

The Griffins Society Visiting Research Fellowship Programme



The Griffins Society

Working for female offenders

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An Exploration Of The Health And Health Care Needs Of Female Offenders

Jane Sheen

1. Introduction

The idea for this study arose from the various professional roles in my life – those of being a Magistrate, Senior Lecturer of Nursing with a background in Health Visiting and as a Link Lecturer for the North Wing (Female Wing) of our local prison. The idea for this study evolved as I observed the NHS restructuring itself once again in line with the Government's plan for *A New NHS. Modern. Dependable* (DoH, 1997).

The creation of this 'new' NHS centres around the creation of Primary Care Trusts (PCT's) i.e. defined geographical health areas – where the co-ordinating and commissioning of health care is designed for the specific needs of that geographical population. Each PCT Executive and Board are required to adopt a population, needs based approach to health care and to commission health services for that population. The result of this has been the requirement to recognise and identify certain parts of the population (and their health needs) that had been historically, traditionally and conveniently considered separate and remote from the main stream activities and thinking of the NHS. One such sub group is the prison population. As the identification of prisoner health needs and health care requirements moves into mainstream NHS thinking and decision making, prisoners are viewed increasingly as part of a PCT's 'normal' community and an integral part of a population that it is required and designed to serve

Rationale And Aims Of Study

My contact as Link Lecturer provided me with insight into the recent health needs assessment exercise that had been recently conducted amongst the female inmates, and its outcomes. My initial rationale for suggesting the study was prompted by a desire to explore in more depth the health and health care needs of current female offenders and the health care needs of resettling female offenders.

The aims of my study were consequently developed and are summarised below: I intended to explore these aims from a range of perspectives – local (Suffolk West and Suffolk), national and international:

1. To investigate and consider the health circumstances and health needs of women offenders generally and around the time of resettlement;
2. To examine data related to the prevalence and incidence of mental ill health in this group, and in relation to their psychological health - the effectiveness of the community health care provided in the West Suffolk area;
3. To investigate the nature and effectiveness of community/primary health care to the needs of female offenders, and to identify examples of 'good practice';
4. To explore the nature and extent of cross agency communication in respect of this population sub group.

Methods

The methods used for undertaking this study included an in-depth literature search and review of national and international literature in relation to the aims of the study. Consideration was be given to:

1. the results of health needs assessment exercises currently ongoing in prisons;
2. the 'new' *National Service Framework for Mental Health* (Department of Health, 2000);
3. the actions and attitude of the local PCT towards the population under study.

I made contact with a range of practitioners connected with the Probation, Prison and health services. These included:

- probation officers based at the local prison and officers in Suffolk with an interest in female offenders;
- members of the prison health care team;
- members of the local Primary Care Trust, including the Director of Public Health;
- members of the NHS mental health services, including the Prison Mental Health Liaison development worker.

Reality Begins

Almost at once I recognised that my aims and objectives for this study were overly ambitious in the time available to me. A year seemed initially a long time, yet I now realise how extensive were the expectations for my original proposal. My study was rendered even more challenging as the time my fellowship covered represented a period of considerable change for many of the agencies that I wished to visit, e.g.:

- The nationalisation of the Probation service;
- The normalisation, integration and development of the prison health care service;

- Government initiatives around female offenders – *The Government’s Strategy for Women Offenders* (Home Office, September 2001);
- The structural and cultural changes in the NHS in respect of Primary Care Trusts (PCT’s) and population, needs based health care;
- The emergence of ‘joined up’ working with commissioning between PCT’s and prison health care services;
- The development and consequent impact of the first National Service Framework for mental health services (DoH, 1999).

Adaptation of Study Aims

It soon became evident to me that there was little contact between the primary health care services and the inmates of HMP Highpoint (North) either during or after discharge. As the Suffolk Annual Public Health Report for 2001 stated “Whilst in a Suffolk Prison inmates are considered ‘Suffolk residents’ however relatively few are originally from Suffolk” (p.23). This rendered my third aim almost null and void.

