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## **Narratives of health in prison**

*Gavin J. Fairbairn*

### **Abstract**

In this paper I want to talk about the use of narrative to explore health issues in prisons. I begin with a discussion of story, the part it plays in our lives and its use in research. After that I discuss a narrative study of health care in three British prisons, in which I was involved some years ago. The study allowed us to gain access to aspects of the experience of prisoners, even though we did not work directly with them, but rather with custody officers and health care professionals. My intention is to argue for the use of narrative in this research, and then to share some of our findings in discussing the importance, not only of providing prisoners with health care that is as good as that available to others, but of arranging continuity of care when they leave prison. En route I shall draw attention to some ethical issues.

**Keywords:** storytelling, ethics, health care, custody, prison

### **Human life is conducted through story**

Human life is conducted through story. We tell stories in the letters we write to friends, in the conversations we have with strangers on trains, and in those we have with people we meet at conferences. Many of our social institutions are comprised almost entirely of opportunities for telling and re-telling stories, for sharing the narratives that constitute our lives. Indeed most human interactions involve storytelling.

Telling stories seems to come naturally to us as a way of communicating with others about what has happened to us, our hopes and fears; our beliefs, the things we value, and those that we don't. We make sense of our lives by telling the stories that we live. We learn about other lives by listening to the stories that people tell about themselves, about what has happened to them and is happening to them; about what they are looking forward to, and what they are dreading. By listening to the stories that people tell, we learn about what matters to them; about what they value and what they don't.

As an applied philosopher and ethicist I grew up with stories, which are an important tool in the exploration of ethical issues, including those that arise in health, social care and disability. As a result, when I first began

working on such issues with practitioners, I would work with them on stories that I introduced, with the intention of illustrating and raising particular issues, before inviting them to share stories from their own practice. Gradually we would negotiate a shared understanding of what was going on in these stories, in a way that allowed me both to introduce ethical ideas and to model an approach uncovering the values that underpin actions. After a while, however, the stories began to take on a life of their own, and I discovered that the most useful part of my ethics teaching was the exploration of the stories themselves, both those that I brought into the classroom with me and those that my participants told.

I began with this very brief story about part of my life, because I want to talk, today, about the use of narrative as a way of accessing information about the health needs of prisoners. I shall do so via some snapshots of research a colleague and I carried out some years ago, in three British prisons, which was the first use I made of narrative as an empirical research method.

Our research aimed to investigate awareness among prison staff, of the health needs of prisoners and their experience of addressing such needs. It was carried out at a time when a number of reports had drawn attention to the need to address the health care of prisoners, who are often less healthy than the general population. More than that, many prisoners have little contact with health services over a considerable period. Our research arose out of the conviction that no matter how aware prisons were, at an institutional level, of the health needs of their inmates, the day to day delivery of care must depend upon the individual awareness of staff, including discipline officers, of those health needs. It produced some interesting results, partly I think, because of the methodology, which grew out of my realisation that for years I had been gathering information about topics in which I had a philosophical and ethical interest, including suicide and the sexuality of people with learning disabilities, by listening to stories shared by participants in my ethical workshops. In other words, my interest in and approach to narrative as empirical method grew out of my work as an ethicist, rather than out of contact with the work of other narrative researchers.

### **Method**

A narrative workshop was held with 6-8 staff in each prison, who were opportunistically selected to allow us to meet with a range of staff; across the three prisons they included a doctor, a chaplain, registered general and mental health nurses, health care officers and discipline officers. Each session was recorded and later transcribed.

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At the beginning of workshops, participants were asked to write stories about:

- The last health related incident in which they were involved.
- A health related incident that they found particularly challenging and/or interesting.

After this we convened a plenary during which participants were invited to tell their stories.

Inviting participants to write their stories before telling them, is a somewhat unusual feature of our narrative approach. We had two reasons for adopting so. First, doing so gave them the opportunity to revisit and recollect or remember their stories before sharing them with the group. Secondly, and more importantly, giving them the opportunity to identify stories that are significant for them, before sharing those stories with others, increased the likelihood that the stories they told would be uninfluenced by those told by others.

### **Results**

Simple thematic analysis of transcripts allowed us to gather together data about related areas into a number of themes, which we then condensed into six major themes:

- Mental health issues, including drug issues
- The Prison/NHS interface
- Prisons as having the potential to make a difference
- Conflicts between custody and care
- Resource Issues
- Emotional and psychological support of prisoners and staff

### ***Mental health issues including drugs and self harm***

It was no surprise to find that many stories we gathered, concerned mental health, nor to find that concerns about drugs surfaced frequently. Some related to the smuggling of drugs into prison:

*It doesn't take a genius to work out that it's more difficult to get that lump of cannabis in which doesn't give many hits. So now what they have is crack cocaine and heroin which comes in under their tongue. I had information a fortnight ago and it was good*

*information and we followed it up and we had results on it and women were bringing crack cocaine in under their tongue.*

We learned about ways in which methadone, prescribed for addicts as part of drug rehabilitation, is redistributed for profit by prisoners, despite being required to take it in the clinic:

