The Griffins Society Visiting Research Fellowship Programme

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

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The Griffins Society
Working for female offenders
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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 Rumgay, 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 Paper 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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Jane Sheen

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Glossary

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.

I observed this emerging 'new' integrated health thinking and service at first hand during my visits as link lecturer for a wing of the local prison housing approximately 300+ female inmates. My contact with the prison has been in relation to a) auditing the female prison health care facilities (in-patient and primary care) for the possible placement of student nurses and b) increasing the links between the prison health care staff and health care staff in the surrounding community.

Rationale for Study

My contact as Link Lecturer provided me with insight into the 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. In respect of community and primary health care, I particularly wondered about :

- the level of awareness and response of primary health care practitioners and PCT personnel to the 'special' ongoing health needs of female offenders;
- the future impact on commissioning of health care services for the PCT's in relation to 'special' populations;
- the nature and extent of cross agency communication and contact between health, prison, probation etc. services and personnel in respect of female offenders.

Aims of the Study

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:

- To investigate and consider the health circumstances and health needs of women offenders generally and around the time of resettlement;
- 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;
- To investigate the nature and effectiveness of community/primary health care to the needs of female offenders, and to identify examples of 'good practice';
- 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:

- the results of health needs assessment exercises currently ongoing in prisons;
- the 'new' *National Service Framework for Mental Health* (Department of Health, 2000);
- 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.

During the first three months of the Fellowship it was challenging and time consuming to be faced with the complexities of:

- trying to identify and access the relatively small and discreet amount of literature available concerning the health needs of female offenders';
- appreciating and identifying the myriad of organisations, departments, key personnel associated with such a population;
- identifying and accessing the volume and variety of policy initiatives, documents, organisational structures etc. related to the population under study.

My study was rendered even more challenging as the time for my Fellowship covered a period of considerable change to 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. Health Needs

Prison Health Care

It is generally acknowledged that prison health care developed and established its own separate model of health care from its inception in 1877 (Smith, 1999). This model remained relatively unaffected and unchallenged by the health reforms regularly occurring in mainstream health care – even that of the creation of a National Health service in 1949. It is clear from the literature that NHS reforms and developments have for almost 50 years bypassed one sector of the population i.e. the prison population. It is also clear from the literature that health care in prisons has long been a matter of concern (Reed & Lyne, 1997) with prison medicine following still the outdated 'medicalised' model of care focusing on illness, not health. It is also a model not normally planned on the basis of need, "and with little attention to prevention, guidelines, multidisciplinary work, audit, continuing professional development, or information" (Smith, 1999 ; cited in Marshall et al 2000, p. 5)

This scenario continued until March 2000 when the NHS and the Prison Department embarked on a major modernisation programme to tackle the two key objectives of reducing offending and promoting better health in the prison population. Developing prisoner health was seen as a vital element in prisoner rehabilitation and in redressing the inverse care law whereby those in greatest need in society are usually the least likely to access services (Blake, 2002). This 'modernisation' programme lead to significant developments:

- All prisons and local NHS partners conducted joint health needs assessments to set out their own plans for action;
- A Joint Prison Health Policy Unit and taskforce was set up to lead and oversee improvements;
- A £60 million investment package was unveiled - £35 million to refurbish or replace prison health care centres; £14 million to improve staff training and tackle infectious diseases (Hepatitis B. etc.) and severe recruitment problems; £10.5 million to provide an extra 4,000 drug detoxification programmes a year;
- Prison hospitals to be cleaned up or rebuilt with recruitment campaigns to attract nurses of a higher grade;
- Desegregation of skills of prison and health care staff;
- New drug detoxification regimes;
- More joined up working with agencies outside of the prison health care service;
- The development of more creative and effective services e.g. health promotion clinics within a prison's 'first night' centre; prison suites created for particularly vulnerable inmates ; volunteer inmates to act as Samaritans and stay with inmates on their first night;
- The encouragement of access by inmates to primary care facilities and visiting GP's with whom prisoners can keep in contact after release.