2. A Synopsis Of My Own Thoughts And Findings From My Fellowship Activities

Now as I reflect on my fellowship year I realise what a valuable opportunity I have had to gain such an insight into my chosen topic. My fellowship year has passed very quickly. From this time I have garnered many thoughts and observations, some I would have liked to pursue further but time was limited. So from the relatively short time that I have had for interviews, reading and observations the following are my thoughts, perceptions, personal findings and personal suggestions that I have to offer in respect of enhancing prison health care for female offenders:

Recommendations

The Further Encouragement And Promotion Of More Self Care For Inmates

It is now accepted that “in prison, women cannot make decisions for themselves or take responsibility for what is happening outside. Existing problems are made worse by the effects of imprisonment, self-esteem and self-confidence can be badly damaged or lost altogether. On release, women are even less well equipped to deal with the complex problems they face than they were before, and the problems are likely to have become worse” (*Women Leaving Prison*, NACRO, 1993, p.6). As discovered in the two health need assessment exercises at Highpoint North “Prisoners are not able to access simple, over the counter, treatments without the involvement of health care staff (*HMP Highpoint North Health Improvement Plan 2002-2003*, Appendix 1, Suffolk West PCT & HM Prison Service). Not only is this a use of unnecessary resources but does little to encourage and promote greater self care for women inmates which is vital for the success of their resettlement.

Such self care could be facilitated by a variety of methods e.g. access to NHS Direct booklets and telephone service; general health promotion programmes on managing anxiety, sleeplessness, smoking or on raising self esteem, reducing self harm, ways of thinking healthily etc. so prison environments are not only secure and reformative but also informative and educative as well as supportive to health and well being. During the literature review several authors mentioned the value and effectiveness of the change model suggested by Prochaska and DiClemente (1986 see references) particularly in respect of changing health related behaviour to being more self managing and caring;

Access

Opening and improving access of inmates (comparable to other members of the community) to other health related practitioners available in the wider NHS e.g. speech and language therapists, occupational therapists, physiotherapists, chiropodists etc.;

Pathfinder Project

Exploring the outcomes of the one resettlement pathfinder project that considered the resettlement factors of female offenders (undertaken in County Durham) for illumination and some direction in respect of developing an integrated model of resettlement practice that could be shared with and responded to by the local PCT and other health practitioners;

Developing The Involvement Of Local Child Health Related Practitioners

Health Visitors, Community Children Nurses, play therapists etc appear currently little involved in the interaction of inmates (who are mothers) and their visiting children. Benefits may be achieved in relation to improved parenting skills, child protection issues, child development concerns etc.;

Prison Nurse Involvement With Prisoner's Friends And Family

At present there appears little contact between the nurses and the significant others of the inmates. This is an unusual circumstance for nursing in the wider NHS where such contact is viewed as important, informative and part of the holistic package of nursing care. It is recognised as a common theme in the literature, that a disrupted family background is a risk factor for re-offending in women, and as research conducted in 1998 of 567 sentenced women aged 18-40 shows many inmates (66% of the sample) have dependent children (BMRB Social Research Report 1999);

Identifying And Responding To Factors Associated With Inmates' Past And Potential Social Exclusion

As stated in *The Government's Strategy for Women Offenders* (Home Office, 2001) "The causes of crime are closely linked to experience of disadvantage" (p.21). The practice of nursing should include an appreciation of the social context of individual behaviour and be imaginative and pro-active in relation to possible previous abuse, violence, risk taking or self destructive behaviours. Health care should not be compartmentalised and separated from the experiences of the women (whether before or during imprisonment) particularly around the experiences of disempowerment and/or abuse;

Discharge Planning And Packages

Discharge planning and the arrangement of discharge packages of health care are an expected part of the provision of nursing care. At present this area of nursing appears an important area for development at Highpoint North. The benefits of improvement to health care services in custody may only be short lived and temporary if not matched by improving the range, quality and access of services on discharge;