*In the community there's a market for spit. Its called spit methodone.*

*It's a common problem, inmates trying to smuggle medication out of the treatment hatch, or vomiting it afterwards just to sell it off.*

Mental health problems are as you might expect, not limited to problems with drug use. For example, we heard that problems arise because when prisoners are:

*... particularly disordered and difficult to manage the only way you can deal with them is seclude them and invariably means they're locked up for 23 hrs a day*

Of course, seclusion itself brings additional problems, which a number of participants talked about. For example, one told us:

*...invariably it makes their health deteriorate it makes the problems they've got worse.*

Some mental health problems were seen more as custody than as medical issues, perhaps because discipline officers have 24 hour contact with prisoners. This was particularly true in the case of suicide and self harm:

*...self harm is not a medical problem it's a prison officer problem that prison officers should be dealing with daily on the wings. You know that's our job to identify people who are depressed...*

It was no surprise to find that self harm figured strongly in stories that were shared, nor to hear that it was viewed as a custody problem.

Some officers talked about the way in which their role has changed and developed as education and training has encouraged them to adopt a more caring approach. However, the full potential of officers to develop their caring role may never be realised because, as another said:

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*If a prison officer shows a bit of compassion and wants to care for a prisoner which at the end of the day is our job you're sort of seen as a soft touch. You know...he's not a proper prison officer*

Several officers used the expression 'care bears' to describe the way in which they tend to be viewed by colleagues if they seem over concerned with prisoners' welfare. One said::

*Yeah... if any officer up there shows a bit of compassion, you know, he's often bullied and ridiculed...*

In spite of such problems, many participants demonstrated considerable empathy with prisoners. For example, some discipline officers talked about their concern with 'poor copers' and about the effects of incarceration. In particular they raised concerns about the bereavements that can result from being in prison:

*I was talking to a man yesterday who I hadn't really spoken with before who told me that shortly after he came into prison, he'd written to his mother and she'd actually gone to the prison authorities and said she didn't want to have any more contact with him. I can't imagine how that would strike me. I don't think any of us could.*

This is an example of bereavement due to the simple loss of contact with loved ones. However, bereavement following the death of loved ones while inmates are in prison was also discussed. One participant told us:

*...that's a problem in itself because they're unable to go through the grieving process. I think a lot of our chaps that...have a loss. They're unable to say goodbye, to actually attend the funeral because they don't want to go handcuffed because they feel that's wrong despite the fact that they need to be. So they just can't put an end to actual sort of grief process.*

Participants often told stories about incidents and issues that upset and disturbed them. For example, one officer related a story about an occasion when he:

*...attended a suicide at a previous establishment a long, long time ago and it was a premeditated suicide this guy...it was obvious that he was going to carry it out to the end and I found that quite*

*difficult to come to terms with. I mean the fact that we found him and he was there hanging really was out of our control.*

The fact that participants were so keen to share upsetting incidents led us to reflect on the possibility that they could benefit from the provision of clinical supervision. And here we are not thinking only of clinical staff, but also of discipline officers.

#### ***The Prison/NHS interface***

Many of our participants expressed a concern about a series of problems that cluster round the interface between prisons and the National Health Service, including difficulties in accessing external health services. Many seemed to believe that NHS facilities were not interested in caring for prisoners, because they tend to be passed from one department to another, with no one wanting to take responsibility for their care. For example, one participant told a story about a prisoner with a shoulder problem:

*...we experienced great difficulties getting him seen.... Finally...one of the medical officers had to go down there with photographs of the man to hand to the orthopaedic surgeon before one of them would be prepared to see him.*

Some participants believed that one reason for such problems, was the common view of prisoners as a threat, no matter who they are or why they are in custody. This is in spite of the fact that security procedures demand that prisoners attending hospital are always accompanied by at least two officers.

Another reason that was offered for problems at the interface between prisons and outside health services was the lack of understanding on the part of NHS professionals, about the nature of prison health care, as if they believe that because prisons often have 'hospital wings', this means that care of a kind that is similar to that provided in NHS hospitals is possible. One result of this that we heard about was that prisoners will often be returned to prison prematurely, because the support they need is not easily available. One participant illustrated this by reference to rehabilitation after stroke:

*...we've had patients go to... that say are rehabilitating after a stroke.... I had to physically go down there myself in the car and explain to them and challenge their view of what the services we provide and say that you know, your criteria for discharge to prisons should be the same as that person's home.*

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***Prison as having the potential to make a difference***

A key issue that arose in the narrative workshops related to the potential that prisons have to make a difference to the health of prisoners, because entry to prison will often be the first opportunity there has been to attend to their health needs for a considerable period. One participant said:

*...we get a lot of these people back on their feet and they actually say to us themselves that they were looking forward to coming to prison so that we could deal with...you know the drug problem but also their diabetes.*

For persistent re-offenders entry to prison can be a bit like a 'pit stop' where they go to be '...checked over and have a service':

*Like you know we health screen...the offending population which is quite good because they're likely to have the high risk of being unwell anyway before...But...that information, you know we don't actually use it to its full potential.*

