- extensive social networks within the prison
- incarcerated in a prison close to home area.

3.3 Interplay with the environment

Prison cultural dimensions were intensified through a number of environmental considerations – namely the role of:

- confined spaces
- allergic reactions associated to the environment
- double bunking
- dirty, unhygienic, cold and uncomfortable living conditions.

3.3.1 Confined spaces

Participants cited many examples whereby confined spaces coupled with extended periods of lock-down produced highly violent environments.

The role of violence needs to be understood in relation to the physical environment. For example, participants who had experienced prolonged lock-down commonly reported that their unit was extremely violent. This was understood in terms of:

- pent-up energy
- a lack of prosocial coping mechanisms.

Violence in relation to confined space
You're in your cell for 23 hours a day. You know everyday for days and days on end. You have all this energy. You're bored, sad and angry all at the same time. You've been missing your family. Then, depending on the prison, things might be really disgusting. In high security you can feel the animosity and tension. *You have all this energy you don't have no other options, you don't do workouts, you haven't got a TV you're pretty had it if you're locked up in a secure unit. So you go out into the yard and you accidentally look at someone the wrong way and BAM. (Langi, Pacific man, 18–25 years)*

The extent of violence in prison creates a major demand for health care intervention. For instance, each of the 63 participants had been involved in some form of violence in prison (as perpetrators, victims or both). Victims appeared to be more likely to discuss injuries resulting from assaults and cited:

- loss of teeth
- broken noses
- perforated eardrums
- broken arms and legs.

3.3.2 Allergic reactions in relation to the physical environment

Prisoners in rurally based prisons reported having extreme seasonal allergies. This was most notable in Waikeria and Rimutaka prison, which are surrounded by farmland and large numbers of trees. Those suffering from allergies reported feeling miserable and having a poor quality of life as allergy medication was either difficult to attain (i.e. because of waiting times to see the doctor) and/or because their medication had been forgotten when the nurse came to the unit to dispense.

3.3.3 Double bunking

Prison interviews coincided with the government considering introducing double bunking within prisons. As a result, this issue was "top of mind" for many prisoners, as well as officers. Throughout the prison interviews, many inmates and prison officers communicated concerns over double bunking and generally identified double bunking as an environmental aspect of prison life that will aggravate existing tensions and result in:

- the removal of a physical space to which prisoners are able to retreat to maintain mental health and to avoid threats to their personal safety
- risks to prisoners' physical safety – including rape and physical assault
- risks to prison officers' physical safety – including physical assault and homicide.

Double bunking – prisoner perspectives
It's really dangerous putting two inmates in one cell. That is so dangerous and I've heard John Key talking about it. There is always a lot of violence when two people are in one cell, always, and it goes unreported. I know of people being raped. I know of a man being murdered... very, very dangerous for two people in a cell... you have two people in that close space, you just drive each other mad and someone goes to the toilet and they crap, everyone has got to smell the crap, it's very, very bad, yeah in the space for two people. (Meki, Pacific man, 30–40 years)
You need your space for yourself. It's your personal privacy and personal space so you can write letters and self-talk without dealing with anyone else. It's hard enough by yourself being here without dealing with someone else and all their problems become yours too. I just know from experience. I've been celled up with others. There'd be more violence. We're doing high intensity stuff [therapeutic programme]. You need to vent out sometimes by yourself; take time out. Can't take time out if someone's always there. (Tipene, Māori man, 18–25 years)
In Mt Eden the amount of space each inmate is given is very limited. It's two-bunked in a single cell so you never have any privacy and it's always crowded. You got two people eating their dinners. You go to the toilet. You have no privacy. I really don't like the double bunking. Double-bunking basically means you don't get any privacy at all. To me that's a real issue. A real health issue. A mental health issue as well. No moment's peace. Gets you irritated. You can't masturbate. There's a sexual tension always

there. I would rather have half the size of the cell and have it private than have twice, or even three times the cell and double-bunk. Two people don't get along. As soon as they shut the door they start beating up on each other. And they beat up on each other all day and night long. The guard opens up in the morning and one of them gets to sleep. And I've known those situations where they fought for an hour and a half before the guards finally went down and dealt with it. High stress – all of the effects of high stress. Over production of adrenaline…. (Scott, Pākehā man, 30–40 years)
Double bunking – prison officer perspective
Our worry [prison officers'] is that it [double bunking] will simply result in more prisoners to manage with no increases in officer numbers. In the end one or more of us will be killed. (Prison officer)

3.3.4 Dirty, unhygienic, cold and uncomfortable living conditions

Prisoners shared their anger, stress and frustration at having to live in dirty and unhygienic conditions in some prisons, which culminates in arguments and violence. Substandard environmental conditions further contribute to feelings of being second-rate, undeserving and unclean. This included:

- having to defecate in a bucket (in one's cell where they also eat and sleep)
- blood from violent incidents being left on floors for prolonged periods
- the presence of flies, cockroaches, rats and pigeons (especially prevalent in older prisons)
- only one mop being available for the entire unit (kitchen, toilet, cells, halls)
- a lack of spiritual cleanliness or imbalance of having to live in an environment where hangings had taken place.

Unclean living environment
It makes you feel unclean especially if you're brought up clean. Mount Eden is a filthy yucky jail. They did hangings there back in the day. You can feel it in that place. Spirits . It stresses you out. Some jails can really trigger stress in this way, you know the way they run it and how old it is. The yards are filthy. It's riddled with cockroaches – they walk around like they're part of the jail. The roaches come out of the air vents at night – they're grand-daddy size. And it makes you crazy, stressed. There's more fights. It's not a happy time. (Heta, Māori man, 18–25 years)

In addition, some prisoners associated long-term back and neck pain and the need for physiotherapy with mattresses and pillows that did not have sufficient thickness or padding. These prisoners expressed frustration in repeated attempts to obtain alternative bedding and could not understand why this was so difficult when replaced bedding would alleviate back and neck problems.

Inadequate bedding
I had a bad back and sore neck for ages. Even trying to get an extra mattress or something was near impossible. I asked for a pillow when I came to this unit five months ago because the pillow they provided me with was well it was this thin there was no neck support which I need to support my neck and keep my spine straight. At first they said I could have a pillow so I done a property form for it then they turned around and instead said I had to go to medical to get it. So I went to medical and got approval from medical and then they turned around to me and told me no you have to write a letter to the unit manager. So I thought oh my god so I wrote a letter to the unit manager and he approved it and then finally they approved it and it's made a big difference. (Pita, Māori man, 30–40 years)

Prisoners also recounted having to make do with insufficient blankets and too small or thin clothing that provided little protection against the cold. While some participants traced catching colds to the lack of warm conditions, the greatest impact was a decreased wellbeing as prisoners consistently described being cold.

3.4 Conclusion

Through prison-specific language, inmates were framed as inferior to officers and other authority figures. The use of prison authorities' discretionary power controlled prisoners by instilling fear of reprisals. Similarly, participants outlined a number of extremely negative cultural and environmental factors that place many prisoners in vulnerable positions and undermine their wellbeing and health. These factors provide the context to understand prisoners' experiences with prison health, dental and mental health care.

MEDICAL CARE

Under section 75 of the Corrections Act 2004, a prisoner is entitled to receive medical treatment that is reasonably necessary, and the standard of health care available to prisoners must be equivalent to the standard available to members of the public.

There is a powerlessness felt by prisoners when they can't get access to medical care. If a member of the public injures themselves they can go to a clinic, fill out an ACC form, they get to go to a physiotherapist. But there is a mindset that being denied access to good medical care is a component of incarceration. (Stuart, Pākehā, 25–35 years)

4 Primary Health Care

Participants generally regarded prison's provision of primary health care as below the standard of "life outside the wire" and traced their dissatisfaction to:

- a lack of continuity of care between public and prison services
- difficulties accessing primary medical care
- difficulties associated with treatment or inappropriate treatment.

While multiple examples of highly satisfactory medical provision were provided, these were generally restricted to emergencies and chronic condition management. Satisfactory experiences with primary medical care occurred inconsistently, as participants commonly countered positive experiences with an equal or greater number of negative accounts. Of note, participants' satisfaction with primary medical care differed strongly across prisons and may be described as ad hoc.

This chapter reviews prisoners' experiences with primary medical care as it affects their health and wellbeing in prison. Areas of satisfaction and dissatisfaction are detailed throughout the chapter along with mechanisms that either facilitate or hinder satisfactory receipt of primary medical care as described by participants. The chapter concludes with a review of outcomes of prisoner experiences with primary medical care.

4.1 Continuity of care – from public to prison

Continuity of care arose as a concern in relation to:

- previously diagnosed conditions requiring ongoing specialist medical intervention and/or monitoring by the prison doctor
- discontinuation of medication upon entering prison resulting in distress and negative health outcomes.

4.1.1 Previously diagnosed conditions requiring specialist medical intervention and/or monitoring by the prison doctor

The majority of participants did not have previously diagnosed conditions that required monitoring and/or medical intervention. Of those who did, satisfactory continuity of care was more commonly reported by those with more obvious conditions (such as orthotics). Those with less satisfactory experiences attributed poor continuity of care to:

- appearing healthy
- being perceived by medical staff as malingering or as "frequent flyers"
- medical records not being thoroughly reviewed and medical staff erroneously citing that no condition had been noted by the "external" general practitioner and/or other prison staff
- some medical staff's negative perceptions of inmates
- "muster blowouts" and other forms of prison transfer undermining any primary care-based relationships that may have been formed (further, repeat transfers made

disclosure less likely in an environment where disclosing one's medical history is embarrassing or simply frustrating when having to repeatedly do so)

- a high rotation of nursing staff
- a reliance on nursing staff to assess the patient's condition and whether or not they will authorise a referral to the medical provider.

Many participants said they "gave up" seeking medical intervention as a result of these experiences.

The following case studies have been selected to further explore the impact of poor continuity of care following an individual's incarceration. These cases reflect the impact of poor continuity of care for those with a previously diagnosed condition.

Case study – failure to receive semi-urgent surgical intervention
Hāmiora related that he had a surgical condition and had been waiting for semi-urgent surgical intervention for the last three years. A review of his medical records revealed that he had seen three specialists over a three year period. The first specialist assessed the condition as semi-urgent and advised that surgery occur within six months. Surgery had been scheduled on three occasions but had been cancelled because "muster blowout" had meant Hāmiora was sent to three different prisons within two weeks of the scheduled surgery. Throughout this period each consecutive prison referred Hāmiora to a local specialist, which resulted in surgery again being scheduled. This had not occurred at the latest prison as the nurse following up on Hāmiora's request for a specialist referral had reviewed his file and had seen no documentation of a breathing problem and related that she had seen Hāmiora running and therefore questioned the nature of the complaint. No further action has been taken. Hāmiora related that he had given up and will seek medical attention once released from prison. Of note, documentation confirming assessment and need for surgery was secured (Hāmiora, Māori man, 18 – 25 years).
Case study – chronic skin condition requiring specialist intervention
Helen was diagnosed with a chronic skin condition six years prior to going to prison. In her words, the condition, if untreated, can result in severe scarring. Over the last six years, Helen had been under the care of a specialist. When first incarcerated, Helen's specialist wrote to the prison and outlined the need for her to see a local specialist. A specialist referral never eventuated and Helen again wrote to her specialist asking that he send another letter to the prison asking why an appointment with a specialist has not been made. *I have not heard anything after that. It's actually got to the point where I have given up because you bang your head against a brick wall. So I will be leaving here [prison] after a year with quite a bit of scarring. (Helen, Pākehā, 30–40 years)*
Case study – failure to receive annual cervical smear following a history of abnormal smears
Three years prior to Annette's incarceration, Annette had received an abnormal cervical smear result. She was subsequently required to have an annual smear. Annette's incarceration coincided with her annual smear and her husband forwarded the annual reminder letter to the prison. Unfortunately, delays resulted in Annette's smear becoming significantly overdue. *I was due for my year one then and it took me nearly a year to get one even though I put in a request so many times, that is not very good. (Annette, Māori, 30–40 years)*

4.1.2 Discontinuation of medication upon entering prison resulting in duress and negative health outcomes

Participants commonly reported temporary and permanent discontinuation of their medications when remanded, sentenced to prison and/or transferred between prisons. For instance, it was common for medications to be temporarily suspended until the prison doctor became available and was able to confirm medical and prescription histories with the prisoner's external provider. Permanent discontinuation appeared to be more geared towards medications with specific

street values that risked the prisoner being threatened and forced to hand over their medication to other prisoners. Of note, prisons differed according to which medications were permitted. Medications specifically mentioned by prisoners fell into benzodiazepine categories.

Inmates prevented from accessing medication often reported experiencing extreme anxiety. Some of this anxiety was attributed to concern over ensuring one's health care is maintained and the fact that discontinuation, even temporary, can be life threatening.

Case studies – temporarily discontinued cardiac medication
David had been diagnosed with heart arrhythmia prior to going to prison and had been taking cardiac and anticoagulant medication for some years. In preparation for sentencing, David had taken a week's supply of medication with him, anticipating a short delay until the prison was able to dispense the required prescription. He had not understood that his medication would be confiscated because there was insufficient evidence to prove that it was his. Four days passed before David received his prescription as he was told that a doctor was not available to authorise the prescription. *I worried for days waiting for my meds. It was a bit of a worry because, with my heart medication, if I stop taking it I go into atrial fibrillation and there's a big risk of having a stroke. (David, Pākehā, 50–60 years)*

4.2 Difficulties accessing primary health care

The majority of participants cited prolonged waiting times to see a doctor as a primary stressor and as having a major negative impact on their health.[10] For those seen by a doctor, the average waiting time was generally seven days and ranged between the same day and five weeks. However, some medical complaints went unseen altogether.

Waiting times differed by prison and by whether or not the situation was urgent. In urgent or emergency situations, inmates were more likely to report seeing a medical provider on the same day. However, a number of participants reported substantial delays in being seen by a doctor and receiving treatment and some were never seen at all. The following section explores a number of reasons given for prolonged waiting times:

- medical request processes
- nurse referrals
- under-resourcing
- other systemic issues.

In response to prolonged waiting times, and especially when multiple requests had been made, participants commonly reported having decided to stop seeking medical attention. These decisions were explained as a way of maintaining a sense of pride and control in an environment that had removed the individual's control over their health and wellbeing.

