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'You can't have them in here': experiences of accessing medication among older men on entry to prison

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ABSTRACT

Older prisoners are the fastest growing sub-group in the English and Welsh prison estate. They have complex health needs, in spite of which there is a dearth of literature concerning their access to prescribed medication. Literature relating to younger prisoners highlights common issues around maintaining continuity of medication upon reception into prison custody. The objective of the study was to explore the lived experience of older male prisoners regarding continuity of medication upon entry into prison. This paper presents findings from part of a large-scale research project regarding health and social care services for older male adult prisoners. Semi-structured interviews were conducted with male participants (N = 27) aged 60 years and over who had been newly received into prison. Interviews were conducted within the first ten weeks of custody. Participants were asked about their experience of accessing medication on entry into prison. Data were analysed using the constant comparison method. Eighty-five per cent of participants were in receipt of prescribed medication when committed to prison. Older prisoners' experiences of receiving medication in prison were reflected in four key themes: delays in confirming medicines; changes to medication; communication difficulties; and enforced helplessness. Whilst these experiences mirrored those of prisoners of all ages reported in previous studies, these issues are especially relevant to older prisoners who are likely to have greater and more complex medication needs than their younger peers. In addition, older prisoners experienced unmet needs related to restricted mobility and functional skills that could have impaired their ability to maintain concordance with medication regimes. This study shows that there is need for increased awareness of prescribing issues specific to older prisoners to allay related feelings of anxiety and distress and to ensure they receive appropriate medication.

KEY WORDS – older prisoners, medication, prescribing.

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Introduction

There are increasing numbers of older prisoners throughout developed countries (American Civil Liberties Union 2012; Gautier 2011; Grant 1999; Ministry of Justice 2013; Uzoaba 1998). Prisoners aged 60 years and over are the fastest growing sub-group in England and Wales, rising by 122 per cent between 2002 and 2012 (Ministry of Justice 2013). There are a number of possible contributory factors for this increase, including the recent trend for older people to receive custodial sentences for historical offences (Ginn 2012); an ageing population overall (Howse 2003); and longer sentencing practices resulting in younger prisoners growing old in prison (Corwin 2001; Her Majesty's Chief Inspector of Prisons 2008; Her Majesty's Inspectorate of Prisons 2004).

The health needs of older prisoners

Prisoners have different health-care needs than people living in the community. There are higher rates of communicable diseases (Thompson *et al.* 2009), mental illness (Birmingham, Wilson and Adshead 2006), substance use (Mason, Birmingham and Grubin 1997; Singleton, Meltzer and Gatward 1998) and smoking (Lester, Hamilton-Kirkwood and Jones 2003). Older prisoners have more complex health-care needs than both younger prisoners and older people in the community, with over 80 per cent having at least one chronic illness, most commonly cardiovascular and musculoskeletal problems (Fazel *et al.* 2001). Older prisoners subsequently experience higher treatment needs for long-term conditions compared to their age-matched peers living in the community (Hayes *et al.* 2012). This has been verified in studies reporting that older prisoners are disproportionately high users of prison health-care services compared to their younger counterparts (McDonald 1995; Smyer, Gragert and LaMere 1997). Furthermore, Cooney and Braggins (2010) reported that prison staff perceived older prisoners to have a physical health status ten years older than people of the same biological age living in the community.

The principle of equivalence

There is a responsibility on Her Majesty's Prison Service (HMPS) to ensure that prisoners have access to the same range and quality of health-care services that are, for the most part, equivalent to those available in the community under the National Health Service (NHS Commissioning Board 2012). This is known as the 'equivalence of care' principle (Wilson 2004). Nonetheless, concerns have been expressed about the feasibility of

putting this into practice. Restrictions on the range of treatments available in prisons are commonplace, and are further reduced by lack of available resources to administer and monitor treatment (Birmingham, Wilson and Adshead 2006). Studies have shown health-care service arrangements vary markedly in prisons across England and Wales, with many services failing to provide care equivalent to the community (Exworthy, Samele and Urquía 2012; Forrester *et al.* 2013).

Of specific relevance to the current study, the provision of services for older prisoners has been found to vary considerably between establishments (Her Majesty's Chief Inspector of Prisons 2008). On the whole, prison health-care systems have been designed to meet the needs of the young and are often ill-equipped to deal with complex health issues presented by older offenders (Williams *et al.* 2010). Given the increasing prison population overall and the rising proportion of incarcerated older prisoners (Prison Reform Trust 2012), pressure on prison health-care services will only increase in future.