As I started my fellowship in October 2001 there was a strong sense of acceptance that change in prison health care was finally happening, long overdue, but now expected and accepted. As Davies (cited in Ramaiah, 2001) commented - the prison health care service relationship with the NHS "has developed to provide a different philosophy of health care". The progress to date is significant, as Martin Narey (Director General of Prison Service) has stated "It feels something like the cavalry coming over the hill" (cited in Spencer, 2001, p.19). But the journey still has a long way to go and has undoubtedly been occasionally rocky – "There has been some blood on the cobbles" (Gareth Davies, governor of Pentonville prison – cited by Spencer 2001, p.20).

Health Needs Of Prisoners

To gain a greater understanding of the health needs of female offenders, literature was gathered and reviewed nationally and internationally in relation to the health needs of female offenders. This subject appears to have received considerably more attention in other countries, notably U.S.A., than in Britain. This discussion will focus on the literature related to female inmates of British prisons.

Throughout the literature, until recent times, the specific needs of female offenders have been largely invisible due to the dominance of interest and concern related to the general prison population which is predominantly male. Reports have identified the most common health problems in the general prison population as – self harm; diabetes; asthma; communicable diseases and drug addiction (UKCC and University of Central Lancashire, 1999). Prisoners have been shown to have higher than average rates of mental illness (Gunn et al, 1991) and as in common with other groups that could be considered marginalised, higher rates of infectious and sexually transmitted diseases, HIV infection and AIDS (Gunn et al. 1991).

Profiles specifically of women in prison have revealed high levels of social and economic deprivation, poor schooling and chronic ill health. Around 20% of women offenders will have spent time in local authority care compared with 2% of the general female population and high numbers of female inmates have reported being the victims of sexual abuse and domestic violence (Lyon, 2002).

A closer look at reasons for female offending, female offending and sentencing patterns, and the response of females to sentencing see a distinct difference in the genders. The female offending pattern is quite different to that of men and their criminal careers are shorter and less persistent (NACRO, 2002). All these factors require careful consideration when trying to assess the health needs and health care services for such a group. For as Spencer reminds us "being 'inside' offers an ideal opportunity to address these health needs and break the cycle of offending so often connected with mental illness and substance misuse" (2001, p. 18). Seeking contact with prison health care services may have little to do with sickness, as the RCN (1991) points out, but is more likely to be the result of more general problems, such as the inability of some vulnerable prisoners to cope with prison life (Acheson, 1993).

A synopsis by Spencer (2001) provides some disturbing statistics about the general prison population: one tenth of female prisoners have a history of self harm; around 90% of all prisoners have a diagnosable mental health problem; some 13% of prison population have diagnosed asthma – but 80% smoke; one fifth of the 16,000 prisoners who have injected drugs are infected with Hepatitis B and 30% with Hepatitis C. According to the Office for National Statistics (2000), the proportion of females who have received help or treatment for

a mental or emotional problem in the 12 months before entering prison was 40%, double the proportion of male prisoners. The latest worldwide systematic review of serious mental disorders (psychosis, major depression, and antisocial personality disorder) in prisoners suggested that about 1 in 7 prisoners in western countries have psychotic illnesses or major depression (Fazel & Danesh, 2002). Whether these are as a result or cause (or both) of imprisonment has yet to be discovered but represent a real challenge for health care.

In 1999 the main recommendation of the publication *The Future Organisation of Prison Health Care* (HM Prison Service & NHSE) was for the responsibility for health care to be shared between the Prison Service and the National Health Service. In addition the undertaking of health needs assessments (HNAs) in all prison institutions was to be undertaken to be used by those involved in the planning and commissioning of health care services. The standardised resource for undertaking this was developed by Dr's Marshall, Simpson and Professor Stevens of the Department of Public Health and Epidemiology at the University of Birmingham – i.e *A Toolkit for health care needs assessment in prisons* (Feb. 2000). The toolkit provides a valuable and extensive synopsis of the available data in relation to the prevalence and incidence of health problems and health care needs of prison populations and the health care available in the prison estate. It also provides the national framework and guidance for conducting health need assessment exercises in prisons.