Case studies – decisions not to seek medical attention
To an extent you can't even beg because you're fighting against a power struggle, you really are. The officers, not all the officers are horrible, some of them are actually very nice and they're extremely helpful and even for them they bang their heads against a brick wall but because effectively we are classed as prisoners regardless of who we are as people or what our conditions are. We have punishment, we are not here for services and that is portrayed a lot in here. (Helen, Pākehā, 30–40 years)

[10] cf Radio NZ (7 August 2009) "Prisoner Health Services Criticised", www.radionz.co.nz/news/stories/2009/08/07/1245c16b1319

Case studies – decisions not to seek medical attention
I was remanded and there was this one girl she had delivered a baby just before she was arrested and she came in and initially she was freaking out because she couldn't stop bleeding. I mean we were helping her clean her room and they were just coming in telling her to put sanitary pads on and things but it was abnormal and in the end she just gave up ringing and ringing and I'm quite sure she got infections and stuff. But I mean she was haemorrhaging from you know delivering a baby. I've had children it wasn't normal haemorrhaging but she gave up she was just she never even got to the doctor it was the shift nurse that was coming to her and just constantly giving her pain killers and sanitary pads and no internals or anything. I mean we were all so angry and we were all saying to the officers "Why? Don't you know this lady is in trouble?" And they said, "We've told medical" you know "There's only so much we can do", you know. But that was just a prime example of someone really, really needing and then just fed up with it. (Mere, Māori woman, 30–40 years)
Tai moved to New Zealand in the 1970s from Tonga and he has been incarcerated for the last three years. When questioned about accessing the prison doctor, Tai related that he had tried but had never managed to be seen by the doctor and had stopped requesting medical attention because he had interpreted previous failed attempts as the medical staff not caring. *I have put in three medical chits since I was in prison. I never got it [medical appointment] so I gave up. The last time I asked to go to the doctor I had a very sore back and neck. I wanted to see the doctor. They said I had to fill in a form. I filled the form and sent it away, and that's it – never get back to me on that matter. That's it. I didn't fill in another form. Because I applied the first time. They say to fill in the form and I filled in the form. No one answered. No one got back to me. So, it's like why should I bother? So, you don't think they care. (Tai, Pacific man, 30–40 years)*
Most of the time you just give up. 'Cause you could have a sore stomach or whatever pain for a couple of days, you're not seen by the doctor for about 2 or 3 weeks and by the time they come it's gone and like so yeah heaps of people end up giving up. (Reka, Pacific woman, 20–30 years)
Well the nurse makes the appointment so you have to ask for a nurse first, to see the nurse and then ask can I see a doctor and they tell you when the doctor is coming in and then they have to make an appointment for you and that could be in a month's time, the doctor might be coming in or sometimes they don't even make the appointment. They just forget. They make you feel like you're moaning. So I just gave up. (Margot, Pākehā woman, 60–70 years)

The following outcomes of decisions not to seek medical attention were cited:

- prolonged periods of pain
- heightened anxiety about one's medical conditions
- a lack of preventative care and/or early intervention
- serious risk of poor health and wellbeing.

4.2.1 Medical requests

Prisoners were generally expected to make requests to see a medical provider by completing a request or "medical chit". Depending on the prison, this form is either given directly to the prison officer to pass on to medical or, in a minority of cases, placed in a box that is then collected by a nurse during their rounds. Medical requests are reviewed by a nurse, prioritised and actioned as considered appropriate, with the nurse deciding whether or not to refer a prisoner to the doctor.

It was common for multiple requests to be submitted. Participants reported feeling compelled to complete follow-up requests because:

- their presenting symptoms had worsened

- their pain and discomfort was persistent or had escalated
- they had not been informed of the outcome of their initial request
- they assumed that the medical request had been ignored or lost.

Prisoners related multiple accounts where their anxiety levels had been unnecessarily heightened because of the length of time they had to wait to hear if their medical request would be granted. Anxiety levels were also reported to be aggravated by:

- a sense of powerlessness associated with not being able to proactively access a medical provider
- unrelenting discomfort, pain and/or concern associated with their condition
- the possibility that isolation and confinement provide no distraction from the presenting issues and may result in a catastrophising of symptoms
- a lack of feedback from nursing staff about the outcome of the medical request(s)
- an inability to track whether or not medical chits have been:
  - sent to medical
  - processed.

4.2.2 Nurse referral

Nurses were consistently positioned as gatekeepers within the prison medical system. In this role, the nurse is responsible for assessing the individual's medical needs and referring, where appropriate, to the prison doctor or directly sending the prisoner to hospital. In many situations, this role was reported as working well, although inconsistent practice often resulted in positive health care experiences being countered with an equal number of negative experiences.

Inconsistent provision of primary health care
You know it differs [nurse professionalism]. I had a seizure and they [nurses] were there straight away. They put me in At Risk and kept an eye on me. Another time I was assaulted and my nose was broken. The guards were real worried and called medical. They were there in a few minutes. Another time I broke my wrist in a fight and they made me wait three days before they let me go to medical. The first nurse said that she thought that it would be alright and that I should wait and see if the swelling goes down. I went back to her the next day but she thought it would be fine. I couldn't sleep it was mad painful. So the next day another nurse came around and I showed it to her. She took me straight to medical. (Tau, Pacific man, 18–25 years)

The speed at which an individual was referred to a doctor was attributed to the degree to which:

- a situation appeared to be an obvious urgent need
- the prisoner had an existing relationship with a nurse
- the nurse had a positive or negative attitude to prisoners

- the inmate's attitude and behaviour impacted negatively or positively on their relationship with staff
- the nurse had sufficient knowledge to assess and refer when necessary
- budget constraints.

Obvious urgent need

Urgent medical situations were generally reported as resulting in the individual being seen by a medical provider on the same day.

I smashed my arm, I told the guard, she told me to hang on, she didn't realise how urgent it was because I kind of just went, "Excuse me; I think I have broken my arm". Instead of going, "Oh ow help me". So I called out again, "Miss I think I have broken my arm", she was, "Oh hang on". The bone was sticking out. Yeah I had bones yeah, smashed my whole hand off the end of my arm. You know five minutes later she came out, she took one look at it and she was straight on the radio, "Medical we need medical assistance right now". The nurse was there within two minutes. They took me straight back to medical and they were on the phone to an ambulance straight away, it all just happened bang, bang, bang, real quick. (Heather, Pākehā woman, 30–40 years)

Existing relationship with a nurse

Participants with an existing positive relationship with a prison nurse reported having few difficulties accessing the prison doctor. Relationships were reported to develop through:

- an existing chronic medical condition that resulted in frequent nurse–prisoner contact
- long-term incarceration.

Having a good relationship with the nurse
Wiremu related that he had developed a friendship with one of the nurses who regularly visited his unit. Over a period of a week, the nurse became concerned about Wiremu's health and arranged for him to be sent to the nearest hospital because she suspected that he had a significant health problem. Through this nurse's intervention, Wiremu received early medical intervention and anything more serious was avoided (Wiremu, Māori man, 50 – 60 years).
I went to the nurse and asked her if I could have an HIV test. She didn't say no but she sort of looked at me like no and I was well how do I know if I don't check? So I felt that I was getting the cold shoulder on that issue so I went to my regular nurse. She'd known me for the last 15 years and she goes, "Oh you. You blimmin' rascal. Get in here, what's the matter with you. Gees you're getting soft in your old age" and you have got that rapport with that person. So that helps in getting things done – you know if they know you and respect you. (Maaka, Māori, 30–40 years)
The fact that I see the nurse every night anyway, she has to bring my Lithium to get my meds, so maybe the women who say that they find it difficult don't have that regular contact with the nursing staff that I do. (Heather, Pākehā woman, 30–40 years)

As previously discussed (see Continuity of Care), transfers between units, especially as a result of "muster blowouts", can negatively affect these facilitative relationships.

Attitude towards prisoners

Some nurses' negative attitudes toward prisoners were described as having a major role in dissuading inmates from accessing health care. For instance, participants reported negative experiences with some nurses that left the inmate feeling judged, disbelieved, not listened to and not cared about. Inherently, many participants had at least one bad experience with a

nurse that left them feeling that they were a *"burden on the system and as criminals we should feel lucky getting Panadol" (Richard, Pākehā man, 50–60 years).*

Negative attitudes about prisoners fell into three categories, which are outlined below. These categories were articulated from comments made by a small number of prison medical staff to the research team about why some prisoners are not given a medical appointment and reflected views expressed by prisoners interviewed.

- **Doubt** – prisoners' medical complaints or concerns were often suspected to be fabrications that emerged out of conversations with other prisoners. For instance, one nurse said, *"Prisoners develop an allergy in the van between here and the prison".*

- **Minimising prisoners' reports of ill-health** – some medical requests were classed as non-urgent because specific inmates were believed to be bored because of the monotony of prison. As a result, some staff asserted that many prisoners develop an unhealthy focus on specific symptoms.

- **Frequent flyers** – two medical staff used this term to refer to patients who make frequent visits to the prison medical clinic. Staff believed frequent visitation to result from loneliness and boredom, with the medical clinic providing an opportunity to alleviate loneliness. *"These diseases come out of the woodwork..."*

The inmate's attitude and behaviour towards staff

Inmates stressed that medical care was more easily accessed when the prisoner adopted an appropriately compliant and respectful behaviour towards staff. Amenable behaviour was rewarded with ease of access to medical care and leniency toward the need for prisoners to complete a written medical request.

Compliant attitude
It all boils down to attitude, you know you've got a good attitude they will see you, if you haven't then you get put on the waiting list. If you go in there and you start banging on the door and demanding nine times out of 10 they will say to you go away and fill out a medical chit. So that means a delay in seeing the nurse. But if you knock and ask nicely they'll most likely see you right there and then. (Maaka, Māori man, 40–50)
As long as the papers were filled out you will get seen. But if you go in there shouting and screaming the nurses won't fill out the paper, they just pass it on to the PCO saying you are unruly or whatever, deal with it. Then that's another day they don't see medical and then another day but they don't, people that play up don't actually see that you know, all they see is they're not getting attention. (Gary, Pākehā man, 50–60 years)

Sufficient knowledge to assess and refer when necessary

Prolonged waiting times were often blamed on a nurse's poor assessment of a prisoner's medical need.[11] Poor assessment was described as a poor review of the prisoner's medical history and poor assessment of a presenting condition and/or situation.

[11] Criticisms were tempered with a strong belief that the prison system, out of a spirit of cost effectiveness, placed an unfair expectation on nurses to assess patient needs (this was especially so when there was no medical provider on site).

Numerous examples were given (and later supported by the review of medical files[12]) in which a nurse had decided not to refer the patient to the doctor because the nurse had failed to read the patient's complete medical history and had decided that the prisoner had been fabricating a particular medical history (see, for example, the earlier case study on the 'Failure to receive semi-urgent surgical intervention'). Similarly, while many examples were given of excellent assessment and referral, an equal number of decisions not to refer the individual to a doctor were provided. The following case studies provide participants' perspectives on a nurse's decision not to refer.

Case study – eye injury
The other day I was outside using the lawnmower and a small stick flew up and went into my eye [indicating five centimetres with his fingers]. I had to pull it out and it's pretty sore. I told the officer that I needed to see the doctor because of my eye. It was real blurry, it still is now [four days later], but he said that it would be okay. I told him I wanted to go to the doctor and he said, "Oh you have to wait for them [the nurses] to come around". And I said, "My eye is very, very sore". Anyway, I had to wait until the nurse came round and I told her about my eye, what had happened and she goes, "Oh you'll be alright love". I was real upset. Then yesterday this other lady [nurse] she came around and asked, "What's the matter honey?" And I told her about my eye. She was cool. She gave me eye drops for cleaning my eye and said that she's going to get me to see the doctor. Some of them [nurses] are great. Some of them just aren't doing their jobs properly. They just ignore it. They're not really treating us properly. (Tay, Pacific man, 18–25 years)
Case study – dislocated finger
I dislocated a finger. It took me over a week to get to medical. My finger was like a V. It was swollen as. I showed them my finger and she says, "Oh well you can't tell". And I says, "You can. I heard it crack, it's not right something's wrong with it". And they just taped them together and every day I was like, "It's sore, I feel sick". But no, no. And then finally, it would have been about eight days, they organised me an appointment to get an X-ray. And then when they did take me for an X-ray, and confirmed that it was dislocated, they took me back to the prison and then two days later they took me to the hospital to get it put back into place. So that was a dislocated finger and that was physically dislocated. But yeah my finger is permanently disfigured now; you can see it's got a bit of a bump. But yeah you could see that it wasn't right. (Sue, Pākehā woman, 20–30 years)

Participants who had initially experienced a poor assessment reported having the situation remedied through:

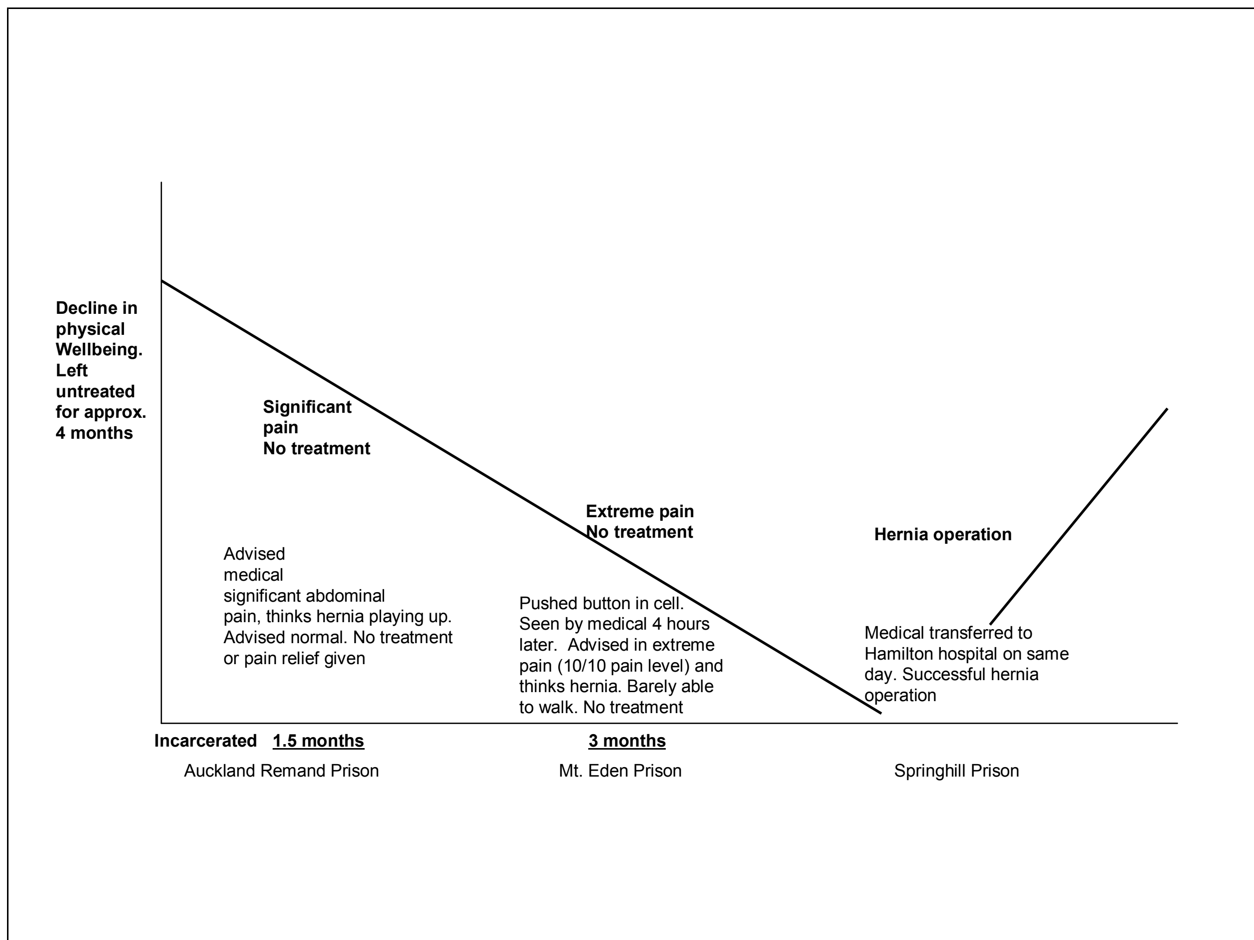
- another nurse's assessment – this generally occurred on a subsequent day and was more likely to occur if the inmate appeared to be in extreme pain and/or if the inmate had an existing relationship with the nurse
- a prison officer's intervention – some participants related that prison officers brought medical concerns to nurses' attention, which often resulted in an assessment and a referral to the doctor
- transfer to another prison, which coincides with a medical assessment.