Prescribing in prisons

A number of factors need to be taken into consideration when prescribing for prisoners. In prisons, there is a high prevalence of people with substance misuse disorders (Fazel, Bains and Doll 2006), coupled with reduced access to illicit drugs. This combination is likely to contribute to increased misuse of prescribed medication, with some prisoners seeking out certain medicines for their hypnotic or euphoric, rather than therapeutic, effects (Royal College of General Practitioners (RCGP) 2011). In a previously conducted qualitative study, staff participants suggested that prisoners may sometimes attempt to deceive health-care staff in order to obtain prescriptions without medical justification (Bowen, Rogers and Shaw 2009).

One issue is that certain medications carry a high risk potential of being misused and are thus regarded as valued commodities. In prisons, an environment where trading and bullying are common (Burns 2009; Nurse, Woodcock and Ormsby 2003), there is therefore a risk that vulnerable prisoners may be coerced into relinquishing their appropriately prescribed medication (RCGP 2011). The RCGP recently issued specific guidance for prescribers in prison which introduced a 'traffic light system' that classified individual medicines as either green (low risk), amber (prescribe with caution) or red (generally inappropriate for prison use) (RCGP 2011). Nonetheless, most prisons in England and Wales report that diverted medication is a growing problem (Her Majesty's Chief Inspector of Prisons 2012).

Few studies have specifically investigated the medications prescribed to prisoners in England and Wales (Bowen, Rogers and Shaw 2009; Hassan *et al.* 2010, 2011). On entry into prison, all prisoners are reviewed by

health-care staff to determine their physical and mental health needs, which includes identifying any prescribed medication (HMPS 2004). Guidelines for good clinical practice recommend that a prisoner's self-reported medication is then verified by the relevant community prescriber, *e.g.* a general practitioner (GP) or substance misuse service (HMPS 2006).

There is a paucity of published research regarding prescribing practices for older prisoners and their experiences of receiving medication upon reception into custody, a stressful point of transition for many (Bowen, Rogers and Shaw 2009). The Prison Reform Trust (2008) found that older people frequently had their medication stopped on entering prison from the community. Furthermore, even where medication is prescribed, treatment may not necessarily be appropriate; in a study of 203 older male prisoners, Fazel *et al.* (2004) found that whilst 77 per cent were prescribed some form of medication, prescriptions did not always match documented treatment needs, with discrepancies most marked for those prisoners with psychiatric illnesses.

This paper presents findings from part of a large-scale research project regarding health and social care services for older male adult prisoners (Senior *et al.* 2013). As part of this study, interviews were conducted with older prisoners who had recently arrived at prison in order to establish to what extent their health and social care needs were met. Medication was one of the key themes identified in the data derived from these interviews. Consequently, in this paper we explore the views of older prisoners regarding their experiences of accessing prescribed medicines on reception into custody.

Method

The current study was a qualitative exploration of the experiences of older prisoners in accessing health care on entry into prison.

Setting

Twelve local prisons were invited to participate. Local prisons hold people awaiting trial, those convicted of short sentences and those at the early stage of a long sentence. Prisons were located in rural and urban areas in England including the North East, Yorkshire and Humberside, the North West and the Midlands. Nine local prisons agreed to participate, comprising six public sector and three privately run prisons.

Sample

Individuals who were newly received into prison following a court appearance (thus excluding those transferred from other prisons) aged 60 years

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and over were invited to participate in the study. Semi-structured interviews (N = 27) were conducted with these participants, until data saturation was reached and no new themes emerged. The sample included participants with a wide range of ages, offence types and sentence length. Most participants were aged 60–64 (59%); nearly half were sex offenders (44%) and unsentenced (41%).

Interviews

Individual, semi-structured interviews were conducted by three researchers. All interviews were conducted during the initial ten weeks of custody. The interview aimed to capture participants' experiences of arrival into custody. The interview guide included questions about how health, social care and custodial needs had been addressed. Participants were also asked if they considered that their needs had been appropriately met and to comment on any additional services that they feel would have been beneficial. Participants who were prescribed medication in the community were asked about their experience of accessing this on entry into prison.