This document highlights the three key features of the prison population, namely that it is largely young (60% of inmates under 30 years of age), overwhelmingly male and has a very high turnover. Fewer than one in twenty prisoners are female. Marshall et al (2000) state that prisoners have general health needs similar to those found in the general population but that these are often overshadowed by health care needs related to offending behaviour e.g. substance misuse and mental health problems. Prisoners also have health care needs which are a consequence of imprisonment (restricted access to family networks, over the counter medication, emotional deprivation, possible violence and isolation) or made more complicated by imprisonment. In respect of general health needs it is important to note that ethnic minority groups accounted for 24% of the female prison population at the end of March 1999 compared with about 6% of the female general population of England (White et al, 1999).

Despite an increase of more than 50% since the early 1990's, females comprise only 5% of the prison population (White, Park and Butler, 1999; cited in Marshall et al 2000). Yet with fewer women's prisons many women may be imprisoned far away from their local areas and families. Prison Service statistics indicate that between 1987 and 1997 there was an 85% increase in the female life sentence population (*Lifers: A joint thematic review by Her majesty's inspectorates of prisons and probation,* HM Inspectorates of Prisons and Probation, Home Office, 1999) and the commonest reason for imprisonment among sentenced females is drug offences (Marshall et al 2000).

Socio-economically the general prison population are over represented by the unemployed and undereducated, compared to the wider community (Marshall et al 2000). Marshall et al also report that the majority of prisoners have experienced three or more stressful life events at some time in their life i.e. bereavement, relationship breakdown, running away from home, money problems, domestic violence.

Women prisoners have been found to report higher rates of various physical and psychological problems than women in the general population. These include asthma, epilepsy, high blood pressure, anxiety and depression, stomach complaints, period and menopausal problems, sight and hearing difficulties and kidney and bladder problems (*Women in Prison: a thematic review by HM Chief Inspector of Prisons*, Chief Inspector of Prisons,

Home Office, 1997). Smoking is highly prevalent among the female prison population.

In 1997 a survey of eight prisons (sample size 3,942) was carried out by the Public Health Laboratory Service and the Prison Service Directorate of Health Care to find out about the prevalence of bloodborne virus infections and associated risk factors (Public Health Laboratory Service, 1998). The survey found that about one in four adult prisoners have engaged in activities likely to put them at risk of infection with HIV, Hepatitis B or Hepatitis C, and 17% of females had a sexually transmitted disease. Around 1% of female prisoners have a baby during their time in prison, whilst approximately 6% of females coming into prison in a year are pregnant (Marshall et al 2000).

The incidence of suicide and self-harm in prison populations are also shown to be higher than in the general community. The Office of National Statistics survey (1998) found suicidal thoughts and reported suicide attempts were more common in female than male prisoners. In an interview of a random sample of women prisoners (HM Chief Inspector of Prisons, 1997) two thirds of the women reported having used illegal drugs at some point in their lives, of these 40% reported heavy use or addiction with over half using heroin and one fifth intravenous drugs.

Health Needs Assessments 2000 And 2002 - HMP Highpoint North

An initial full health needs assessment (HNA), using the *Toolkit for Health Care Needs Assessment in Prison* (Marshall, Simpson and Stevens, 2000), was carried out at Highpoint North in November 2000. With the creation of the local PCT in April 2002 it was decided to review the findings and issues contained in the original report and to update the needs assessment (August 2002) to reflect changes that may have occurred in the prison's population. Health needs assessment has been defined as '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), a definition well suited to this project.

Health Needs Assessment HMP Highpoint - 2000

At the time of the assessment the number of female receptions (1262) was approximately six times the Average Daily Population (199). Women inmates who are pregnant are transferred to a prison with a mother and baby unit at 32 weeks. The key features of the HNA can be summarised as below:

- 81% of female respondents of the main questionnaire stated that they currently smoked – 31% would like help giving up;
- the health topics of most importance to female inmates were depression (37%), sleep problems (35%), stress (32%), healthy eating (23%), Hepatitis B or C (23%), relationships (23%);
- at the time of the survey there were 52 female prisoners with asthma (national expected prevalence 28);
- at the time of the survey there were 12 female epileptics (national expected prevalence, 2);
- at the time of the survey there were 3 female diabetics – a number similar to the expected number calculated

from general practice surveys;

• 67% of female respondents admitted to ever having used illicit drugs - 47% admitted to injecting drugs at any time and 58% of which had shared equipment at some time;

• 37% of the respondents had attempted suicide, and 15% admitted to self-harm;

• There was a significantly higher rate of mental disorder for women prisoners compared with their male counterparts.