[12] The review of medical files was conducted by the lead researcher who has extensive experience with medical file review. If required clinical support was available through a pharmacist and three physicians. Again, the researchers acknowledge the assistance of the Department of Corrections in enabling the review of medical files, and the assistance given initially to help the researchers navigate the medical database.

Case study – untreated hernia
When on remand, Mikaere experienced severe pain that was diagnosed four months later as a hernia. For the one and a half months he spent in remand, he made numerous medical requests but was told by the nursing staff that everything was normal. At the end of a month and a half, Mikaere was transferred. He again requested medical attention as he was experiencing extreme pain and found it difficult to walk. Again he was told that what he was experiencing was normal. After three months, Mikaere was transferred to another prison. At reception, he was assessed by a nurse and sent immediately to hospital for an emergency hernia operation. (Mikaere, Māori man, 18 – 25 years)

The following diagram provides a representation of Mikaere's experience. This reflects his account and is also supported by a review of his medical file.

The Impact of Poor Assessment and an Untreated Hernia



Budget constraints

Medical staff within one prison related that, at the time of interviewing, they were working within the following budgetary parameters:

- no more than two external medical referrals per day due to costs associated with the provision of prison officers for security and distance required to travel

- the requirement for a nurse's permission for an ambulance to be called as ambulances charged per call-out.[13]

4.2.3 Under-resourcing

Prisoners' access to medical staff seemed to be constrained by a lack of resourcing. Few of the prisons visited appeared to have a medical doctor working on the weekends and some prisons had a doctor on-site only part-time. For instance, at one prison, two doctors were employed on a part-time basis: one doctor works four hours on the Monday and a second works the remaining hours on a Friday.

4.2.4 Systemic barriers to accessing primary health care

A number of systemic barriers to accessing primary health care arose out of the interviews:

- cost of care
- continuity of care through dedicated nursing staff for each unit
- breaches to patient confidentiality
- below-functional literacy
- compromised safety accessing primary health care.

Cost of care

At one prison medical centre visited by the research team, it was noted that a flyer on the clinic wall stated that flu vaccinations were available for a cost of $9.00 to the prisoner. When questioned, the medical staff related that, as with the wider population, inmates over 65 years and with chronic conditions received the vaccine for no charge but remaining prisoners had to pay. Follow-up interviews with inmates revealed that none of the participants were willing to pay the required $9.00 as this fee went a considerable way towards purchasing phone cards, cigarettes and necessities. This was especially true in situations where inmates were being forced to purchase goods on behalf of another inmate. As such, requirements for inmates to carry primary health care costs do not reflect an understanding of the complex and often threatening prison environment and the relative lack of purchasing power.

Continuity of care through dedicated nursing staff for each unit

The need to dispense medication and to uplift medical request forms generally means nurses, across prisons, visit units on a daily basis. However, prisons differed according to whether nurses were exclusively dedicated to a unit. For instance, at one prison, the researchers were informed that one nurse was dedicated per prison unit. Dedicated staffing was given as a primary explanation for effective continuity of care. This is in contrast to prisons with a nursing rotation system or "floating" nursing staff who visit units when staffing levels require. In rotating systems, it is difficult for nurses and prisoners to form relationships that facilitate the ongoing provision of care and/or monitoring of the individuals' health status.

Impact of nurses on rotating system
No one is permanently here. There is a different nurse on a rotating system. So there is little continuity. Requests made on one shift – there is a high chance that it will not be passed on. (Stuart, Pākehā, 25–35 years)

[13] The Department of Corrections advises that these limitations around external medical referral are neither policy nor practice.

Breaches to patient confidentiality

The medical request process acted as a barrier to accessing medical care because of concerns that the request process risks breaches to prisoner confidentiality. For example, inmates were required to hand the completed medical request to an officer or place the request in a box held in the guard house. In either scenario, participants related that they had experienced embarrassment and cited a number of examples of breaches of their confidentiality. As a consequence, the medical request process was found to serve as a disincentive to participants to complete future requests.

Below-functional literacy

Participants with below-functional literacy said that the written medical request system often acted to compromise their access to primary health care because of:

- embarrassment at having to rely on officers to complete the medical request
- embarrassment at having to disclose medical concerns to a third party (prison officers).

Below-functional literacy as a barrier to accessing primary medical care
It gets very frustrating. You explain your issue to a nurse and they say, "Fill in a medical chit". So I go and ask someone to help me and I get a chit filled in. Nothing happens so I go to another nurse and she says, "You need to fill in a chit". So I go and ask a guard. They might or might not make fun of me ... I don't know what they're writing, but I take a chance and get another chit filled out. I put it in... but still nothing happens. So you know. I just give up. It is too humiliating. (Siaki, Pacific man, 20–30 years)

Participants' frustration was compounded when:

- English was a second language
- the unit nursing staff changed regularly. This meant that nurses were not able to develop adequate levels of knowledge about individual prisoners to inform their assessment, triage and referral decisions.

Access impacted by changing staff
When communications are verbal there is no paper trail. Therefore the prisoners rely on medical staff to remember the issue and follow through. Because they [medical staff] are human they go home and forget the issue. It's understandable but we're left here in pain and worrying ourselves to death. (Stuart, Pākehā, 25–35 years)

Compromised safety accessing primary health care

Participants reported that waiting in the medical clinic holding cell, with other inmates, posed a significant risk as it created an opportunity for violence.

Case study – medical clinic holding cells
*I had been in prison only three days and I have a condition that requires daily medication. And when I went to go to daily medication they put me into a cell with another 14 prisoners in it and I got attacked. Which isn't too surprising since I was new I didn't know what the f*** was going on. Pardon my language. Therefore I was very hesitant to go back to medical. But you have people in segregation in one holding cell and literally two metres away from them are a group of mainstream people who are making threats to the guys from segregation. The only thing keeping those prisoners from walking into yours is the guard. It is possible to lock those holding cell doors but the times I've been to medical I have only seen them locked once. (Alexander, Pākehā man, 40–50 years)*

4.3 Difficulties associated with treatment

Treatment-related concerns were almost always restricted to nursing staff, with very few negative comments made about prison doctors. Concern over treatment focused on:

- dispensing
- a lack of communication and follow-up after a medical visit.

4.3.1 *Dispensing*

Many participants with chronic conditions required medication to be dispensed at least daily. A number of issues with dispensing medication arose in two of the prisons visited. In these situations:

- medication was dispensed to the wrong person
- medication was forgotten and so the inmate missed out
- ingesting the wrong medication resulted in some prisoners getting seriously ill
- concern over maintaining appropriate therapeutic dosage levels affected some prisoners' wellbeing.

Medication
You wouldn't believe the number of times they forget my medication. I mean I am on antipsychotics. I really need the meds. The system really sucks. I spend a lot of time worrying about it. (Siaki, Pacific man, 20–30 years)
I had an incident about two weeks ago when one of the nurses was trying to give me someone else's medication. I was saying, "No that's not mine!" and that nurse was trying to say "Yes it is, it's got your name on it, here it is" and yeah I ended up, 'cause this was in our wing and we knew who that belongs, no that belongs to thing you need to take that to her and yeah. There's been heaps of stuff like that. You have got to check your medication to see if it is your own or not 'cause sometimes they get the names mixed up or your name is down for some other type of medicine. If you don't check it, everyone does though, they check it themselves to make sure that it's the same thing that, they know what it is. (Reka, Pacific woman, 18–25 years)

4.3.2 *Communication and follow-up*

One of the greatest complaints among participants was not having appropriate follow-up communications with medical staff after medical tests and/or procedures. This was reported as having resulted in a high degree of frustration and anxiety that escalated with each unsuccessful attempt to secure information from the medical unit.

Lack of communication resulting in confusion and anxiety
Joy related that she had not had a period since she was incarcerated eight months ago. The prison doctor conducted a test five weeks ago but the results have not been given to Joy, despite Joy asking to see the doctor every two days. This has caused Joy a great deal of anxiety and concern. *You know that is really bizarre for me, I usually get it monthly and they're not doing anything about that. I've got no energy you know, hot and cold flushes and stuff like that. These are telltale signs that something is not right. They said "Oh well that just sometimes happens in jail". But it doesn't you know, for me, it wasn't like that last time I was in here. I know my body. So I thought that is something very important I need to have done and they're not doing anything about it. If I was out I'd see my GP and would have test results straight away and after the tests there would be I don't know a scan or something else to find out what the problem was. (Joy, Pākehā woman, 18–25 years)*

Inadequate communication
Two years ago, while in Rimutaka prison, Fale Lima collapsed on the floor with a pain in his arm and was immediately taken to hospital. When interviewed, Fale Lima reported that he had had a heart attack and was worried that he hadn't seen the doctor since he transferred to the new prison five months ago. Despite numerous requests to see the doctor, an appointment never eventuated. This has caused Fale Lima significant anxiety as he has not been able to secure medication for his cardiac problem over the last five months. Following the interview, Fale Lima's medical record was reviewed. Much of his account was corroborated. However, rather than a heart attack, the doctor at the hospital reported that reason(s) underlying his collapse were never isolated and there was no indication that Fale Lima had had a heart attack. Fale Lima's experience highlights a significant communication breakdown with medical staff. This may be partly attributed to Fale Lima's lack of fluency in English but it also reflects a lack of appropriate communication regarding his health status. Appropriate follow-up might have addressed the major misunderstanding and concern Fale Lima has about his health. (Fale Lima, Pacific man, 40 – 50 years)

MENTAL HEALTH

Under section 75 of the Corrections Act 2004, a prisoner is entitled to receive medical treatment that is reasonably necessary, and the standard of health care available to prisoners must be equivalent to the standard available to members of the public.

"Mental health care provided to prisoners must be reasonably equivalent to the standards of care available to the public."

(Department of Corrections Policy and Procedures Manual – A16 Mental Health, National Policy)

5 Mental Health

Participants consistently reported that mental health services were under-provided. Concern was traced to:

- a lack of continuity of care between public mental health services and prison
- difficulties associated with accessing mental health services
- the impact of the prison environment on mental health.

This chapter reviews prisoners' experiences with mental health in relation to the prisoners' health and wellbeing in prison. Areas of satisfaction and dissatisfaction are detailed throughout the chapter, along with mechanisms that either facilitate or hinder satisfactory receipt of primary medical care as described by participants. The chapter concludes with a review of outcomes of prisoner experiences with primary medical care.

5.1 Continuity of care – from public to prison

Continuity of care arose in relation to:

- previously diagnosed conditions required psychiatric intervention and/or monitoring
- discontinuation of medication upon entering prison resulted in distress and mental health deterioration
- the prisoner chose to discontinue their medication, resulting in negative health and wellbeing outcomes.

5.1.1 Previously diagnosed conditions requiring psychiatric intervention and/or monitoring

Of the 63 pre-release participants, 30 had been diagnosed with a psychiatric illness prior to their incarceration and the majority of these had not received mental health treatment since their incarceration. Rather than concern about not establishing a relationship with a prison-based mental health professional, participants instead focused on the impact of their medications being discontinued.

5.1.2 Discontinuation of medication upon entering prison resulting in duress and negative health outcomes

Participants commonly reported extreme anxiety when their mental health medications were discontinued. This anxiety was attributed to concern over ensuring the maintenance of mental health and the fact that discontinuation, even temporary, can result in suicidal and homicidal ideation, paranoid delusions and violent behaviour.

Participants commonly reported that medications were temporarily suspended until the prisoner's medical and prescription history was verified. Extreme worry was frequently reported throughout the verification process as participants feared that their mental health would deteriorate. Anxiety levels appeared to be aggravated by a lack of regular updates. As such, the inmates felt isolated and not in control of their mental health. Participants related that they found themselves ruminating about their health and whether or not their medication would be reinstated. In the interim, a lack of information contributed to growing anxiety levels.