Data from the qualitative interviews were recorded, transcribed and analysed using the constant comparison method (Patton 1990), an approach developed within grounded theory (Glaser 1965). Constant comparison aims to ensure that theory stays rooted in the data (Boeije 2002) and is most appropriate for studies where little is known about the topic or a new perspective is required. It involves fragmenting and then connecting data; pieces of data are coded and separated from the original interview transcript and then compared with other fragments until the researcher is able to understand the overall picture (Boeije 2002). According to Glaser (1965), there are four stages involved in the constant comparison method of analysis: comparing incidents applicable to each category; integrating categories and their properties; delimiting the theory; and writing the theory. These stages were followed in this research and involved identifying provisional themes and comparing incidents that apply to such themes. Comparisons were then made and integrated into themes, which was done until no new themes emerged.

NVivo (version 8, QSR International, Southport, UK), a qualitative software package, was used to facilitate the analysis of transcripts. Such programmes aid the researcher to store, sort and code qualitative data and can increase the rigour of a qualitative study (Leech and Onwuegbuzie 2011). Two researchers conducted qualitative analysis, providing the opportunity for one researcher to act as a 'peer debriefer'. The two researchers held periodical discussions regarding matters of methodology and analytical procedures. This provided an opportunity to test emerging themes and increased the credibility of the findings (Leech and Onwuegbuzie 2011).

Findings

Participants were asked questions relating to their experience of receiving medication on entry into prison. Twenty-three (85%) participants were in receipt of prescribed medication upon reception into custody. Analysis of interview data yielded four sub-themes relating to medication: delays in confirming medicines; changes to medication; communication difficulties; and enforced helplessness. Each of these themes will be discussed in turn.

Delays in confirming prescribed medicines

The issue that was most frequently reported and caused the most anxiety to participants was the delays they experienced in obtaining their medication when they first came into custody. Participants stressed how medics in the community had emphasised the importance of taking their medication daily and therefore they were exceptionally concerned about the impact that any delays in receiving their medication on entry into prison would have on their health. This was particularly the case for medication taken for heart conditions or diabetes. Participants reported considerable delays in confirming prescriptions for medicines they previously received in the community. Where prescriptions were reinstated, the length of time reportedly varied from a few hours to one month. As one participant reported:

> [It was] maybe up to three weeks before you were back on something … Well I think it's absolutely ridiculous that, three weeks! I mean if you have got a problem outside you don't wait three weeks do you to see a doctor, you see them the next day. (prisoner participant 10)

Yet, another interviewee reported that the process of reinstating medication could be much quicker. There was no identifiable pattern for why some prisoners had to wait days and months, whereas others received their prescribed medication within a day:

> I had no medication for the first day that I were in here … until they got my medication, you know, they had to get it through to the chemist or whatever, and then I started on what I should be on. (prisoner participant 29)

Even when participants brought medicines with them into prison, they frequently had it taken from their possession by health-care staff. Staff would have to clarify that these were medications that were allowed in prison and that they had been prescribed to the appropriate person. This required them to contact the prisoner's community GP to obtain a copy of their prescription. Therefore delays were likely if prisoners were received into prison when the community practice was closed, such as in the evenings and at weekends. There were still delays in prisoners receiving appropriate

medication when the prisoner had brought confirmation of their repeat prescription with them and the medication was provided in clearly labelled sealed packaging:

> Well, I brought everything in, a month's supply … so when I had been in three days, they came and took my blood pressure and it was 190 … I said well, I haven't got my pills … I didn't see another person for a fortnight and then they come and took me blood pressure again and it was 170. And I says well, I haven't had my pills … When I went up and saw the doctor, the nurse I had seen had already put them on and the doctor said well they are on; 'you'll have your pills by Friday and then get a blood pressure check in the triage'. Anyway, it was Saturday when I got them. (prisoner participant 33)

A number of participants reported that they had to wait for prison healthcare staff to complete investigations and tests to confirm whether or not medications were indeed required. Some participants reported that such delays in accessing their regular medicines led to negative physical health outcomes, including 'flare-ups' of previously controlled chronic conditions and, in some cases, pain. As one participant described: '[I have] been waiting two or three days … [it was] painful!' (prisoner participant 10).