The thoughts of the inmates in the survey about the current prison health service concerned mainly the long waiting times to see the doctor (average wait 3.7 days), dentist (average wait 31.7 days) and visiting specialists; the lack of access to medications for minor ailments and recurrent medical conditions. They felt that they were primarily treated as prisoners rather than patients and that health care was under resourced and rushed.

Health Needs Assessment HMP Highpoint North - 2002

Between the two assessments Highpoint North saw an increase in prisoners (+80), with a disproportionate increase in the number of remand prisoners. As with the previous HNA in 2000 only 6% of the female prisoners were normally resident in Suffolk. The population of Highpoint North was shown to be slightly older than the national average with only 47% being under the age of 30. There has been a marked increase in the number of inmates seen by a psychiatrist since the HNA in 2000.

Both the 2000 and 2002 HNA's show that there are significant problems with regards to recruitment and retention of medical officers and nursing staff. The reasons cited for difficulty in attracting permanent staff are: low pay, an unacceptable on-call rota, stress and professional isolation. There was concern amongst staff and prisoners about the large number of cancellations to NHS outpatient appointments due to the prison establishment – an estimated 21% of appointments being missed or cancelled.

Two years on the average waiting time to see the doctor was still 3.7 days – 18% saw the doctor on the same day, and the average wait to see the dentist was still 31.7 days. The main issues of dissatisfaction with health care were also depressingly similar: unnecessary waits, lack of 'normal' medication, detoxification regime being inadequate. However in almost 100% of cases female inmates felt that the counselling they had received had been a valuable use of their time - "a time, often the first, when they were able to talk about their past without recrimination", and gain help with dealing with difficult situations in the future and gain self-esteem (Health Needs Assessment HMP Highpoint North, August 2002, p. 35).

The picture in the report of the health needs and health care services of Highpoint North in August 2002 can be summarised as follows:

• A high proportion of prisoners smoke and many would like help to give up;

• More information about healthy eating, sleep problems, depression and coping with stress requested by over one third of patients;

• Consultations with the genito-urinary medicine consultant are considerably above national averages;

- Only one third of female respondents thought they had been vaccinated against Hepatitis B;
- Prisoners identified long waiting times to see the dentist;
- There are no guidelines in place for the detection and treatment of hypertension and coronary heart disease;
- Prisoners are not able to access simple, over the counter, treatments without the involvement of health care staff;
- The training needs of healthcare staff are not being met.

Responding To Health Needs At Highpoint North – Health Improvement Action Plan For 2002-03

The action plan to respond to the health needs of the inmates is contained within the Health Improvement Plan for 2002-2003 (Suffolk West PCT & HM Prison Service, 2002). It describes how health care services and staff are to be developed to better meet the needs of the population. The general areas to be addressed and actioned are summarised below:

Needs Assessment (NA)

quarterly health checks and a full needs assessment to be undertaken in 1yr-18 months;

Primary Care

a primary care team approach is to be developed with access to clinical governance and continuing professional development activities. The PCT has undertaken to develop two or more GP specialist posts in collaboration with HMP Highpoint and local general practices;

Substance Misuse

the vision for this service is to develop a 'community-based' detoxification model of service utilising 20 beds in new accommodation. Partnerships, which do not currently exist, need to be developed with the CARAT (Counselling, Assessment, Referral Advice and Throughcare) team;

Health Promotion

Healthy Highpoint Plan – a project is to be initiated to promote health in Highpoint North in order 'to make HMP Highpoint North a healthier place to live and work in through a collaboration of the multi-disciplinary team and prisoners'. Drawing on the needs assessments, policies which affect health will be mapped and activities which affect health will be carried out e.g. smoking cessation, healthy eating, sexual and mental health and wider issues of family, work and housing. It is proposed to establish a prisoner-led group to develop and implement an evidence-based action plan;

Chronic Disease Management

issues of access to protocols and National Service Frameworks will be explored e.g. development of smoking, lifestyle and triage clinics;