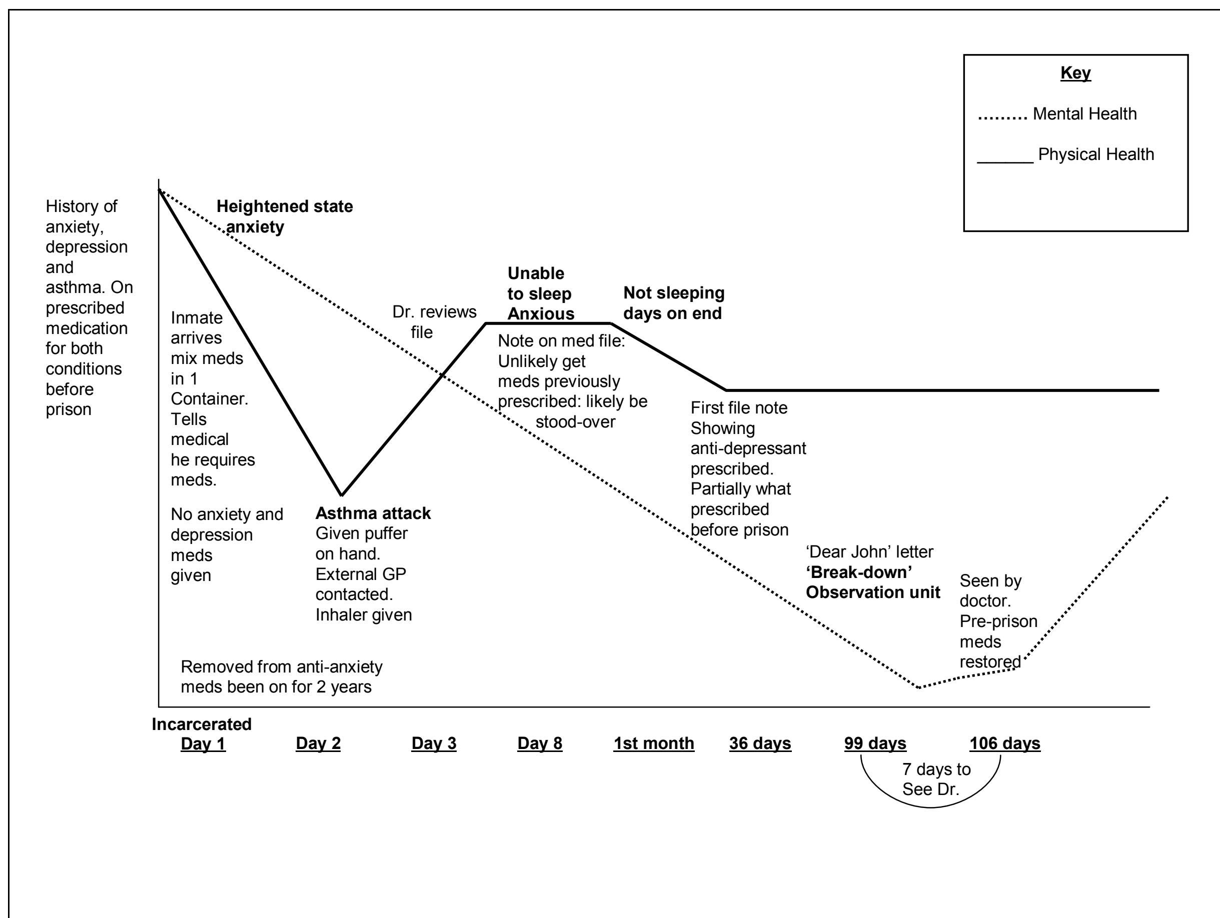
Permanent discontinuation was more frequently reported for medications with specific street values, as continuation risked the prisoner being threatened and forced to hand over their medication to other prisoners. Prisons differed according to which medications were permitted. Medications specifically mentioned by prisoners fell into benzodiazepine category.

In many cases, medications were reinstated within a few days of the prisoner arriving at reception. This relatively short timeframe was attributed to the professionalism of specific nurses and/or the severity of the condition. However, a significant amount of time elapsed for a number of participants, and in some cases medication was never reinstated. On these occasions, the prisoner reported a drastic deterioration of their wellbeing and health.

Case study – the impact of removing medication on mental health
Richard had been prescribed anti-anxiety and anti-depression medication for a number of years prior to coming to prison. He had regular monthly appointments with his GP and visited his psychiatrist every six months. On entering prison, Richard was told that his medication would be discontinued until his external medical provider was able to confirm his medical and prescription history. *When I arrived at the prison they removed all my antidepressants. They said that I might be stood over for them. I was unable to sleep so after about a week they gave me antihistamines. It didn't really help... I was too anxious. I had a lot on my plate. I just came to prison; I was reliving past events; I was not sleeping for days on end. I was at maximum despair. I could feel myself going downhill in this negative environment. You get bullied and have to be on the alert. It's like high school, but more intense. Violent and intense and you're confined to one area. You have limited movement and you can't get away...* *After about a month they gave me a different antidepressant from the one I was on on the outside. But it was a really low dose and things didn't improve. Another two months went by. I was in agony and I was put in Self Harm [also known as At Risk] as I'd started spinning out. I couldn't see the way out. A week after going to Self Harm the doctor came and visited me and he prescribed the same meds I was on on the outside. Yeah, it was a real bad time. I was in agony. (Richard, Pākehā, 40–50 years)*

The diagram below represents Richard's experience, as described to the researchers by Richard and supported by a review of his medical records.

The Impact of Removing Anti-Anxiety Medication



Severe distress was reported by participants who had had their medications permanently discontinued. This was especially true in situations where inmates experienced a forced "cold turkey" withdrawal (i.e. no substitution or countdown). Most dramatic negative outcomes were reported by people who had a forced withdrawal from benzodiazepines and when psychiatric medication was not reinstated.

Case studies – forced benzodiazepine withdrawal
Um, when they just stopped it completely [Temazepam] it was horrible. Um, I was nervous, I was scared, I was shitty I was shaking all the time. The anxiety is huge. You feel like everything is just on top of you, you can't, there's no normality to your thoughts. I think it's wrong because I relied on those at the time and to be completely struck off from them when you need them the most to me it felt like another form of punishment because it was what was keeping me level at the time. (Helen, Pākehā, 30–40 years)
Umm because I had been prescribed Temazepam for quite a number of years now and I was diagnosed with ADHD and the prison doctor kept me on the Temazepam and kind of monitored it and everything like that and the day that I transferred prisons they cut it off completely and you know like I've been getting like head tremors, like I have laid down and my head is still shaking and spin out and stuff like that but they tell me that I just have to handle it until I get over it. And I get a lot of anxiety and stuff like that. *I went to go to the toilet and I stood in front of the toilet door and it was like my brain and my body wouldn't communicate, like I wanted to go to the toilet but I couldn't like actually physically go in the toilet or anything and I was standing out there and my girlfriend came up and was like what's wrong, and I was I can't open the f***ing door and she was like aye, and I said I think I am watching myself go crazy, that's what I thought was happening to me. She opened the toilet door for me and*

I went in the toilet and that and I came back out and her friend had come back out by then and nothing would come out of my mouth. *I am a quite violent and aggressive person, I have been since I was a child, and that was one thing I was scared about coming off, that the violence would come back out, my violence hasn't been there since I have been on Temazepam and that... (Annette, Māori, 30–40 years)*
But what annoyed me, what actually stuffed my system up, when I first got arrested, I was on Larazapam and Arapax and one other medication. They denied my bail so I had to go to prison for the weekend, so that was all good and fine, now I had my medication in my handbag in the packets that I got them from the Chemist and they were not given to me. They had no proof they were my medication they would not give them to me and I kept saying to them, well you're not meant to take me off this medication you know that's part of the rules is do not stop taking. They wouldn't give it to me, so on Monday, I was going through the full withdrawals of being on those three medications. (Sue, Pākehā woman, 30–40 years)

5.1.3 The prisoner's choice to discontinue their medication for safety reasons

Some participants discussed discontinuing their medication because of the dangers posed by the prison environment. Some medications were believed to reduce the individual's reaction time or cloud thought processes. In either case, the individual reported feeling as though medication compromised their ability to protect themselves. The following medications that were believed to compromise clarity of mind, awareness of the environment and reaction speed were discontinued:

- anti-depressant
- anti-anxiety
- anti-convulsant
- hypertension medications.

The prison authorities (including health staff) were not aware of the prisoner's decision as medical record requests had not been made.

The following account details Wiremu's choice to remove himself off his medications.

Case study – personal choice to discontinue medication
Wiremu was sentenced to four years in prison two years ago. At sentencing, Wiremu took himself off his anti-depressant and anti-anxiety medication because his medication *"clouded his mind"* and he wanted to be able to think clearly so he could protect himself in case of threats of violence and/or intimidation. As a consequence, Wiremu related that for the last two years he has been in a constant state of anxiety and fear as he constantly feels he has to *"watch his back".* He suffers from diarrhoea, insomnia, palpitations and weekly panic attacks that result in him wetting himself in public. When questioned about his decision to remain off his medication, or at least discuss the issue with the prison doctor, Wiremu related his belief that starting the medication again posed a greater risk than his current levels of anxiety and panic attacks. *(Wiremu, Māori, 50 – 60 years)*

Impact of prison environment on mental health

Many participants had had no history of a mental illness prior to their incarceration. However, as a result of a combination of the prison environment and culture, a large number of participants reported having developed:

- insomnia
- anxiety
- depression
- suicidal ideation
- anger and violent tendencies.

Participants attributed their poor mental health to an interplay between prison culture and the environment. For instance, as previously discussed, the authoritative use of punishment and degradation was found to negatively affect participants' wellbeing, as was the incidence of violence, extortion tactics and the role of confined spaces and extended lock-downs as a precursor to excessive violent behaviour.

Case studies – difficulties associated with accessing mental health services
I was labelled a nark [informant]. I wasn't though but it [the accusation] took on a life of its own. I was constantly harassed, verbally and physically. Women on either side of my cell would yell out, "NARK, NARK, NARK". I became really timid. I couldn't sleep. I got really suicidal. I only had the screws to talk to. I was put on antidepressants. I went from a happy go lucky person to wanting to harm myself. Now I can't get off the pills. (Whetu, Māori woman, 30–40 years)
When I was in prison they thought I was an undercover cop and they gave me the bash. They beat me so bad I ended up in hospital with a burst ear drum. I've lost hearing in that ear. Since then I have extreme panic attacks. I never had anything wrong with me before I came inside. Now I get terrified leaving my cell. What's that called... that's right agoraphobia. (Maaka, Māori, 30–40 years)

5.2 Accessing mental health services

The following prison-based mental health services were identified:

- Forensic services – "forensics" and "psychiatrists" were used synonymously. Forensics encapsulates the provision of secondary and tertiary mental health services delivered by DHBs through Regional Forensic Mental Health Services.
- Accident Compensation Commission (ACC) sexual abuse counselling – ACC funds sexual abuse counselling for men and women who had been either sexually abused as children or sexually assaulted in adulthood.
- Drug Treatment Unit (DTU) – DTUs are long-term residential alcohol and other drug programmes that are based on a therapeutic community model. DTUs are designed to address alcohol and other drug additions, addictive behaviours and related offending patterns.[14]

[14] Ministry of Justice (August 2009) *Review of the Interface between Mental Health and Alcohol and Other Drug Services and the Criminal Justice System, Paper Four: The Corrections Setting* (page 2). www.justice.govt.nz/effective_interventions/cabinet_papers/paper-four-mental-health-alcohol.asp 26 August 2009.

While forensic services and DTU were highly praised by those who had managed to access them, they were generally regarded as too difficult to access. This resulted in a large number of inmates going undiagnosed and/or untreated.

In addition, participants related that there is a lack of non-psychiatric counselling services in prison (not covered by ACC) and reported that, for those not in special programmes, the following issues go unsupported:

- anger management
- relationship issues
- misogyny
- pornography addiction
- depression
- anxiety
- coping with antisocial influences.

Prisoners also discussed the need for more intensive alcohol and other drug programmes in prison. Only DTU programmes were discussed with high degrees of satisfaction, as the short-term programmes were generally regarded as ineffectual. However, the limited places available on DTU programmes and restrictive DTU eligibility criteria[15] meant that it was extremely difficult for inmates to address drug and alcohol issues in prison.

Participants recommended:

- easier access to forensic services, which would result in a greater amount of diagnosis and treatment of inmates
- more DTUs, which would contribute to decreased recidivism.

ACC sexual abuse counselling was generally rated as adequate but too narrow in focus. For example, participants commonly stated that sexual abuse-related counselling was but one aspect of their counselling needs and reported needing counselling to address being the victim of:

- spousal abuse
- childhood neglect
- physical abuse in childhood.

5.2.1 Mental health-related concerns

Mental health-related concerns included:

- prisoner detoxification – extreme concern over the lack of appropriate assistance prisoners receive when detoxing from alcohol and/or other drugs

[15] Prisoners with short sentences and/or who were not considered to be 'low-risk' and/or whose offending was not considered to be significantly influenced by drugs or alcohol were unlikely to be able to access appropriate alcohol and drug treatment.

- insufficient amount of services to cope with a high demand for mental health services
- extreme delays for psychiatric assessment and intervention (in many cases, not eventuating at all)
- a high number of prisoners with undiagnosed and/or untreated mental illnesses
- high numbers of prisoners dissuaded from accessing mental health services.

5.2.2 At Risk – a barrier to accessing mental health services

While non-receipt of mental health services was attributed to a lack of mental health care, an equally influential factor was that fear of At Risk discouraged inmates from accessing services.

Avoiding At Risk
You've got to be very, very careful what you say to them, like I say they will lock you in observation and you will be in an empty cell and if you thought you were depressed before you will certainly be depressed when you get out of there. (Siaki, Pacific man, 20–30 years)

At issue was prisoners' fear that indicating a mental health need might result in their solitary confinement. As a result, participants employed a variety of alternative ways of accessing support "appropriately" (i.e. with minimised chance of being placed in At Risk).