It is self evidently a good thing that individuals who are not in receipt of regular health care, should benefit from the health care provided by prisons when they are inmates. However, the lack of follow-up when they returned to the community was viewed as wasteful:

*Controlling their asthma whatever the case may be and that then all falls apart the moment they walk out the door because there's no follow up and they'll either walk straight back out and be prescribed benzo's even though you've just spent months getting them off or they got out there and become non compliant with treatment and thereby become ill again.*

The problem seems to be that having achieved some change in a prisoner's health status, he will lose the benefit when he leaves prison:

*Time and time again...the same people are coming back and forth to prison. You've dealt with their health problems...They go out and come back exactly the same problems again...It seems you're banging you're head against a brick wall sometimes..*

***Conflicts between custody and care***

A major issue raised in several stories, concerned problems that arise because of the conflicting demands of custody and care:



*After all we are a prison where custody and discipline are paramount. Which take over health care needs possibly. We've always been second fiddle.*

The very strong emphasis that is placed on custody and security issues can lead to dangerous circumstances at times:

*There was a chappie who had dropped a big weight on his foot. 20kg in fact.... fractured ...custody issue ...'Oh we haven't got the people to take him down to hospital' or 'We've got another one to go down as well...'*

Even in emergency situations, custody often seems to take priority over the welfare of prisoners. As a result the minimum time to get an ambulance into prison is 15 mins:

*If its 999 their minimum time, you know to get into because of security is 15 mins. [new speaker:...they can do it in 15 mins and that's at a push. But you know, that can be a problem in itself...what you're dealing with is an emergency].*

Clearly the primary business of prisons is to ensure that inmates are securely held in custody. However, as this account suggests, this means that in emergency circumstances the health of prisoners may be compromised, because their situation means that the time that it takes to get them to hospital for treatment is longer than it is for most citizens.

### **Resource Issues**

Finally, I'd like to say a little about resource issues, which seemed to underpin many of the other themes, because without adequate resources not only can the best service not be provided, but much of what is provided will be wasted. They arose in relation to a several areas, including the provision of very basic equipment. Sometimes they were quite disturbing. For example, one participant talked about a gentleman who::

*... was incontinent to urine but... couldn't have a plastic mattress or a plastic underneath the sheets so I think he went through about 10 mattresses. He couldn't have them because it was too expensive. But the amount of mattresses he went and the amount of times I had to go over and show him the ... way of packing a bed so that more of the urine is absorbed in through sheets in preference to mattress and I found that really...Like something out of the dark ages.*

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Another participant related a story about an inmate with a stoma:

*...with stoma care you need to have daily showers and you need privacy and all of the clean things and things. You know we couldn't just say to the officer 'make sure he has a shower everyday'...It's impractical. Its not that you don't want to offer him a shower everyday you can't there are too many who want one everyday.*

Resource issues also arose in relation to mental health, including the inability to monitor inmates with severe mental health problems adequately:

*I mean we had particular situations at the weekend where the prison...wanted to reduce us to one officer in the health care centre. One officer! You know for an in patient area of over 21 beds. With people who are mentally disordered, detox, physical health problems and that officer as well has got to respond to any medical emergency throughout the jail...*

### **Some questions about narratives in research**

In offering an overview of some of our findings I wanted to illustrate the power of narrative enquiry to allow access to the experience of prison staff, and through them, to some of the experience of prisoners who have health issues during their time inside. There is a good deal of disagreement about the place of narrative methods in research. Some people believe that, along with other approaches which aim to find ways of capturing the authentic voices and views of respondents, narratives are useful as a kind of reconnaissance flight over the territory that is being investigated. The idea is that having done such initial work, it is then possible to be more rigorous in a main study.

For example, they might believe that using a questionnaire survey can allow them to capture a respondent's views in ways that can be properly analysed – using statistical processes to support results. One reason that some of those occupy this view of narratives have for doing so, is that they do not believe that it is ever possible to really trust the stories that people tell, since it is always possible to elaborate and invent a story.

Another reason is related to difficulties in determining how far the stories they tell actually match up to reality, even when they have told the truth as they see it. This is the difference between their being truthful and their speaking the truth - a distinction that is of importance in all areas of

research and for all methodologies that involve gathering information about human beliefs, behaviours and experiences. However, it is beyond the scope of this paper to fully explore.

Others believe that the stories people tell are, in themselves, a valid way of developing one's understanding of the area that is being researched. It should be clear that I belong to this group, and I hope my selection of extracts from the stories shared by participants makes it obvious why this is the case.

**Gavin Fairbairn** is a teacher and 'jobbing philosopher' with interests in the ethics of health and social care, including mental health, disability and end of life issues (especially suicide). He also has strong interests in philosophical and ethical issues in peace and conflict, including nuclear deterrence, and the relationship between reconciliation, truth, apology and forgiveness. He is committed to the use of storytelling in teaching and research, and as a model for academic writing of all kinds. In the past he worked for many years as a practitioner in special education, social work and teacher education, and occupied chairs of Professional Development in Nursing and Midwifery, then Education, before moving to Leeds Metropolitan University, UK, where he is currently Professor of Ethics and Language in the Faculty of Health.