Staff Development

in order to respond to the health needs of the inmates in the most effective manner addressing staff issues and concerns are vital: Workforce Development/skill mix reviews will be undertaken and responded to; Occupational health services for staff are to be more comprehensive and undertake a needs analysis for staff. Clinical Information Systems will be piloted; Clinical Governance programme in prison to be included in the wider PCT clinical governance agenda; and an annual self-audit of healthcare standards to be carried out;

Sexual Health

a New Service Led Agreement (purchasing agreement) required for medical input in Genito-urinary care (possibly from local hospital); the nurse led blood borne virus clinic will be expanded;

Infection Control

infection control policy from Suffolk Prisons Communicable Disease Control Steering Group completed and subject to ongoing review and implementation;

Dental And Pharmacy Services

negotiations underway to develop dental services, guidance awaited from Promoting Dental Health in Prisons; current pharmacy service identified as inadequate, alternative provider being sought;

User Involvement In Health Care

in order to encourage this the PCT will initially provide good evidence-based leaflets and health information posters on each unit information board, prisoner involvement in an in-house PALS (Patient Advice and Liaison Service) service on the special unit will be developed to provide confidential help, advice and information on NHS services – the Head of Healthcare will liaise with PALS in the wider NHS to develop these ideas.

All of these declared intentions by the PCT and Prison Service constitute a real attempt to change for the better the nature and quality of prison health care at Highpoint North, particularly in providing care that suits and respond to the needs of the inmates. This is important not only for the health of individual inmates but the effect on society generally for as the newsletter from the Criminal Justice Consultative Council reminds us " ...women's offending carries a higher individual and social cost that men's offending" (2002, p. 1). With women being the usual primary carers of children, any resulting social exclusion and disadvantage experienced by the women may effect and be transmitted inter-generationally to their children and our future generation.

Mental Health Services And Prison Health Care

National Context

As highlighted in *The Government's Strategy for Women Offenders* (Home Office, 2001) "....the best way to reduce women's offending is to improve women's access to work; to improve women's mental health services; to tackle drug abuse by women ....." (p.8). One distinct area of concern in the document was the "limited provision of appropriate and accessible mental health treatment services to women in prison" (p. 21). The launch, therefore of a national framework and a set of standards for mental health services in England and Wales was an area of necessary interest for me. *The National Service Framework for Mental Health, Modern Standards & Service Models* (Executive Summary, DH, 1999) addressed the mental health needs of adults up to 65 and set out seven national standards for mental health care in England in Wales. A sum of £700 million was earmarked to deliver the strategy over 3 years. Investigating the framework it appears that Standards one, two and three are particularly relevant to prison populations and the improvement of their mental ill health:

Standard 1 – Health and social services should :

- Promote mental health for all, working with individuals and communities;
- Combat discrimination against individuals and groups with mental health problems, and promote their social inclusion (p. 7).
- This standard requires the provision of effective health promotion for 'individuals at risk' and 'vulnerable groups, 'those in prison' receive a special mention: "there is a high rate of mental health problems in the prison population" (*Modern Standards and Service Models – Mental Health, Executive Summary* Department of Health 1999, p.7).

Standard 2 – Any service user who contacts their primary health care team with a common mental health problem should:

- Have their mental health needs identified and assessed;
- Be offered effective treatments, including referral to specialist services for further assessment, treatment and care if they require it (p. 9).

Standard 3 – Any individual with a common mental health problem should:

- Be able to make contact round the clock with local services necessary to meet their needs and receive adequate care;
- Be able to use NHS Direct, as it develops, for first-level advice and referral on to specialist helplines or local services (p. 9).

My meetings with key mental health workers inside and outside the prison, illustrated clearly the slow response to this key document and achieving the standards set. The first Health Needs Assessment (HNA) undertaken in Highpoint (North) in 2000 describes "limited psychiatric input to the prison" from Community Psychiatric Nurses (CPNs) and forensic psychiatrists etc., with minimal services 'based on what can be acquired rather than on clinical need'. The second HNA undertaken in 2002 showed little change in mental health care or services over the two years yet it identified still a high level of mental health need and limited psychiatric input to the prison.