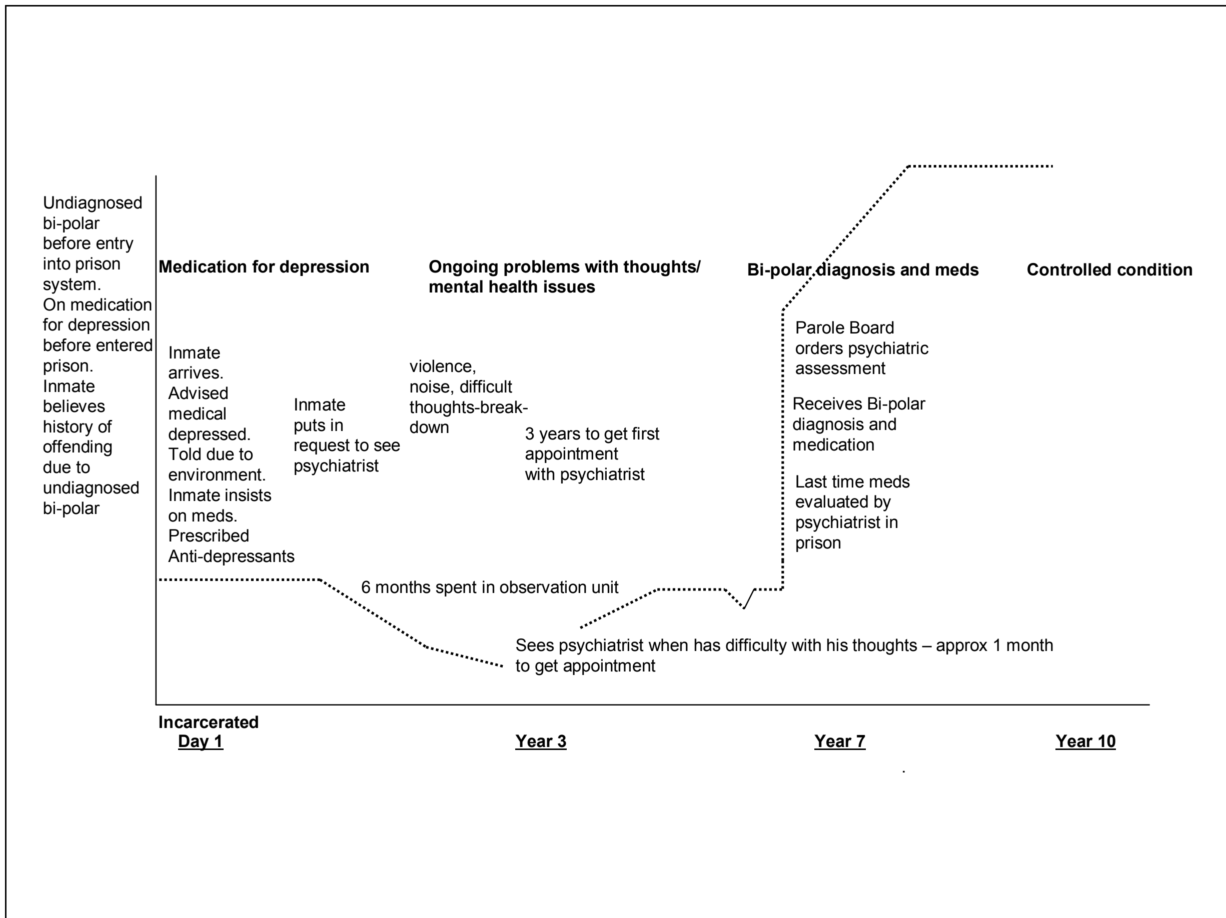
Turning to alternative means of coping
In the end I went to the Chaplain. That was my one opportunity to vent. You know share what was going on. (Irehapiti, Māori woman, 30–40 years)
I had so much anxiety. You know I couldn't sleep. I couldn't eat. I really wanted to get clean but in the end I started smoking again [marijuana]. In the end you could say I was self-medicating. (Hāmiora, Māori man, 18–25 years)

The role of At Risk and the impact of prolonged waiting times to receive mental health care are vividly portrayed in Siaki's experiences.

Case study – difficulties associated with accessing mental health services
Siaki had been diagnosed with depression prior to his imprisonment. Throughout his incarceration, he felt that his mental health had deteriorated and the prison environment exacerbated his condition. Siaki asked if he could be temporarily placed somewhere as a "timeout" as he felt he needed to gain control over his racing thoughts and anxiety and the hostile prison environment was making things worse. As a consequence, he was placed in At Risk and stayed in solitary for the next six months.
"I needed timeout. Somewhere quiet, peaceful and safe. But there's only Observation [At Risk]. Observation is an empty room with no stimulus. It makes you go crazy. It's a punishment. You lose all privileges. After your first time you do everything you can to avoid it in the future."
In his seventh year of incarceration, the Parole Board ordered Siaki to have a psychiatric assessment. At this point, Siaki was diagnosed and treated for bi-polar disorder. Treatment provided Siaki with an immense sense of relief, as with medication Siaki's extreme violent tendencies dissipated and he developed an extremely positive outlook – realising that his criminal offending was related to his psychiatric condition. (Siaki, Pacific man, 20 – 30 years)

The diagram below reflects Siaki's account which is supported by a review of his medical file.

Timeline and Major Events Associated with Siaki's Receipt of Mental Health Care



ORAL HEALTH IN PRISON

"All prisoners receive prompt pain relief."

*(Minimum Dental Services National Requirement,
Department of Corrections)*

6 Dental

Out of all prison health services, prisoners were most consistently dissatisfied with dental care. Underlying this dissatisfaction was the sense of unjustness in receiving a standard of care that prisoners consider second-rate to what would be experienced or accepted on the outside.

Dissatisfactory standard of care
*I had a tooth ache, my tooth was real sore, I mean to the point where I was getting headaches, Panadol, it took them like four months before a dentist would even see me. I was eating Panadols all day, every day. I had to see a nurse just to get brufen, just put it in the canal. I think it took them about nearly five months for me to get a dentist appointment. So I had my teeth filled; that was a mission. They prefer just to pull them out. I said to the dentist 'have you checked my file?' and he goes 'yeah'. I said 'what does it say on the file? It says to fix my tooth.' 'Oh no he says it's to be pulled out.' I said' f*** off, read the file properly, the dentist down in Pap was going to fix it' and a week later I seen the dentist 'cause he cruises round the country this dentist, the dental nurse. He goes 'Oh yeah I need to fix your tooth aye.' These pricks just want to pull it out, he goes 'like hell they'll pull it out it's a good tooth' so he filled it in, he said, 'I will fill it in right now'. (Rangi, Māori man, 18–25 years)*

Dissatisfaction centred on:

- extensive waiting times (even when in significant pain)
- a low standard of treatment
- basic treatment due to restrictive eligibility criteria
- negative experiences that have to be endured in getting treatment.

Each of these issues is discussed in turn below. This section culminates with an analysis of the impact of these issues on inmates' health and wellbeing.

6.1 Extended waiting times – appointments and treatment

Participants' accounts of dental waiting times ranged from the same day to 16 months. Average waiting times depended on the prison concerned, but ranged from two weeks to one month.

Extended waiting times
Last year I filled in a form in July. I didn't get seen till just before Christmas. But by then I'd already pulled it out myself. They'd given me Panadol, cloves, no good. It was too painful. I couldn't eat I was in so much pain. I was losing weight. It's not uncommon. I've pulled three out myself so far. (Timaiti, Māori man, 40–50 years)

In some cases, dental concerns involving significant pain were dealt with relatively quickly. However, in a number of cases, prisoners remained in pain for weeks or months while they waited to have a first or follow-up appointment with the dentist.

Significant pain due to waiting times
I remember when I had a filling fall out. At first I didn't really think much of it. About a month went past and I thought shit I better see the dentist so I put a form in. About two months later the tooth was infected so I was put on antibiotics for a month and then I waited about another month until they gave me another dose of antibiotics. It got to the stage I couldn't even eat it was that painful and then I finally got to see the dentist again. But that's just normal, that's normal process. It's not the dentist's fault it's just a huge backlog. (Siaki, Pacific man, 20–30 years)

Extended waiting times were commonly attributed to a health care system that was "slack" and insufficiently resourced to meet the demands of its service. While participants sympathised with a lack of resourcing, the following issues were commonly put forward as aggravating waiting times.

Aggravating Issue	Example
Human error in medical file record keeping	*I went and seen him [the dentist] and he said to me that yeah we'll pull that tooth out next week and then next week came around and I was thinking what's going on here and I asked about the dentist and the officers looked up in the thing and said 'oh no you've been treated'. I was like what! I haven't been bloody treated. (Pita, Māori man, 30–40 years)*
Human error in medical chits being lost	*I've had to fill in three dentist forms so far over a four-week period. Like the nurse just brought me another one round to fill out and I told her I had already filled two out. (Annette, Māori woman, 30–40 years)*
A high demand for prison dental services	*I am waiting for the dentist now for well over two weeks. I got a massive hole in my tooth. I don't think they feel, I don't think they care about it. But I know there's a lot of people on the waiting list to go and see so I am not special to put myself in front of the line. I just punch it every time it hurts. (Mika, Pacific man, 30–40 years)*
Under-resourced (not enough dentists)	*There is just one dentist and there are so many inmates. I had bad teeth pain and he gave me Sensodyne toothpaste and said that he would make an appointment to see me in two weeks. There are just too many inmates. He didn't see me for two months. Why don't they bring another dentist in? (Rawiri, Māori man, aged 18–25 years)*
Muster blow-out	*I was scheduled to see the dentist. I had been on the list for over a month. I had this really bad toothache. The day before I was scheduled to see the dentist I got sent up to Pare [Paremoremo]. By this time it was November. I ended up seeing the dentist in Pare in March and I got the tooth pulled out. I got it actually pulled out which was about five months. Five months in pain and this was extreme pain and all they would feed me was Panadol. I suppose they did offer me some of that clove stuff or whatever it is that numbs it but they were acting like it was going to go away it was a big huge hole in there. (Pita, Māori man, 30–40 years)*
ACC-related administration errors	*It's been about 16 months. I've made a claim to ACC for my missing teeth. They [ACC] say there's a lack of information. It's been over 16 months and they haven't done anything and they haven't seen my teeth. I've put in requests to see the dentist every month or every two months since I have been waiting and waiting. (Niu, Pacific man, 30–40 years)*

6.2 Low standard of treatment and care

Some participants expressed concern at the standard of dental treatment or practice experienced in prison. This concern was heightened by the lack of control that prisoners could exert in response to substandard medical care, and the lack of choice of dental providers. Shared experiences included:

- having the wrong tooth extracted – *I had two teeth with holes in them and the lady ripped out the wrong ones. So I lost two perfectly good teeth. I was going huh and I was like oh you pulled the wrong one miss. (Tipene, Māori man, 18–25 years)*

- having the tooth extracted when it was instead expected that the tooth was to be filled

- feeling unsafe or uncomfortable due to the attitude of the dentist
- incomplete and substandard procedures.

Low standard of care
*I'm not going again. I'd rather wait and see a real dentist. 'Cause last time when I went there for a filling it was supposed to be a filling, he ended up pulling the tooth and when we got back to the wing and I was like open my mouth up and the other tooth that was next to the one that needed fixing it, which had had nothing wrong with it, half of it had just came out when I was rinsing my mouth out and I thought what the f***. We ended up in an argument over it 'cause at the first appointment he said that he was able to do a filling and a buff and a polish and then at the actual appointment he said, "Oh no, no I didn't say that cause we don't do those buffing". He had a mean as attitude man. He said, "No, no I am not going to service fillings". And he was like already had this big attitude thing and he was like standing over me and I was really kind of iffy about him working on me. I didn't really want to but I felt a bit safer 'cause the officers were standing right there watching me. His assistant, this lady, the poor thing, she prepped some machine and he just spun around and really nutted out at her and I was like sitting there going f***. It* was shocking. *I'd have to be in hard out pain to go back to the dentist. I need to go back for a root canal but I've declined to go back. (Reka, Pacific woman, 18–25 years)*
It's not too bad, but the dentist at [that prison] can be a bit rugged. I saw him for fillings and they were left kind of rough; not sanded properly and stuff like that. It's quite a rugged job, not like what I get from my own dentist where you pay for it. (Annette, Māori woman, 30–40 years)

6.3 Basic treatment due to restrictive eligibility criteria

The Department of Corrections' national minimum requirements for dental services distinguish minimum standards depending on the length of incarceration, as well as a prisoner's previous "dental responsibility". Hence, prisoners detained for one year or more and who can prove they have maintained their dental health prior to incarceration are eligible to receive an array of dental treatment options, including restorations, root canal treatment and minor surgical operations. Conversely, those who have not shown previous dental responsibility or those detained for less than a year are eligible predominantly for pain relief only (extractions or dressings). Otherwise, costs for treatment not covered by these minimum requirements are to be met by the prisoner.

In practice, this restrictive eligibility criterion was said to result in tooth extraction as the standard form of prison dental treatment. In a number of cases, participants indicated that teeth are extracted regardless of whether tooth restoration, such as a filling, is the more appropriate or the easier course of action.

Tooth extraction as norm
They'll just say we'll just rip it out but nothing's wrong with it, it just needs to be filled in (Tipene, Māori man, 18–25 years)

As a result, participants felt that little consideration was given to the long-term consequences or optimal dental treatment for the individual concerned. Rather, there is an attitude of "they're only prisoners" not deserving high-quality medical and dental treatment.

Treatment due to prisoner status
And something else I just sort of thought about you know. If people have got bad teeth they go to the dentist, he pulls them out. I have got good teeth yeah... But yeah prisoners don't actually know what the, whether he is under a budget or getting bonuses or cause you know if a prisoner goes in and he just pulls their teeth out it's easy. It's like oh we will just pull her out, they don't think about hey 10 years down the track I am going to need that, that's like part of me that he's, it's like he's removing a bone out of their body that they can't replace and their attitude oh yeah she'll be right and because they don't know any better. (Stuart, Pākeha man, 25–35 years)

While tooth extraction or an inability to afford dental care may be a reality for a large number of people on the outside, putting money aside in prison to “pay off” dental treatment is considered largely unrealistic, unless one has external financial support.

Treatment unaffordable
I’m going to try and get some teeth when I get out. I’ve asked them but they said no to me because I’m not here long enough. You have to be in for two and a half years. Otherwise you have to pay them back. It’s only paying them back $5 a week in here. But that’s not possible. I only get $14 a week in wages. (Sally, Pākehā woman, 50–60 years)
They want you to pay for something you can’t afford, so because you can’t afford it they rip it [the tooth] out. They told me if I wanted to get a wisdom tooth in the back there – because of it being three crowns, we’re best to pull it out. But I asked him if I had some false ones – wouldn’t it better to have something to hang onto? He said ‘yes, but if you want to keep it, you’ll have to pay for it.’ It would cost $300–$400. I said to leave it in there till I get out and can make a proper choice. (Timaiti, Māori man, 18–25 years)

For many prisoners, the prospect of putting aside some of their weekly allowance or prison wage seems impossible while in prison, not only due to the small amount this equates to in comparison with dental costs, but also because weekly allowances are used for other costs that take priority (e.g. phone cards to talk to family and cigarettes due to addiction, to pass the time or as currency in prison). There is also no ability to “shop around” for dental quotes or dentists who offer different payment options.

6.4 Negative experiences endured to get treatment

A common negative experience related by prisoners at Arohata Women’s Prison was the process of transportation required to enable dental treatment. This was because dental treatment was carried out at Rimutaka Prison. It was not having to go off-site that was of concern, rather it was having to be placed in waist restraints and cuffs and transported over some distance in a paddy wagon with several other prisoners. The trip back to Arohata was worse, as prisoners were often in pain from dental treatment.