One participant who had had gout for several years reported having to undergo further investigations to confirm his diagnosis. During this interim period, he was denied access to previously long-standing medications, which caused a painful exacerbation of the condition:

> You seen a doctor, well, not a doctor, like a nurse and she asks you if you're on medication, you know what I mean, and what kind of medication were you on like, and my gout had just started and I said 'oh', I said 'I've got gout', so they said 'oh, who's told you you've got gout', I said 'well, the doctor outside here'. I couldn't remember the name of the tablets I was on like … but when I got in [to prison] it flared up after two days and I could hardly get out of my bed when I got here … So the nurse came up and then I was saying, 'you know, you need a doctor in here', I said 'I can't even, I can hardly move'. As soon as the sheet touches my leg, you know, so … the doctor did come yeah, but after about six/seven hours and then he [the doctor] said well, 'we'll need to get a blood test' … I said 'well look, I've got gout', he said 'but we can't take your word that you've got gout'. So the nurse came again and then took the blood test, and then two days later I got the tablets. If they'd have given us the tablets when I asked for the tablets … I had the tablets at home and when I felt it coming on, I'd just take the tablets and after two days that was it and I'd put the tablets by and when I felt it coming on again, I done the exact same thing. But because they never give me the tablets, it flared up here, that is how it is sore in my elbow, that knee is now out of proportion. I've never had it so bad you see. But they said they 'can't just take my word for it, you know'. I said well, 'my doctor is only a mile and a half along the road there'. (prisoner participant 34)

In addition to recurrence of symptoms, these delays and the associated uncertainty caused a more general sense of stress and anxiety. Participants found this distressing and were often concerned about the impact that

disruption to long-standing medication regimes could have on their health. In particular, they expressed frustration at having to chase health-care staff to find out reasons for delays, often having to wait long periods before being able to speak to staff to address these issues. This lack of communication during the interim exacerbated this anxiety.

Changes to medication

Many participants reported that previously prescribed medicines were changed in prison, either to lower dosages, or replaced with alternative medications. Examples of the types of medications which were reportedly refused included opiate analgesia, benzodiazepines and nebulisers. One participant described how the GP informed him that he was unable to continue with the medication he was prescribed in the community: 'He [the doctor] said I can't have that, I can't have that, I can't have that' (prisoner participant 40). Prisoners were reportedly not provided with an explanation for why they could not continue with their prescribed medication in prison. These decisions appeared to be based on considerations specific to the prison environment, rather than individual health needs:

> I've seen the doctor, I told [him] what tablets I'm on, been on for 40 years. They said 'you can't have them in here' … I saw the medical officer, not a doctor, and I told him what tablets I'm on. 'You won't get them here.' So the next day I've seen the doctor, told the doctor; then the medical officer, or the nurse that was with him, said, 'We don't do them tablets in this prison.' And he said, 'You can't have them.' 'But I've had them before in here.' He said, 'We don't do them now.' And the doctor asked me who my own personal doctor outside was. I told him. He rung them up to check to make sure I was on them, and they verified that I was on the tablets; but they still won't give them me. (prisoner participant 5)

Prisoners also expressed concern about alternative medications provided to them. Substitute or alternative medications provided were generally viewed as being weaker, inferior and ineffective at controlling symptoms: '[I have a] substitute, that doesn't help' (prisoner participant 5).

> [I was on] codeine phosphate … as a pain killer … they're more stronger than paracetamol, you know, and they do help me with me pains in my back. (prisoner participant 25)

In addition, numerous participants reported that they received medication less often, in reduced dosages or at different times than they were used to:

> They gave me one tablet instead of two, like two Tramadol and two co-codamol, but I just got Tramadol and it doesn't work, it doesn't … It doesn't stop any of the pain … I might as well not take it. (prisoner participant 10)

Changes to the frequency and timing of medication sometimes appeared to be due to restrictions on prison regimes. Due to security restrictions,

prisoners were not always permitted to store and administer their own medicines. Rather, they had to wait for medicines to be dispensed to them by health-care staff at set times during the day. This meant that medication was generally dispensed only two or three times a day as a result of the resources required to conduct this task. This caused difficulties for prisoners who usually took their medication more than three times a day; such prisoners would have to either take two doses together or miss doses. This is a particular problem for pain medication. For example, one prisoner reported:

> I used to take it at home four times a day, but [here] I get it three times [a day] during the week and twice [a day] at the weekend. (prisoner participant 10)

For some prisoners, the limited time periods during which they could take their medication created pain, 'if you had them in your cell you could take them four times a day, like I used to do, and it wouldn't be so bad then … and you could take it before you go to bed and then you'd be able to sleep, where you have to, like, blank the pain out to get to sleep' (prisoner participant 10).