My observations and interviews within the prison found the majority of mental health care for the inmates was currently provided by a privately employed Counsellor. This male counsellor focused mainly on trauma related work, assisting the women to stabilise and work through traumatic issues (normally) from their pasts. It seemed surprising to me how little contact the majority of female inmates had with the prison psychology department which appeared to deal mainly with small, discreet, specific areas of psychological input e.g. with lifers. There appeared only a small window of opportunity for the use of such mental health services by the general inmates. The department also seemed to operate quite separately and remotely from the other prison, health care and Probation services.

Developing The Mental Health Services At Hmp Highpoint (North)

The secondment of a Prison Mental Health Liaison/development Worker (PMHLW), from the local community Trust for October 2001-2002 signalled a significant development for mental health services in Suffolk prisons. His role was to develop 'a way forward' for mental health services for prison inmates, for four Suffolk prisons (including Highpoint North). Following a mental health gap analysis in the prisons the PMHLW "started applying a sticking plaster in January 2002".

The mental health needs/service gap analysis undertaken by the PMHLW was in line with the strategy for developing and modernising mental health service provision within the prison setting detailed in *Changing the Outlook – A Strategy for Developing and Modernising Mental Health services in Prisons* (National Prison Health Policy Unit & Task Force, Home Office, December 2001). Within the health needs/gap analysis of the mental health strategy at HMP Highpoint North mental health needs of the inmates were assessed, existing services were considered and priorities for action were decided (completed 2002). The Prioritised Action Plan states the need for the mental health issues within prisons to be addressed in a consistent managed manner. It calls for the development of a Specialist Mental Health Practitioner to address many of the issues highlighted within the gap analysis and provide a resource to other Prisons, Suffolk West PCT and the Local Mental Health Trust. The key elements of the Plan focus on the promotion of mental health and primary care services; the improvement of referral, and transfer procedures for patients; improved suicide prevention; access of inmates to effective treatments and the collection of demographic and clinical data.

In response to the mental health gaps/needs analysis significant changes and developments are afoot:

- October 2002 – Mental Health Steering Group established to be responsible for actioning the methods to meet the gaps/needs identified;
- April 2003 – substantive post of Specialist Mental Health Practitioner to begin;

- Referral of patients to local General Psychiatry to occur within 2 years;
- Development of protocols for prison transfers for adult prisoners to NHS facilities: to provide a mechanism for speedy assessment, active engagement of professionals, and avoidance of delays.

For the PMHLW the mental health NSF represents an important document and strategic vehicle which has "generated vital discussion" for improving mental health services for prison populations. It has made making complex and hard decisions more necessary and acceptable.

My meeting with the Co-ordinator for Suffolk Mental Health High Risk Scheme (who is also the team leader for the forensic Community Psychiatric Nurses in Suffolk) stressed the need in Suffolk for more longer stay, low security beds (currently 10 beds). She expressed the pressing need in Suffolk for more primary and enhanced secondary services for women who self harm. This practitioner is currently the health representative on Suffolk MAPPP (Multi-agency Public Protection Panel).

3. Health Care Agencies

Female Offenders And Suffolk Probation Service

Meeting and speaking with certain probation officers in Suffolk with a particular interest or role with female offenders was both instructive and illuminating. Although the interest in female offenders (and offending) was evident and considered long overdue in Suffolk, there appears a long way to go before Jack Straw's vision of prison and probation services working effectively and together is achieved. The beginnings are evident but in their infancy. Considerable interagency working and provision of appropriate services is needed in order to provide an effective network of support for vulnerable women in the communities of Suffolk, both to prevent "...offending in the first place and to support the resettlement of offenders" (*The Government's Strategy for Women Offenders,* Home Office 2000).