Negative transportation experience
I think it took three weeks or four weeks before I actually went to the dentist and that’s a long, well not a long but what is it you have cuffs and you have a waist band on and you’re in a paddy wagon and then six ladies, so you’ve got two, four and then one in the little cage type of thing and it’s sickening. Straight up the whole ride there is, like the ride on the way back because you’ve had a tooth ripped or something like that you’re kind of, the ride was well me personally like I was kind of quite sick. (Atarangi, Māori woman, 20–25 years)

6.5 Positive experiences with dental care

Despite the number of negative dental treatment experiences conveyed, some participants had positive dental care experiences. Such experiences appeared to be prison-specific and influenced by factors such as the specific dentist, the location of the dentist and prison population numbers. Positive dental care and treatment in prison was related to:

- receiving treatment that a prisoner was unable to access in the past on the outside (in this regard, prisoners were satisfied with receipt of basic dental treatment) – *It was pretty okay. I had two extractions. It was okay because I’d have to pay otherwise on the outside or go to the hospital. (Leah, Māori woman, 25–35 years)*

- prisoners who could afford to pay for dental treatment that went beyond minimum requirements – *The dentist was fantastic. I got my plates at Christmas. I had my two front*

teeth knocked out seven years or so. It all happened really fast too, I went over for a filling and said I would like to be measured up for dentures and within eight weeks I was wearing the new dentures. I had to pay $700. (Heather, Pākehā, 30–40 years)

- receiving professional and quality treatment – *She does her job, like I have been up there for fillings and stuff and she does a good job with it, she is professional, I think she is really professional. And that's important being in prison, when you come across the ones like that they don't discriminate you or treat you in a certain manner because you are inmates so. (Tia, Māori woman, 20–30 years)*

- receiving priority treatment where the situation requires it (depending on a facilitative system) – *If it's like a bad toothache then you're likely to get bumped up the list and be seen on that day, depending on how bad it is, but if it's like some minor say probably in that week get seen. I know that she does a good job. (Mihi, Māori woman, 20–30 years)*

- presenting a compliant attitude to medical/dental staff – *No I didn't wait. I just went straight to the nurse and said hey my teeth are aching. It was very fast cause I didn't, you know only just, I think it's a favouritism against the inmates, the nurses you know, if you go there with good manners you are in her favour book, if you go there and give them assholes they, it's going to take their time to proceed you. They pulled it out cause it had a hole right through the middle. (Pere, Māori man, 20–30 years).*

6.6 Outcomes

The following outcomes were attributed to poor receipt of dental care and treatment in prison:

- intensive pain over prolonged periods of time, resulting in distress, significant discomfort, inability to eat and weight loss – *I had a swollen face and I kept pushing to see the bloody dentist. My teeth were just really sore – I couldn't eat. They said they'd already put my name on – they just kept giving me painkillers. I say 'painkillers are no help' – until I show them my face has started swelling, and that's when they start pushing that I can go to the dentist. It took over a month. (Tai, Pacific man, 30–40 years)*

- intensive pain resulting in drastic action (or consideration of) such as extracting one's own teeth – *I had a toothache in my top wisdom tooth. It took four weeks to get it out. It was sore as. I'd put in two medical chits. I'd just been given clove oil to numb it but that didn't work. There are huge waiting lists. I got very close to using the pliers myself to rip it out. (Moana, Māori man, 18–25 years)*

- In non-urgent situations, inmates commonly reported "giving up" or deciding to wait until their release to get their teeth fixed. Associated reasons included:
  - poor dental treatment experiences in the past
  - not wanting to be transported via waist restraints, cuffs and a paddy wagon
  - concerns with quality of care
  - a desire not to engage in a poor health system
  - as a means of maintaining dignity and control.

Given up
I actually do have problems with my teeth, but it's something – I don't want to go there, to be honest. As I said before, I gave up. I can't see no point in me going and asking to see them. From what I've seen in the past, I just don't want to go. I'll just wait until I get out and do something about it. (Hera, Māori woman, 30–40 years)

FAMILY

"If it does not pose a threat to the safety of the community, or any member of the public, every prisoner must be encouraged and assisted to maintain or establish relationships with their family/whānau in a culturally appropriate manner to assist their well being and promote the prisoner's effective reintegration into society."

(Department of Corrections Policy and Procedures Manual – A.02 Family/Whanau Relationship Maintenance & Enhancement, National Policy)

7 Impact on Family

In considering the impact of incarceration on family, national and international literature has focused on the emotional, financial and psychological burden and pressures experienced by partners and family members of inmates, and the stigma and the resulting erosion of partners' and family members' social networks. For children of inmates, stigma, shame, guilt, grief and feelings of abandonment have been found to result in behavioural and developmental problems. Inmates' re-entry into the family can create a financial burden and stress for partners and families, as well as for inmates. Those released may also experience a complete loss of social support.

Differences were apparent in how men and women noted the impact of their incarceration on the wellbeing of their families. Men generally focused on:

- the financial strain felt by their female partners
- the added strain on their female partners due to a loss of parental and childcare support that they had previously provided
- relationships ending while they were incarcerated.

Women also commonly cited financial strain and breakdown of relationships as impacts of their imprisonment on their families. However, female participants were more likely to focus on child-related impacts and also focused on the effect of incarceration on:

- their children's wellbeing
- the impact of childcare responsibilities falling to their parents or siblings (usually female)
- the financial strain associated with childcare.

Stigma was not raised as a significant issue for families. For instance, family members did not cite stigma as negatively impacting on social networks and support for families and children of inmates. Rather, inmates more commonly reported loss of friends and family as a direct result of stigma. Moreover, while incarceration was identified as significantly impacting on the wellbeing of family, a number of inmates also relayed the detrimental effects of a criminal lifestyle upon family wellbeing and stability prior to incarceration.

This chapter explores the impact of prison on the health and wellbeing of family from the perspective of both inmates and family members.

7.1 Impact on children's health and wellbeing

7.1.1 During incarceration

The majority of participants had children under the age of 18 years. The most commonly reported impact of incarceration on children was anxiety and the child's sense of loss and responsibility for their parent's incarceration. These reactions were believed to be compounded by the visiting process, which negatively portrayed their parents and prevented them showing affection.

Impact of visiting
And you know at this age the kids know where they want to be and where they don't want to be and when we used to go and visit their Mum they would say, "We hate coming here Nana. Do we have to?" I said, "Well this is where Mum is and at least once a week she gets to see you". (Grandmother of two children under six years of age)

While indicative only, the impact of imprisonment on children appeared to differ according to the age of the children. The following is an amalgamation of accounts collected during the pre-release and post-release components of the research and includes the inmates' and family members' perspectives. Needless to say, the length of time incarcerated has a major effect on the child.

Age of child	Impact of incarceration on children	Examples
0–3 years	Low degree of attachment to incarcerated parent and loss of bond	*She was born three months after he went inside so she never had the same opportunity to bond with Tau like the older one did. You can see in the way that the older one plays with Tau. The younger one sort of keeps away from him and he's been home for almost two months. (Mother of children aged one and two years)*
	Separation anxiety	*We had to tell her that dad's gone and then it was like a bus would go past and that was the hardest, cos he was a bus driver before he went inside, and she'd stand on the window and call 'dad' whenever she saw a bus. That was hard. (Mother of two aged 9 months and 2 years)*
4–7 years	Separation anxiety	*They kept on asking about their parents and when they were going to come home, how long do we have to stay with you Nana? (Grandmother of two aged 4 and 5 years*
	Bedwetting	*The four year old was quite disturbed. She began wetting the bed. She forgot how to use the toilet. She lost all her toilet training. (Grandmother of child aged 4 years)*
	Night terrors	*Oh it was terrible they didn't sleep a lot at night. They were so worried. (Grandmother of two aged 4 and 5 years)*
	Aggression and violence	*My son got really angry and stressed and would shout and hit other children. (Mother of child aged 5 years)*
	Lack of engagement in school	*Yeah he started playing up at school and not taking part. (Mother of child aged 6 years)*
8–10 years	Aggression and violence	*He often lashed out. (Father of child aged 8 years)*
	Depression	*At first yep they were really depressed and they were confused and they would write to me and they were all sick, had the flu because they were all mentally and spiritually down their physical wellbeing was affected as well. It was made worse because I hadn't seen them for almost a month when I came in because of the process that they have to go through to get approval for visits and that. (Mother of children aged 7 and 9 years)*
	Truancy	*He just didn't want to go to school anymore. (Mother of child aged 8 years)*
11 – 15 years	Violence	*Yeah well it impacted on him ... he was stressed out um having his anger but he's since done an anger management course at the women's refuge (Mother of 13 year old)*

Age of child	Impact of incarceration on children	Examples
11–15 years	Assuming the role of the absent parent or parenting the parent	*He's always been the big boy of the house kind of thing and while I was drinking before I went to jail and he'd had more responsibility than I would even give him you know what I mean because I was drunk and I didn't know what I was doing. He was caring for the younger one you know he was doing everything that a dad should be doing so now I noticed he's still like that with his sister so I've been trying to pull him up. I'm trying to give him his kids' space back basically. With me having had a drinking problem and having been in prison he watches me. If I go out is mum going to buy a bottle of bourbon like I used to you know what I mean. That would be his train of thought definitely. (Mother of two children aged 7 and 13 years)*
	Truancy	*We had a bit of a problem with him turning up to school. (Grandmother of child aged 12 years)*
	Decreased academic achievement	*I know while I was in jail his grades slipped and a couple of teachers did ring my partner and said that they are were worried about our boy. He wasn't being himself and he was slipping behind. (Mother of 14 year old)*

Participants also commented that they suspected that children suppressed their emotions and how they were feeling. A number of children also experienced a change in caregivers and schools (sometimes several) during the period in which their parent(s) were incarcerated, which would undoubtedly be unsettling and require adjustment for the child concerned.

7.1.2 Post-release

Incarceration continued to negatively affect parent–child relationships following the parent's release from prison. This was a stressful period of readjustment for both child and parent and sometimes resulted in parents and children withdrawing from one another or a sense of a loss of control and hopelessness by the parent in seeking to re-establish the relationship with their child or children. This was most notable for children aged five years and older. Generally, it stemmed from the child's resistance to the newly released parent imposing parental structure/rules on them.

Younger children (under 12 years) reportedly tried to undermine the parent's attempt to impose boundaries and structure by enlisting their caregivers (e.g. the grandmother who had provided care while the parent was incarcerated). Children aged 13 years and older were more likely to actively defy the parent or to show resentment at having been abandoned by their parent (usually their mother), feeling that their parents now owed them for the time they had been away.

Difficulties re-establishing relationships
It's been a little bit difficult because he is nearly 15 and when I first came home we sort of butted heads and he would say, "Whatever Mere". You know like not Mum. And he just said, "You know I don't do that. You haven't been here for 14 months; I don't do it like that. I do it like this". And he would say, "I don't want to be with you, I am going to be with my dad". Everyday is getting better, you know we are communicating better every day but in the beginning it was definitely rough and I really didn't know how to cope. (Mother of 14 year old)

7.1.3 Positive effects of incarceration

Parents with extreme drug and alcohol use histories reported that incarceration had a positive effect on the family. They reported a lack of structure and routine in the home before the parent was incarcerated, which had a detrimental effect on the children's school, nutrition and overall wellbeing.

Positive effects
My man and I were hard out into drugs. We could hardly get ourselves out of bed let alone get the kids up and to school. The best thing that prison did was give me time to get myself together and give my kids structure, you know regular schooling. My sister made sure they were fed and went to school everyday. Their reading and writing is way good now. They've gained weight and are really healthy. (Mother of two aged 7 and 9 years)

Participants also commented that the impact of incarceration on children was lessened when the child received counselling or had regular and frequent positive contact with their parent.

7.2 Impact on partners, parents and other family members

Adopting a caregiver role, prison visiting, financial stress and stigma were predominantly identified as key pressures affecting prisoners' partners, parents and other family members. These pressures affected people differently, often depending on the extent of other support that could be accessed to ease these pressures. For most, it was a matter of significant adjustment. Impacts of such pressures included worry, anxiety, loneliness and isolation and sacrificing one's own wellbeing for the sake of other family members. In one extreme example, an inmate's wife committed suicide. With her husband's long prison sentence, she lost her sole companion and source of emotional and financial support.

Isolation
Well I think she was isolated. She was lost without me. I think I was her we were soul mates, best friends. Pressures I suppose also about money and her having to go out to try and get work to make the money to pay the mortgage. (Richard, Pākehā man, 50–60 years)

7.2.1 Assuming a caregiver role

Childcare more often than not became the responsibility of female partners, mothers and sisters of incarcerated parents. For a prisoner's partner, incarceration meant that a key source of emotional and practical support was taken away. Partners had to adjust to an absence of childcare support and parenting assistance. Stress was further heightened if the partner had to care for older or unwell family members.

Loss of support
Put it this way my wife was put under a lot of pressure. She had her father disabled – he's in a rest home. Her mother – she had the cancer. So, she was under a bit of stress. We have a six year old who she's looking after and had just started school. For my wife it wasn't very good in the beginning. It was pretty hard dealing with her mum, father, and looking after my son – and at the same time of course looking after the house – trying to maintain everything. It wasn't very easy for her. Thanks God I had my family as well supporting her in that. She's only 31 and had had all these responsibilities put on her own. That's a lot of pressure. (Tom, Pākehā man, 30–40 years)

The assumption of full-time childcare responsibilities by prisoners' parents and other family members meant a complete overhaul in the lives of these caregivers. This included:

- coping with a new parenting role
- adapting to the extensive needs and demands of raising children of incarcerated parents
- giving up one's own routines and activities in order to care for the children.

Of concern was the number of grandparents adopting these roles at an age or life-stage where they had expected their full-time care of young children to be over and where the physical and emotional toll of parenting was felt to be higher than it would have been in their younger years.

Older caregivers
I took the children on – like the age group – it's really tiring. These kids need lots of attention. It was pretty stressful. It was like a burden. You couldn't afford to take them anywhere. You couldn't do anything. There was no money. So all you could do was just look after them. (Grandmother of two aged 4 and 5 years)

7.2.2 Support needed

Caregivers related a heightened sense of isolation and a lack of support looking after children. The need for support included:

- Respite from childcare – this was especially true for grandparents who reported feeling exhausted from providing childcare. In addition, without other childcare support, children had to accompany the caregiver to prison even where visiting was stressful for the children.

- Communicating the parent's imprisonment to children – *Umm, 'cause she was quite close to Tau and like I could lean on him for help with her while I was feeding baby you know just the basic round the house and yeah the next day she woke up looking for her dad and I didn't know what to say so I was confused and hurt so we found that hard. (Mother of two aged 1 and 2 years)*

- Communicating the parent's imprisonment to non-family members (i.e. a child's school) – not knowing what was necessary to disclose or how to field questions associated with the parent's incarceration so as not to hurt the parent's ongoing relationship once they are released from prison – *I didn't know how to answer the school's questions about where their mum was. So I just said they'd gone short term. But then someone told the school. (Grandmother of 7 year old)*

- Knowing how to access support – participants commonly expressed a lack of knowledge about what support existed and how to access it. This included not knowing that PARS provided assistance with travel to prison, the type of support that could be requested from Work and Income, local support groups and the existence of Whānau Liaison Workers in some prisons – *Even though they might be grandparents or aunties, whatever, uncles, sisters, brothers. They actually need lots of support for little children they need a lot of support that I didn't get because I didn't know where to go. I didn't know WINZ could give clothing or blankets for them. I suppose there was nowhere to go (Grandmother of two under 7 years)*

- Counselling – for children distressed about separation from parents and trauma associated with visiting parents in prison – *Well for a start I would have thought that there would be something where we can go to for a bit of counselling, you know to help us through the times of when it's the first time your daughter has been taken away and you don't understand it, you know and then the kids needed a bit of counselling because to me it was like a trauma for them to know that their mum and dad's not going to be there at this instant when they needed them. There was none of that, well I would say counselling for a start (Grandmother of two under 7 years)*

7.2.3 Prison visiting

A number of family members were physically and emotionally affected by visiting in prison. This related to the emotional distress of having to leave their loved one once prison visiting concluded and then worry about the prisoner's wellbeing once they had left.