These changes of medication type, dosage and frequency, combined with the loss of personal control, created fundamental worries in some participants, as one participant stated: 'Sometimes I'm not sure that they're giving me the right things [medication]' (prisoner participant 13).

The prisoners found it difficult to access health-care staff in order to discuss their concerns; they were required to put in an application to the prison to be able to request to see the prison GP and there were long waiting lists for appointments. Thus they were unable to receive explanations or reassurance about the impact of such changes on the management of their health-care condition in a timely manner, which led to increased anxiety. In the meantime, they were left to rely on alternative medications, which were often perceived to be inadequate.

Communication difficulties

Problems with communication between prescribers and patients was a common theme. As noted above, a frequent concern among participants related to long-standing prescriptions being changed on entry into prison. Several participants were concerned that they were not given sufficient information as to the reasons behind these changes. As one participant reported, little justification was given:

> I was told [by] one doctor, 'I'm your doctor now, not your doctor on the outside', which I don't think was right. (prisoner participant 13)

Where reasons were given for changes to their medication, prisoners sometimes found the explanations unhelpful, incomplete or confusing. For

example, the explanation provided to another participant appeared to contradict other medical advice: 'They're doing away with them [nebuliser] … my doctor never told me that' (prisoner participant 29).

Other communication difficulties noted related to participants being unable to discuss their concerns with health-care staff due to long delays in accessing appointments. As mentioned earlier, prisoners had to make a written application to make an appointment, often leading to long delays in accessing GPs. As one participant explained:

> I said, 'I want to see the doctor.' He [the nurse] said, 'I'll put you down but I don't know when you'll see him.' That's how bad it is. And at weekends you can't see a doctor, there's no doctor in … But one called me up on Sunday – or a week ago, ten days ago – to see me, and he gave me a dose of tablets, three tablets a day, antibiotics for a kidney infection. I said, 'I've still got the kidney infection.' They said, 'Well, you only get them for a week, if it's not worked you see the doctor.' I said, 'well, push me forward to see the doctor, can I see him today?' 'No', she said, 'It might be tomorrow, but I don't think so, it might be a week off.' (prisoner participant 34)

Reasons for changes to medications, doses or timings were poorly explained to participants and they felt unable to access reassurance about alternative regimes imposed on them. One prisoner participant explained the types of problems experienced:

> They know what medication I should be on, but they've only missed one tablet out … I never got it last time I was in and it don't seem like they're giving it me this time. (prisoner participant 25)

Enforced helplessness

In some cases, participants had previously received help from carers or personal support from their spouses or family in the community in administering their medication, applying lotions or creams, or monitoring their chronic conditions. There was little or no exploration of this on entry into prison, where they found that there was little consideration as to their functional ability to use new technologies (such as a blood glucose machine), or effectively use or apply existing medications, such as creams. As one participant described:

> I don't understand it, and I've had this [blood glucose] machine … and I've asked them to come and help me, show me how to work the machine, and they still haven't bothered … So I've got a machine there but no-one's showed me how to use it. (patient participant 24)

For some prisoners, medical devices that they had used for many years in the community were changed in prison with little or no explanation or instruction as to how to use them. The participants found it embarrassing

to ask their peers to assist them in these areas when no other support was available, as one participant explained:

> My wife always helps me [apply creams] … with no-one there to help me I was struggling and how I done it, I do not know … My inmate did it for me but he didn't do it all that well. I've managed to put one foot on the chair and I've managed to get round it with my hand. (prisoner participant 24)

Participants were therefore left feeling unable to monitor and manage their physical health conditions. This further compounded anxieties around changes to their medication regime.