Developing A System Of Patient Held Passports/ Records

There would appear to be considerable value in developing a health record in prisons that could be used by all the agencies, departments, therapists etc. that an individual inmate may have meaningful contact with during their period of imprisonment. This could provide a contemporary, comprehensive record of their health needs and care during their period of imprisonment. This individual 'passport' should be commenced at the initial prison assessment and travel with the inmate, being added to as necessary. A patient held copy of the record may well encourage more self awareness and self-care by the inmate and better inter agency communication. As with some child protection records used in the wider NHS, a duplicate a copy of the document could be kept by the prison health care team. This individual 'passport' would be a very useful document for the resettling offender during their resettlement period should they require further healthcare. It would of course be at the discretion of the individual offender who they showed the document to but it could be a key component in trying to generate better continuity of care, and reducing inappropriate care during resettlement, as well as improving discharge planning both within and outside the prison thus 'improving post release continuity in health' (a key message from *The Government's Strategy for Women Offenders*, Home Office, 2001, p.11);

Accessing Medical Notes

There is a need to review the current, unsatisfactory system for requesting and accessing prisoners' previous health care record via GP and Hospital medical and other records;

The Use Of Prison Based Psychology Services

The narrow focus and use of this service appears an under utilisation of a valuable health care resource, a resource that could be well used for the general psychological health needs of the general inmate population;

The Health Co-Ordinator Role

Although a recommended role in *The Government's Strategy for Women Offenders* (Home Office, 2001) the Prison Service funding for this post at Highpoint North was discontinued as of April 2002. Yet this position was valued and considered " a good role that worked well" by probation and prison nursing staff, particularly around behaviour related to the management and prevention of blood born viruses, substance misuse, information giving and counselling for individuals and groups. This role that was held by a probation officer seemed to encourage more dialogue and interaction between the prison, probation and health care service;

Co-Ordination Of Practitioner Roles

Co-ordination of the different roles and boundaries of those practitioners involved in either caring, or monitoring, an inmates health e.g. prison nurses, specialist practitioners, health care officers, Probation service, psychology departments. Where do the boundaries of individual practice lie? Research is available (Dale & Woods, 2001)

to support better understanding of boundaries and roles: what is happening in reality;

Delivery Of More Prison-Based Community/Primary Care/Hospital Day Care Facilities

(as recommended by Dale and Woods, 2001). The present model of health care at Highpoint North reflects still mainly the traditional medical, acute model of care provision and structure – with a ‘bedded’ unit and a number of clinics with prescribed access. If more contact could be achieved with practitioners from the ‘community’ e.g. occupational therapist, chiropodists, physiotherapists, complementary therapists, general practitioners etc. it may be possible to move towards a more holistic, general practice model of health care. With this model the variety of health care provided within the prison would be more flexible, varied, accessible, self selected and appropriate for the breadth and variety of this populations’ health concerns and needs;

Integration Of Professional Development Into Prison Health Care Nursing

For prison nursing practice to improve there is a need to strengthen the professional links and profile of such nursing so that the role and function of nurses in a secure environment is clearer, more understood and better supported by the wider nursing community. A start could be made by considering the issues of professional accountability and record keeping as well as the mechanisms to initiate clinical supervision and clinical governance in the prison health care setting;

Increasing Interaction And Interdisciplinary Networking And Activities With Nurses Working In The Wider Primary And Acute Nhs Care Areas

Increasing such interaction could have many benefits for prison nursing, including a reduction in professional isolation, an improvement in professional knowledge and development, and an increase in the sharing of good practice (as suggested in *Nursing in Prisons*, 2000). This could be facilitated by e.g. shared study days; occasional shared professional meetings; comparative benchmarking exercises; arranging alternative short clinical placements in the wider NHS; attending and sharing student nurse mentorship support activities;

Enhanced Recognition And Use Of National Service Frameworks

(particularly those concerned with Coronary Heart Disease, Diabetes, the Elderly). The use of such national frameworks are common place in the general NHS yet my perception is that these appear to have made little impact on the practice and delivery of prison health care. The exception, of course, being the NSF for mental health;

Identification And Possible Integration Of Risk Assessment Tools And/Or Information Gained