Stress of visiting
My grandmother she got quite sick. She came to see me once and I had to say to her look don't, don't come back it's too hard for you. The stress was huge for her having to come in there. (Helen, Pākehā woman, 30–40 years)

Prisoners discussed the impact of the prison environment on children when they come to visit incarcerated parents. Two prisoners related that their family members had stopped their children visiting because of a lack of a "child-friendly" environment for visits to take place. In addition, visitation processes such as searching and physical contact restrictions resulted in children:

- experiencing heightened anxiety
- experiencing depression
- experiencing night terrors
- physically acting out against the prospect of visiting parents.

Some prisoners indicated that they had specifically told their partner or family members not to visit due to concerns about the impact on families' physical and emotional wellbeing, as well as distance and the financial and logistical difficulties of getting to the prison.

7.2.4 Financial stress

Significant financial pressures were commonly experienced by family members due to the imprisonment of their partner or family member. This commonly required the reallocation of finances which potentially or actually affected health and wellbeing. Different financial pressures were described during incarceration and upon release.

During incarceration

The financial impact and pressures experienced with the imprisonment of a family member were more acutely felt by family members who found themselves adopting full-time caregiver roles to their relatives' children (usually mothers or female siblings of prisoners) and by female partners of prisoners who, with imprisonment, lost a key source of financial support. In both cases, family members and partners had to assume additional and significant financial responsibilities (including financially supporting their partner in prison). These additional financial pressures and their resulting impact on health and wellbeing included:

- Increased financial responsibilities of childcare, compounded by delays of up to three months to access financial entitlements (i.e. where Work and Income may require a letter from the prison). These responsibilities included the added costs of having to provide for the many needs of children's schooling, food, medical, transport, clothing, bedding and personal needs, placing significant financial strain on families already living within tight budgets. Often, this meant that the primary caregiver had to "go without", including having less food, not visiting the doctor and scrimping on basic needs.

- Loss or reduction in household income – particularly for female partners of male prisoners who had been the main household earners. The impact of this was felt strongly by parents with children who now had to support themselves and their children on an individual benefit, as well as financially supporting their imprisoned partner. Predominantly, this resulted in the partner reducing their intake of food and no longer being able to afford anything beyond the very basics. In some cases, participants had to move accommodation or location due to being unable to keep up with rental or mortgage payments.

- Costs of maintaining contact with prisoners – the fact that a large number of prisoners and their family members were separated by distance and with limited financial means meant that family, partners and children were unable to visit their incarcerated family member or visits took place only infrequently. In addition, at a cost of $1 per minute for toll calls, partners and family members were financially stretched to provide money for phone cards to enable prisoners to maintain contact. Often, family members sacrificed basic necessities (such as food) to avoid compromising the frequency of visits or to provide phone cards.

Childcare-related costs
You have to cut yourself back to come up with enough money to look after the children. A lot of times I went without to ensure they got what they needed. Things were real tight. My problem was that I was going without food so that the children could have enough – though they had nothing luxurious like sausages. I was lucky if we had $2 left for bread on Monday for lunches. I'd make fried bread and tell the kids it was donuts. I went to the food-bank once but got declined so I didn't go back. I stopped going to the doctor. I have lots of chest infections. I made do with lozenges so that the money for the doctor could be there for the kids. (Grandmother)
Reduced household income
My partner, yeah she lost our house in Auckland. She couldn't afford the payments. So she had to pack up and move to the provinces to be close to her family for support. It's meant we haven't been able to see each other since then 'cause it's too far away for visits. (Mikaere, Māori man, 18–25 years)
Costs of maintaining contact with prisoners
My partner lives six hours away. He has no car and the bus costs too much. We haven't seen each other in nearly a year. The phone calls cost too much so we have to talk quickly and I forget what I meant to say! (Atārangi, Māori woman, 20–25 years)
There's families out there sending money in so people can ring up their children and it's causing some sort of hardship – children going to school with no lunch and stuff like that just so dad can ring them a couple of times a week. I think it's disgusting actually the price of phone calls... I'd love to ring my children but I can't afford it to be honest because I don't want my family supporting me. I don't want them giving me too much money... we are talking about people here who are the lower class level of life they are not in that high income nor are their wives and families. They can't really afford to send these phone cards and stuff like it's way too expensive for them but they'll do it and they'll do all they can to do it. (Pita, Māori man, 30–40)
It's the cost too for families like my mum she really beats herself up because she doesn't come see me but I can sort of understand that it is hard. And like she's right up the north island and she always beats herself up because she doesn't come to visit me but I sort of tell her I can understand plus she doesn't work my mum doesn't work. I just tell her I can understand as long as I get to talk to her that helps a lot but then to do that it takes money to talk to her sometimes you know which is hard for all the girls in here really. (Mere, Māori woman, 30–40 years)

Post-release

For partners and family members who have learnt to adjust to financial pressures experienced during the period in which their partner or relative has been in prison, there is increased financial pressure experienced when the prisoner is released and returns home to live.

The return of the prisoner often means an additional financial stress to the household. In the majority of cases, participants related that they had intended to contribute to the household through a Work and Income benefit. However, the first three to five weeks were often very stressful as benefits were often delayed because of administrative errors, a lack of appropriate identification and not knowing how to navigate the welfare system.

Stress of readjusting
With me coming out it's like an extra mouth to feed you know. I try not too eat very much but I'm not a light eater... it feels like she's got to start all over again then I put all this pressure on her and stuff ... (Tau, Pacific man, 20–30 years)

7.2.5 Stigma

The stigma of imprisonment was felt by some families more than others, depending on the crime and also whether or not the individual's incarceration was the first in the family. Hence, stigma would be more prevalent if the person or their family were not known to have previously offended and had not previously served a prison sentence. Thus, the more normalised imprisonment becomes, the lesser the impact a sentence of imprisonment may have.

Similarly and supporting this notion of normalisation, an absence of stigmatisation was commonly explained as a result of the neighbourhood or location the prisoner had come from. Hence, if a prisoner came from an area where it was not uncommon for residents to go to prison, the event of imprisonment was not a shocking fact that would get others talking or casting judgement.

Normalisation of imprisonment
It's common here in Otara for people to go to prison so there's no stigma. It would be different if you were from Remuera. (Mika, Pacific man, 30–40 years)
In a small town like ours it's just about the norm. I know that sounds really awful but my son has got a couple of friends whose fathers are in prison where I am probably the first mother but you know fathers being inside it's just about the norm. One of my son's friend's father's is inside at the moment and another one's father has been in and out, in and out. (Mere, Māori woman, 30–40 years)

Stigma was also considered to be based on normalisation linked to stereotypes, in that a Pākehā woman would be more likely to be the subject of stigmatisation than a Māori or Pacific man.

Stigma and other stereotypes
There's a different thing attached to it, it just seems more acceptable for guys to go to jail than women, especially being seen as a European woman as well, it's more like they would be more accepting of me if I was a Māori or Samoan to them but they are like oh. If a guy goes to jail there is not that thing attached to it, but for women, mothers, it's like oh gosh loser you know. (Leah, 25–35 years)

Feelings of stigmatisation were either actual or perceived and resulted predominantly in feelings of being scrutinised, judged and subject to gossip.

Stigma was identified as a potential barrier to securing employment. The partner of an inmate who struggled to find work after he moved to be close to the prison had wondered whether his lack of employment success was a result of his openness to prospective employers about his partner being inside. Similarly, several released prisoners spoke of their trepidation at having to disclose their convicted status at job interviews and the extent to which this would have an impact on their chances of employment success.

While international literature attributes stigma to a loss of social networks and support for families or children of inmates, this was alluded to by one family member only. A grandmother caring for the children of her daughter, who was serving a first sentence, avoided friends and family members because of judgements cast on her daughter's incarceration. Unfortunately, this led her to shy away from seeking the support of friends and family at a time when external support would have been of huge benefit.

What was commonly identified was the loss of relationships and support between the inmate and his or her family member(s) or friends. Participants believed that the shame and embarrassment of having a friend or family member in prison caused relationships to end. For some, there was also a desire not to be tarred with the same brush and linked to the known offender. For others, the fact of imprisonment was potentially a wake-up call to the type of person being associated with, or brought home the realities of offending.

Loss of relationships
I think shame is probably the biggest one on the family of me being inside. I've got aunties and uncles and cousins in this city but I haven't seen or haven't heard from them the whole time I've been down here. And they don't want to know. They don't want to talk about it. They don't want to acknowledge the fact that I'm even here or that I've been inside. (Helen, Pākehā woman, 30–40 years)

Similarly, inmates also commonly spoke of prisoners receiving "Dear John" letters and marriages and personal relationships breaking down during periods of incarceration (particularly as time went by).

For prisoners, the loss of friendship and family or partner support caused significant loneliness, isolation and an absence of support networks both during imprisonment and upon release.

CONTINUITY OF CARE

It would have been good to have someone to help you before leaving prison when you're freaking out about everything you need out there. And then when you get out, a support person or something to stop you panicking when you're trying to understand what WINZ and all those places want. (Heather, Māori woman, 30–40 years)

8 Post-release Continuity of Care

Post-release participants discussed continuity of care in terms of pre- and post-release considerations. This chapter discusses barriers and facilitators to continuity of care both pre- and post-release.[16]

8.1 Pre-release considerations

The majority of participants related that the first 3–4 weeks following release from prison were critical adjustment periods that risked ill-health, compromised wellbeing and re-offending. However, the degree to which a recently released inmate felt vulnerable appeared to depend on whether or not the following basic needs had been secured prior to their release from prison:

- prerequisites for the individual's release – securing appropriate identification and a bank account
- basic living needs – financial support (Work and Income application filed) and accommodation
- supportive travel arrangements from the prison to new accommodation
- continuity of care – the prison's provision of the inmate's medical record, prescriptions, referral and an appointment with an affordable medical provider in close proximity to their new accommodation.

In six cases, each of these basic needs had been secured and the participants reported feeling extremely supported and well positioned in terms of continuity of care and reintegrating with their communities. Participants attributed the success of this initial reintegration phase to the prison's assistance with referrals (such as community mental health services) and documentation (proactively preparing copies of medical files and prescriptions).

Case study – basic needs
The prison was fantastic. The Reintegration Officer made sure that all the ducks were in a row. You know, all the referrals were made. I had appointments scheduled with WINZ, my Probation Officer and community mental health. They asked me if I had a doctor on the outside and I said I did. So they just sent my medical record to him. You know you can't fault them. Amazing. (Heather, Pākehā woman, 30–40 years)
I heard terrible stories about a lack of help from the other guys but I have to tell you that I was real impressed. I didn't even have to go into WINZ. WINZ came out to the prison about two weeks before I was released. I did all the application stuff there. They [Reintegration Officer] helped me open up a bank account, get id [identification]. They even took me out for three hours in the community. After 11 years inside I can tell you that was hard but at least I got that three hours. That's more than most. You know though, the one thing that could be improved is a few more of those community outings. I had a panic attack with the one I had. I almost wet my pants and couldn't wait to get back to prison. (Siaki, Pacific man, 20–30 years)

Participants who had received assistance from prison staff attributed the high level of assistance to having:

- been incarcerated for at least four years

[16] This study's discussion of post-release continuity of care is restricted to the first 6–8 weeks following the participant's release from prison.

- been regarded as high-profile violent offenders
- a psychiatric diagnosis that, if untreated, placed the individual at risk of reoffending.

The majority of participants did not have this level of assistance and inmates were inherently responsible for securing their own basic needs. Some extremely proactive participants did successfully manage to ensure that their basic needs were met, although their success was attributed to[17]:

- supportive family members who were able to act as a liaison between the inmate and the relevant agency
- a pre-existing relationship with a social service agency that was able to act as an advocate for the soon-to-be-released inmate.

Case study – basic needs
You see I wasn't able to make the phone calls. I had begged to see the Reintegration lady but she never turned up. PARS couldn't help because I wasn't being released to a town within their region so I had to rely on my mum to make all the phone calls. (Helen, Pākehā woman, 30–40 years)

Unfortunately, the majority of participants did not have social support networks that could act in a facilitative role on their behalf and experienced extreme anxiety attempting to gain an adequate understanding of requirements and processes. As such, the majority of participants reported being confused when they were released and did not know how to ensure that their basic needs were met. A failure to acquire pre-release basic needs directly affected continuity of care when participants were not able to secure:

- a copy of their medical record or summary sheet
- medications prior to their release
- prescriptions to be filled once released.

As a result, some participants reported leaving prison with only enough medication to last one week and/or without a prescription to be filled. This was not seen as realistic, given the amount of time an individual can wait before their Work and Income benefit takes effect.

Insufficient meds
I asked for my medical record and enough prescriptions to get me through, you know until I was on my feet. Instead of my medical record all I got was a statement listing my conditions and my meds and a prescription for a weeks meds. (Sue, Pākehā woman, 20–30 years)

8.2 Post-release considerations

8.2.1 Social support networks – supporting reintegration

All participants reported feeling extremely vulnerable following their release from prison. Vulnerabilities were characterised by fear and uncertainty associated with:

- venturing out of their homes

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[17] While many inmates were able to learn as much as possible about system requirements, they were limited in how much they could organise their basic needs while incarcerated. As such, despite a desire to be proactive, participants were reliant on people they had established relationships with to intercede on their behalf.

- financial stressors
- drug and/or alcohol temptations
- social interactions
- re-learning how to make decisions
- deciding whether or not to tell people of one's incarceration history.

Vulnerabilities appear to have been more easily mitigated by those with strong social support networks. For instance, friends and family would accompany released inmates to help them adjust to open spaces. Also, when there were delays with Work and Income benefits, friends and family reportedly assisted the individual – either financially or in-kind.

Those without strong networks were extremely vulnerable. In situations where basic needs were unmet, for instance delays with Work and Income, participants reported:

- hunger and homelessness because of a lack of funds
- inability to pay for health and mental health care
- failure to fill prescriptions
- a lack of advocacy and a lack of support in attempting to rectify issues.