Older prisoners' restricted mobility contributed to difficulties collecting their medicines within the allotted times of the prison regime. In some prisons there were lifts which eased access to some degree, but queuing at medication times was often painful as a result of their physical health conditions. Participants found that no allowances or concessions were made for their difficulties, such as allowing them to attend for medication first or having suitable seating; describing either none or where it was available, uncomfortable wooden benches, as one participant explained:

> Oh you'll need a nurse if you want tablets, so I goes to the nurse and I'm stood in this big queue … so, that's me stood all the time and I was in pain. (prisoner participant 24)

Participants perceived the limited medication times to be restrictive and were frustrated at being unable to have some medications in their possession, to store and administer themselves, instead having to attend regularly to receive single doses, as two participants described below:

> I've got my own pills in my locker, in my pad, but the Warfarin they won't give me, I don't know why but I've got to go down for them. (prisoner participant 24)

This had the effect that participants who had previously established a routine of taking medication, with which they often felt comfortable, had to adapt to taking medication at times set by the prison. In contrast, where individuals were permitted to hold medication 'in possession' (as it is known), this appeared to be associated with enhanced feelings of control over timing of medication and, as a result, better perceived symptom management.

Discussion

Main findings

We found that access to medication was a topic of considerable importance among older prisoners who were newly received into custody. For the most part, the concerns reported by participants in this study mirrored those

experienced by prisoners of all ages in other studies (Bowen, Rogers and Shaw 2009; Hassan *et al.* 2010, 2011; Plugge, Douglas and Fitzpatrick 2008). These included delays to receiving medication, changes to previously prescribed medication and poor communication. These are likely to be particularly prevalent issues amongst older prisoners who are more likely to take prescribed medications than their younger peers. Furthermore, our older participants reported specific needs not mentioned in the literature about younger prisoners. These included their functional inability to utilise certain medical devices or to apply creams, and mobility issues affecting their inability to make their way to the prison dispensary or to queue for prolonged periods. Strikingly, previous research has shown that older prisoners do not experience delays in receiving medication when they are released from prison (Forsyth *et al.* 2014) and therefore such delays should not occur on prison entry.

Interestingly, participants in this study did not report that they felt vulnerable or liable to being bullied by other inmates with respect to their medication, which directly contrasts with commonly held beliefs. However, it must be noted that the participants included in this study were, more often than not, housed within a vulnerable prisoners' unit, which may have afforded them some protection from pressure from other prisoners in the general population with respect to being coerced into diverting medication.

Clinical implications

A key finding of this study is that uncertainty issues around the prescription, supply and use of medication is a cause of considerable anxiety among older prisoners. Whilst we have no evidence that the delays in receiving medication were specific to older prisoners in the establishments we sampled, their experiences highlight their vulnerability when trying to maintain personal autonomy in a controlled and controlling environment. We suggest that the anxieties identified may be reduced in a number of ways through changes to practice.

Medicines reconciliation is the process of obtaining an up-to-date and accurate medication to ensure that the 'right person gets the right drug at the right dose at the right time' (NHS National Prescribing Centre 2008). Such processes are necessary to ensure medications are safely prescribed. However, more effective medicines reconciliation in prison may minimise unnecessary delays and tests. This could be achieved through developing closer and more effective partnerships and open lines of communication with community care providers, particularly developing protocols to ensure the rapid transfer of health information through improved information technology. Access to a person's medical history would prevent duplication of

tests and investigations, allow rapid confirmation of diagnoses and facilitate continuity of care, upon both reception and discharge from prison.

Lack of clear communication was a major concern among the participants. Whilst it is accepted that health-care professionals should routinely involve all patients in decisions about their care, this may be even more important for older adults with chronic conditions (Bastiaens *et al.* 2007; Bodenheimer *et al.* 2002). In particular, prison-based clinicians need to be aware of the inhibiting effects of the prison environment on a person's ability to access information, feel empowered to make decisions about their care and, at the most basic level, simply to understand how systems work with regard to appointments, decisions around in-possession medication and ordering supplies. Routine prison practices, such as requiring independent corroboration of medication from community prescribers, should be fully explained, with timescales for action given. Older prisoners should be involved in decision making and able to express their concerns and thoughts about treatment and have those concerns taken seriously. When changes are made, health-care staff should take time to clearly communicate decisions, identify concerns and provide reassurance.