My visits to various agencies exposed me to a range of differing risk assessment tools, some of which may at times have been applied to the same individual offender e.g. the Prison and Probation assessment system OASys (the Offender Assessment System), mental health risk assessment, prison risk assessment on admission, self harm risk assessment. Information gathered by these did not seem to be formally or routinely shared with other agencies. Although the issue of confidentiality is an important and prevailing principle I wonder if the benefits of sharing the nature and outcome of the different risk assessment tools, being used by different agencies, would reduce duplication and improve communication that could ultimately be of benefit to the individual offender. Would a generic risk assessment tool, with different segments for different agencies, that rotated around the agencies and followed or preceded the inmate be too revolutionary?

Conclusion

In conclusion I feel that I generally achieved my adapted aims but the time passed very quickly and some of my perceptions were formed from quite minimal interaction(s) and information. There were many areas of my study that I would have wished to revisit and/or explore deeper but time was not available.

Glossary

Clinical Governance

A framework through which NHS organisations are accountable for continuously improving the quality of their services (A First Class Service: Quality in the new NHS, Department of Health, July 1998, Chapter 3).

Commissioning

The research, planning and development of services or service elements to meet need and the identification of people or organisations with the potential to deliver it (How to Influence Commissioning, Royal College of Nursing Guide, April 1997).

Health Needs Assessment (HNA)

The process of exploring the relationship between health problems in a community and the resources available to address those problems in order to achieve a desired outcome (Pickin and Leger, 1993).

Health Improvement Programme (HIMP)

A local plan of action to improve health and modernise services for the community developed in partnership with other agencies and organisations involved in health and social care (Consultation Document for the Establishment of Suffolk West Primary Care Trust, Suffolk Health Authority, 2001).

Multi-Agency Public Protection Panel (MAPPP)

National Service Frameworks (NSF'S)

Evidence-based National Service Frameworks setting out what patients can expect to receive from the NHS in major care areas or disease groups (A First Class Service: Quality in the new NHS, Department of Health, July 1998, Chapter 2).

NHS Direct

A telephone service staffed by nurses (launched Spring 1998), giving confidential healthcare advice and information 24 hours a day (Help is at hand, Department of Health January 2001).

Primary Care Trusts (PCTS)

The lead NHS organisation in assessing need, planning and securing all health services and improving health. They will forge new partnerships with local communities and lead the NHS contribution to joint work with local government and other partners (Shifting the Balance of Power, Department of Health, July 2001).

Prison Mental Health Liaison/Development Worker (PMHLW)

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The Griffins Society

The Griffins Society is a voluntary organisation working for the care and resettlement of female offenders, including those with a history of mental illness and violent behaviour. The Society was set up in 1966. At that time there was little residential provision for women offenders and the Society concentrated its efforts on filling that gap by providing specialist hostel and move-on accommodation. Those residential projects were transferred to another voluntary organisation in 1997 and the Society decided to alter the focus of its activities. This change of emphasis included establishing the Griffins Society Visiting Research Fellowship Programme in the Social Policy Department at the London School of Economics and Political Science in 2001.

The Griffins Society Visiting Research Fellowship Programme

The aim of the Fellowship Programme is to provide ‘thinking space’ for those working in the criminal justice system or allied fields who wish to study a particular aspect of the circumstances or treatment of women offenders. Applications are welcomed from anyone with an interest in female offenders, such as magistrates, probation officers, staff of supported accommodation, drug/alcohol counsellors. In keeping with its origins, the Griffins Society welcomes applications from the voluntary sector, as well as statutory organisations. Fellowships are not awarded to people in academic employment, or studying for a degree. Each Fellowship runs for one year and Fellows are awarded a grant. Academic support and supervision is provided by Dr Judith Rungay, Director of the Griffins Society Visiting Research Fellowship Programme. Fellows have full access to all facilities at the London School of Economics.

The views expressed in this Research Briefing are the author’s own and do not necessarily reflect those of The Griffins Society or the London School of Economics and Political Science.

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The Griffins Society
PO BOX 22791
London
N22 8WH
email: admin@thegriffinssociety.org
www.thegriffinssociety.org

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