Non-receipt of basic needs
The WINZ lady turned up to my unit two days before I was released and I asked her to help me get some id. She said that I could do that on the outside. It's been six weeks. I've gone to WINZ heaps of times. I keep getting the run around. Long story short I have nothing. I'm hungry. (Tau, Pacific man, 20–30 years)
Just before I came out a lady in the Faith-Based Unit found me some accommodation with some good Christian people. Trouble is I had to move out because WINZ stuffed up my benefit. Just as well I was able to move into my Mum's otherwise I would be on the street. (Stuart, Pākehā man, 25–35 years)

While this group remains a primary concern, it is noteworthy that some of the more vulnerable participants reported floundering until a sympathetic and proactive figure was able to assist with basic need referrals. These figures were generally one of the following:[18]

- Work and Income case manager
- Probation Officer
- alcohol and other drug counsellor.

[18] Sadly, some participants' attempts to lead proactive lifestyles exacerbated this vulnerability because proactive lifestyles meant choosing to be released into a different community from where the individual previously resided. In this situation, participants lack any network and reported experiencing extreme isolation and loneliness in the months following their release.

Non-receipt of basic needs
I came out wanting to do real good. I went to WINZ and had this amazing guy treat me real well. You know, no judgement. So he sorted all my papers. Then I went and saw my Probation Officer. He gave me an hour. I told him I didn't know how to get into A&D [alcohol and other drug counselling] and he made the referral and asked that they take me right away. (Sue, Pākehā woman, 20–30 years)
I came out of the Māori Focus Unit; a real whanau environment and I felt really alone. I was real worried you know keeping straight. Anyway my Probation Officer, she hooked me up with a job and made appointments for me with a counsellor. I don't know where I would be without her. (Te Māia, Māori man, 18–25 years)

8.2.2 Cost of care

Generally, finding a medical doctor was not a challenge for participants. Rather, the challenge was finding an affordable provider. This appeared to be less of a challenge for participants with a strong social network, as their network was able to guide them to the most affordable options. In situations where the cost of medical care was prohibitive, participants consistently chose to pay for food and accommodation over medical costs. This sometimes placed participants at risk of exacerbating their mental health due to worry and stress and not accessing medication or counselling. Others were placed at risk of poor chronic care management (e.g. asthma and diabetes) if medication or medical appointments were not accessed.

Experiences accessing a medical provider			
Recently released prisoner	**Cost of primary medical care**	**Affordable or not affordable**	**Impact of cost**
Joy	$15	Affordable	Continuity of care
Tipene	$10	Affordable	Continuity of care
Tamati	$0	Affordable	Continuity of care
Stuart	$60 first visit, $16 the following visit	Not affordable	Delayed going to doctor for five weeks
Mere	$35 (once a month)	Not affordable	Decreased amount eaten
Sue	$30 (three visits in one month)	Not affordable	Decreased amount eaten, delay in filling prescriptions
Miri	$60 first visit. Doesn't know if second visit cheaper	Not affordable	Will not go again unless in extreme pain
Helen	$60 first visit. Doesn't know if second visit cheaper	Not affordable	Will not go again unless in extreme pain
Leah	$60 first visit, $16 the following visit	Not affordable	Pregnant. Delayed seeing doctor because of cost
Pita	$25	Not affordable	Mother paid. Continuity of care
Heather	$60 first visit. Doesn't know if second visit cheaper	Not affordable	Mother paid. Continuity of care

Appendix 1: Incidence of health care needs reported by participants

Participants generally reported a wide range of health care needs. The variety of health care needs, mental health and addiction histories are outlined below.

Table 1: Incidence of Participants with a Diagnosis of a Common Chronic Condition

	Female	Male	Total
Chronic neck or back pain	3	11	14
Allergies	4	8	12
Asthma	3	7	10
Migraine	5	4	9
Heart disease	0	7	7
Epilepsy	2	4	6
Arthritis	1	2	3
Cancer	1	1	2
Diabetes	0	0	0
Stroke	0	0	0

Table 2: Incidence of Participants with a Diagnosed Impairment

	Visual Impairment	Hearing Impairment	Mobility Impairment
Female	5	1	1
Male	7	1	3

Table 3: Incidence of Mental Health Diagnoses

Of the 63 participants, 30 had been diagnosed with a psychiatric condition prior to their incarceration. The following figures outline these diagnoses. Please note that some participants reported multiple diagnoses.

	Anxiety	Depression	Bi-polar	Schizophrenia
Female	6	5	3	0
Male	7	9	2	2

Table 4: Incidence of Addiction Histories

	Alcohol Addiction	Drug Addiction	Injecting Drug Use	Gambling Addition
Female	11	9	0	2
Male	22	16	0	3

Appendix 2: Pre-release Interview Schedule

EFFECTS OF PRISON ON THE HEALTH OF PRISONERS AND THEIR FAMILIES

Thank you for agreeing to participate in this study.

We are interested in looking at how you think imprisonment has affected your health and wellbeing. We also want to discuss your views on health and disability services in prison and how you plan to follow up on your health needs once you leave.

Ask participant if they have any questions

To do this we would like to look back over your times in prison, including this one, and talk about your health each time.

If in prison more than three times focus on the last two times only.

1. Before we begin can we talk about what health means to you?

Prompt –

- *Provide visual cue (diagram outlining mind, body, whanau and spiritual dimensions of health).*

Seek participant's definition of health and use this as basis of interview.

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2. Are your experiences with health care in prison different from what you originally expected? If so how?

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3. Health services experience

	Health service use before prison – Prior to entering prison – when was your last health service contact? – What was it for? – If over one year – has anything stopped you from seeking medical attention in the community?	**Health service use and experiences while in prison** – Did/do prison and health service staff appear to have knowledge of any prior diagnoses or therapies? – Did prescribed medication or other therapy continue upon entering prison? If not why?
Current time		
Previous incarceration		

4. Prison health services experience – What are your experiences with health and disability support within prison?

– What went well for you in prison?
– What did not go well for you in prison?

	Primary health care – Screening and assessment – Diagnosis? Treatment? Medication? – How satisfied were you?	**Drug and alcohol** – Access? – How satisfied were you?	**Mental health** – Access? – How satisfied were you?	**Dental** – Access? – How satisfied were you	**Disability support** – Access to support – Personal care – Access to equipment – Mobility	**Hospital or specialist care** – Access? – How satisfied were you?
Current time						
Previous incarceration						

5. Environment and its effects

Question – How has prison life affected you? For example, health and wellbeing, visiting arrangements, prison culture facilities, the way the prison is built, bullying (stand over tactics) and isolation

Current time				
Previous incarceration				

6. CONTINUITY OF CARE – FROM PRISON TO THE COMMUNITY

Question – What are your experiences of continuity of care in transitioning from prison to the community?

	Transition to community?	**Suggested Improvements** – How could the transition (from prison to the community) be improved? ***Prompt*** – *Health provision? Housing? Transport? Work? Other?*
Current time	Ongoing health issue? Referral made? Did you have a GP before you went in? Any thought given to finding a GP? Access to community-based health and disability support services?	
Previous incarceration	Ongoing health issue? Referral made? Did you have a GP before you went in (or other provider that there may be a need for)? Any thought given to finding a GP (or other provider that there may be a need for)? Access to community-based health and disability support services?	

7. FAMILY –

Question – How have your families' wellbeing been affected by your incarceration? What are your experiences of continuity of care in transitioning from prison to the community?

	Impact of incarceration on family	**Suggested improvements** – How could the negative effects be avoided or mitigated? *What could be done to improve the health and wellbeing prospects for family members?*
Current time	Connections? Children? Partners? Parents?	
Previous incarceration	Connections? Children? Partners? Parents?	

8. Influencing Factors

In terms of health – are there any differences between prisons?

How would you explain these differences?

Appendix 3: Post-release Interview Schedule

EFFECTS OF PRISON ON THE HEALTH OF PRISONERS AND THEIR FAMILIES

1. **What happened when you first got out – Story of the first six weeks:**
   - **Housing**
   - **Employment**
   - **Health (physical, emotional)**
   - **Drug blow out**
   - **Connecting with community**
   - **Connecting with friends and family**

SUPPORT

2. **How supported do you feel now that you are out?**

3. **What type of support do you need?**

FAMILY

4. **Now that you are out – what has it been like reintegrating with your family? (Isolation, support, relationship breakdown, difficulties coping)**

5. **What's it been like reintegrating with children?**

EFFECTS OF IMPRISONMENT ON YOUR FAMILY

6. **What do you see as the effects of imprisonment on your family? (prompt – health and wellbeing)**

Health – Continuity of Care – From Prison to the Community

7. **We want to ask you about your experiences of continuity of care in transitioning from prison to the community? For us, continuity of care means that you continue to receive the medical services and medication you needed when you were inside and your health needs are met now that you're on the outside.**

   First can you answer the following?

Chronic Conditions	Yes/No
Asthma	Yes/No
Arthritis	Yes/No
Cancer	Yes/No
Chronic obstructive pulmonary diseases (COPD, emphysema, bronchitis, bronchiactisis)	Yes/No
Chronic head, neck or back pain (state which)	Yes/No
Diabetes	Yes/No
Heart disease (IHD, cardiac event, arrhythmia, angina)	Yes/No
Migraines	Yes/No
Stroke	Yes/No

Oral Health	Yes/No
Any dental problems – state	Yes/No
State	

Chronic Care Management Plan (see Out Box) NB need 2 or more chronic conditions to signal need for CCMP	Yes/No
Chronic Care Management Plan?	Yes/No

Nutrition	Yes/No
Special diet/meal indicated (if yes, check with inmate to see if received)	Yes/No
State which diet	Yes/No

Impairment	Yes/No
Visual impairment (if yes do they have glasses)	Yes/No
Hearing impairment (if yes do they have an aid)	Yes/No
Learning disability	Yes/No
Mobility impairment	Yes/No
Intellectual disability	Yes/No

Alcohol and Drug	Yes/No
History of alcohol addiction	Yes/No
Drug addiction (state which)	Yes/No
History of gambling addiction	Yes/No
History of IDU	Yes/No

8. **Can you tell me if you have accessed the following health and disability support services?**

Question	Response
Did the prison doctor or nurse make a referral for you to see a doctor on the outside?	**Yes** ☐ **No** ☐ **N/A** ☐
Did the prison doctor or nurse give you a prescription for your medication(s)	**Yes** ☐ **No** ☐ **N/A** ☐
Did someone talk to you about having your medical file transferred?	**Yes** ☐ **No** ☐ **N/A** ☐
Did you try and get it yourself, were you able to get it?	**Yes** ☐ **No** ☐ **N/A** ☐
Did you have a doctor to go to before you were released?	**Yes** ☐ **No** ☐
If no, did you know how to find a doctor?	**Yes** ☐ **No** ☐
Have you found a doctor now?	**Yes** ☐ **No** ☐
Are there barriers to you going? **In what circumstances would you go?**	
Did you have a dentist to go to?	**Yes** ☐ **No** ☐ **N/A** ☐
Did you have a mental health specialist/service to go to?	**Yes** ☐ **No** ☐ **N/A** ☐
Did you have a need for a specialist?	**Yes** ☐ **No** ☐ **N/A** ☐
Have you seen your doctor on the outside about this issue?	**Yes** ☐ **No** ☐
Have you access to disability support services?	**Yes** ☐ **No** ☐ **N/A** ☐
If yes, did the prison give you a referral for these services?	**Yes** ☐ **No** ☐

9. **Can you tell me what it has been like getting your health needs met since you left prison?**

____

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____

10. **Are there improvements which could be made to ensure better continuity of care?**

REINTEGRATION

DEFINING REINTEGRATION

11. What does reintegration mean to you? When should reintegration begin?

REINTEGRATION EXPERIENCES

12. Can you take me through your experiences of reintegation while you were in prison? (Prompt – what kind of preparation for release did you get while you were in prison)

13. What type of reintegration assistance did you need to prepare you to go back into the community? (immediately before release and longer time periods)

(Prompt – Prison officer, Case officer, Reintegration officer, PARS, WINZ, Other)

14. Did you have a reintegration plan?

- **Was it implemented?**
- **Was it useful?**
- **Did it reflect your needs?**

15. How did you find out about what these people do for you?

Specific people	How did you find out of each of the following	How accessed?	Any problems?
Prison officer			
Reintegration officer			
PARS			
WINZ			
Other			

Ideas for improvement

16. How could reintegration be improved? (pre-reintegration and post-release reintegration)

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17. How could reintegration be improved in terms of each of the following?

Specific people	How could reintegration be improved in terms of each of the following?
Prison officer	
Case officer	
Reintegration officer	
PARS	
WINZ	
Other	

18. What else could each of them have done?

Specific people	What else could each of the following have done?
Prison officer	
Case officer	
Reintegration officer	
PARS	
WINZ	
Other	

19. Before we go any further, can you tell us if anything was stressing you out about being released?

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CLARIFYING SOME ISSUES

Statutory Release

20. Did you have to stay for your whole sentence? If yes, why?

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____

Other issues

21. Is there anything about your health and wellbeing in prison that is easier talking about now that you are out?

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Getting medical treatment while in prison

People can receive medical treatment for urgent and not so urgent conditions. A broken arm or a severe pain in your chest might be an example of an urgent situation whereas a headache might be seen as non-urgent.

We need to know how long it took you to get medical treatment for both types of situations.

URGENT

22. Can you think of an urgent medical situation in prison?

____

23. How long did it take for you to see the nurse?

____

24. How long did it take for you to see the doctor?

____

25. **How many medical chits did you write out?**

____

26. **What was the health outcome**

____

____

____

____

NON-URGENT

27. **Can you think of a non-urgent medical situation in prison?**

____

28. **How long did it take for you to see the nurse?**

____

29. **How long did it take for you to see the doctor?**

____

30. **How many medical chits did you write out?**

____

31. **What was the health outcome**

____

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____

Getting dental treatment while in prison

We need to know how long it took you to get to see the dentist.

URGENT

32. **Can you think of a time when you had a dental problem in prison and wanted to see a dentist (ie a tooth ache)?**

    ____

33. **How long did it take for you to see the dentist?**

    ____

34. **How many medical chits did you write out?**

    ____

35. **What was the outcome?**

    ____

DEMOGRAPHIC INFORMATION

36. **What prison were you released from?**
37. **How long have you been out now?** ________________
38. **Age** _____
39. **Ethnicity (check for multiple ethnicities) (CIRCLE ONE)**

    Maori ☐
    European ☐
    Pacific ☐
    Asian ☐
    Other ☐

40. **Gender**

    Male ☐

    Female ☐