A particular concern among older prisoners in this study was a perceived increase in pain experienced, attributed to medication changes. Due to higher rates of physical disability in this group, older prisoners may be more likely to be prescribed analgesic medicines, many of which have a high abuse potential, of obvious concern within a prison environment. In general, older adults are more likely to experience pain than younger people but less likely to have effective analgesia (Lynn *et al.* 1997; Pickering 2005). Inevitably, some medications will be routinely changed on entry into prison due to their exclusion from prison formularies, based on concerns about safety, diversion or misuse. However, this then places a clear responsibility to ensure alternative, clinically appropriate, pain-relief strategies are in place to avoid unnecessary pain.

This study also demonstrated that for many older prisoners who may have previously received support from family and other care-givers, an assessment of their functional skills is required. Crawley (2005) and Crawley and Sparks (2005) found that prisons were often poorly adapted to the needs of older prisoners. This was termed 'institutional thoughtlessness' and described as 'the ways in which prison regimes (routines, rules, timetables etc) simply roll on with little reference to the needs and sensibilities of the old' (Crawley 2005: 350). Such practices may have the effect that older adults in prison simply avoid activities due to such practical difficulties, for example, as noted above, they may not attend for their medication due to inability to queue for prolonged periods (Crawley 2007). Current Department of Health (2007) guidelines recommend that functional skills be considered

as part of a specialised assessment of need that each older prisoner should receive on entry into prison, repeated at least every six months.

One way of reducing the complexities and difficulties encountered by older prisoners with regard to access to medication may be to increase use of in-possession medication, where prisoners store and manage their own medication, rather than requiring prisoners to present themselves at fixed times to receive single doses of medication, supervised by staff. It was difficult to determine from interviews whether individual risk assessments were being carried out, in line with current policy, or whether blanket policies were being applied. Use of in-possession medication, where appropriate, may promote increased autonomy in medication management, allowing older prisoners to take prescribed medication at more suitable times, without being restricted to dispensing times dictated by the needs of the prison timetable, rather than clinical efficiency. The Department of Health and Her Majesty's Prison Service (2003) recommends that prisoners should have medicines and devices in their possession as a matter of principle. Whilst it is important to consider the impact that age-related problems may have upon the ability to self-manage medicines, older prisoners should at least have the opportunity to be risk assessed for this purpose.

Limitations of the research

It is worth noting that older prisoners may adopt a stoical approach and may be reluctant to seek out health-care staff to voice concerns about their health. Community-dwelling older people have been shown to avoid seeking help for fear of negative interactions with health-care staff and not wanting to be viewed as a 'burden' or 'cause a fuss' (Kumar and Allcock 2008). This is also the case in older prisoners; some have reported that older inmates may also under-report illness or be reluctant to seek medical help (Crawley 2007; Senior *et al.* 2013). This may be due to insufficient knowledge of their symptoms or due to fear of the outcomes (Aday 2003). Consequently, the older participants in this study may have also been reluctant to raise their health concerns with the researchers.

The findings of this research form part of a wider study on the health and social care needs of older prisoners; consequently, the topic of medication was not explored in as much detail within interviews as it would have been if it was the main topic of interest. For this reason, nor did we collect wider information on medication policies or related service developments that may have provided useful contextual information on access to medication within particular establishments. Further research would be required to explore initiatives that may improve medication-related support and ameliorate concerns among older prisoners, such as the introduction of

medication lockers and peer carers. In addition, this study did not include the perspectives of prison or health-care staff. Future research should explore staff members' perspectives to gain a greater understanding of the challenges faced within the current medication processes and how they can be overcome.

Conclusion

The number of older prisoners in the United Kingdom is rising, importing into prisons a range of complex mental and physical health conditions. This prisoner group is more likely to be prescribed medication and more likely to encounter difficulties in accessing them than their younger peers. Older prisoners' experiences of receiving medication described in this study have highlighted a high degree of anxiety caused by delays in confirming medication, changes to prescriptions and poor communication. This corresponds with data from existing studies of difficulties faced by prisoners across all ages. What this study has added to the pre-existing literature is that older prisoners may have restricted mobility and functional skills that may further impair their ability to use new devices, apply creams and fully participate in the systems around access to medication. Additionally, older prisoners may take a stoical approach and unnecessarily accept negative outcomes for fear of raising their concerns or difficulties. Increased awareness of prescribing issues specific to this group and changes to clinical practice are needed to allay anxiety and distress and align practices for prescribing medication in prison with processes in the community.

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