The following is a synopsis of what I found during my contact with the Suffolk Probation Service:

- Suffolk Probation Service have a named officer leading and chairing a group Effective Practice with Women Offenders Group;
- A 'Women Offenders Policy' was approved in 2001. The policy considers all of the areas of work in which offenders come in contact with the Probation service and makes clear proposals for how this should be undertaken in order to meet their particular individual requirements;
- Health data gained by probation officers is generated in relation to individual clients not as a standard procedure and remains in the probation officer's file ;
- In line with the government strategy for women offenders (Home Office, 2001), an offender assessment system is being developed by the Probation and Prison services to assess factors linked to individual offending and overall patterns of need;
- Until recently the probation service had an officer as Health Co-ordinator at HMP Highpoint (North). Her post was financed by health and prison services. Many officers mentioned the value and importance of this role in relation to mediating with inmates around communicable diseases, substance misuse etc. This post was recently axed when the prison service declined to financially support it any more. This seems to be against what is recommended by the government i.e. the post of Health Co-ordinator in each female prison;
- In the opinion of most probation officers, short sentences of under one year seem to render no benefit and little access to supportive strategies and programmes provided by probation, not only during the length of the sentence but also on planning and preparing for resettlement and during resettlement itself;
- There seems to be a high turn around and movement of officers within the service and at HMP Highpoint prison.

HMP Highpoint North And Nursing Care

As Home Secretary David Blunkett highlighted "Disturbingly the number of female prisoners doubled between 1993 and 1998" (Forward to *The Government's Strategy for Women Offenders*, Home Office 2001). The Criminal Justice Consultative Council (CJCC) newsletter also illustrated that "The female prison population increased by 20 per cent in the last year, to over 4,000 at the beginning of 2002" (May 2002, p.1). Similar to the national picture, Highpoint North has experienced in the last two years a significant increase in prisoners. It is anticipated that prison numbers will increase by a further 80 prisoners by November 2002 to 298 (data from interview in July 2002 with Senior Nurse). The prison has an operating capacity for about 20 remand prisoners, however it currently houses about 40-60 remand prisoners and it is anticipated that this will increase to 60-80 remand prisoners within the next 18 months (HIMP October 2002). Such rising figures exerts particular strains on the health care resources, which are predominantly nurses.

As the literature reflects clearly prison nursing has long been beset with difficulties and problems: professional isolation, low morale, staff shortages, lack of role clarity, clashing prison and nursing cultures and philosophies. All of these I found during my visits to the health care centre. I also found a real determination to improve the quality of care provided and forge strong and meaningful links with the wider NHS. Considerable plans are in full swing to improve the detoxification services for the female inmates with the development of a new 20 bed, 24 hour detoxification unit. More nursing staff are also being recruited with plans for specific nurses to take on specific care areas to develop e.g. mental health and reception; primary care and chronic disease management; sexual and female health; detoxification services.

The Health Needs Assessment exercises have provided the PCT, Prison service and prison nurses with considerable data about the deficiencies of the service and the requirements of the women inmates. Where to start? An important starting point has been the production, by the PCT and Prison Service, of the first joint Health Improvement Plan for HMP Highpoint North Prison. This document, which has been previously discussed, represents the result of real and active 'joined up' working by the PCT and relevant groups e.g. Prison Service and Health Task Force, public health, Drug Advisory Service, the local hospital, Patient Advice and Liaison Service, pharmacy and health promotion.

Recent Influences On Nursing In Prison Health Care

Historically and traditionally prison nursing has always been regarded as the Cinderella of the nursing profession yet prison nursing is facing a radical transformation: it now looks as if the time and opportunity for prison nurses to 'go to the ball' is upon them. There are inherent and real difficulties in providing nursing in a prison setting where the culture of security can inhibit professional nursing aspirations and the primary purpose of that environment is not health (Pearce 2001, RCN 2001). Yet it has been estimated that ten per cent of the prison population report sick each day (Wool, 1993). This is nearly eight times higher than the proportion of people who visit their GP every day (RCN 2001) and about two-thirds of inmate consultations involve contact with a nurse or a health care officer (NHSE and HM Prison service 1999).

Reformation Of Prison Nursing Begins

In 1999 the first concrete movement in bringing nursing in prisons more in line and in tune with health care in the wider NHS world came with the publication of *The Future Organisation of Prison Health Care* (NHS Executive & HM Prison service, 1999). This document led to the establishment of a formal partnership between the NHS and the Prison service to improve the health care provision for prisoners in England and Wales. In December 1999 a working party was established to consider the future development of nursing in the Prison Service and the effective integration of prison health care as members of multi-disciplinary health care teams. The report of the working party, *Nursing in Prisons – Summary and Key Recommendations* (NHSE & HM Prison service, 2000), provided recommendations for the enabling of prison health care to be delivered by appropriately skilled health care teams with a range of qualifications and competencies linked to the health needs of prisoners. This would provide a model of health care considerably more in keeping with the culture of the NHS than that of previous prison health care.

During the time of my fellowship I have witnessed an almost unprecedented interest in prison health care from the nursing profession. Examples of this are the following:

- *Nursing Portfolio* (HM Prison Service & Department of Health): a portfolio provided for all staff in England and Wales engaged in the delivery of nursing care in HM prisons – to collect information and evidence in relation to individual professional and educational development - as a medium for integrating practice, supervision, mentorship, peer review, reflection and performance review;

- *Caring for Prisoners* (Royal College of Nursing, 2001): a summary of a report into the roles and practice boundaries of prison service nursing staff. The report aims to give such nurses increased authority and confidence to develop their practice and relationships, by working in partnership with colleagues outside the prison service (Pearce, 2001);

- *Workforce Development Officer*: for Eastern Region of England recently appointed to identify staff training needs and review training delivery for prison health care staff across all 8 prisons in the region;

- *Establishing Clinical Supervision in Prison Healthcare Settings* (Freshwater, Storey and Walsh, 2001): a project undertaken to establish a strategy for the effective implementation of Clinical Supervision within a group of prisons, and to identify barriers to the success of the same.

Prison Health Care And Primary Care Trusts

The local Primary Care Trust (Suffolk West PCT) is now expected to identify and commission health care services for prison inmates in their geographical area, namely those prisoners at HMP Highpoint. The aim of the PCT in this respect has been made clear by many policy documents i.e. " To ensure that prisoners have access to the same quality and range of health services as the general public receives from the NHS" (*The Future Organisation and Delivery of Prison Health Care,* Health Service Circular, 1999/077, p. 3).

This is a new challenge and evolutionary experience for many members of the Suffolk West PCT who are for the first time considering the particular health needs and health care requirements of prison inmates. The joint working between the PCT and many agencies (including the prison service) has resulted in the first joint

Health Improvement Plan (HImP) for HMP Highpoint North Prison. This document represents the "joint and concerted efforts of a number of local organisations with the collective aim of improving the health of prison inmates and supporting staff and the local community" (*HMP Highpoint North Health Improvement Plan 2002-2003*, Suffolk West PCT & HM Prison Service, 2002, Foreword). The vision of the HImP is 'to develop prison health services to ensure that the health services and support available to prison inmates and staff are similar as possible to those provided to the local community in west Suffolk, and to enhance, where necessary, the particular needs of the prison community'. Such health care rights are firmly established in the United Nation's declaration (1991) that prisoners have the right to health care equivalent to that available to those outside prison.

- **This first HImP represents a significant development in joining prison health care to the wider NHS service. Only time will show the success of the actual action plan contained in the HImP, but it is a recognition that The NHS can no longer avert its eyes and interest from what is happening in health care settings in prisons in their local community - this represents a form of success in itself.**

The Future Funding Of Prison Health Care

As I conclude this fellowship (Sept. 2002) the government has announced that it will "at last hand over" (Gould 2002, p.12) prison healthcare to the NHS. As Gould commented this highly significant decision has passed virtually unnoticed with no huge impact in the national press or even in the NHS. For him this represents a singular lack of interest in the health and well being of the UK's 70.000+ prison population.

Yet from April 2003 funding for prison health care will be transferred from the Home Office to the Department of Health as part of a five year programme. This programme will see PCT's take full responsibility for commissioning and providing for the healthcare of prisoners in their area. There is also a promise from the Home Office of further resources to improve these services, rising to an extra £46m a year by 2005-06. This is only six years after Sir David Ramsbotham, then Chief Inspector of Prisons, published his controversial discussion paper *Patient or Prisoner* (Home Office, 1996). This ambitious paper did much to generate discussion around the quality of (or lack of it) and way forward for health care provision in prisons. It is interesting to note that at the time of its publication the paper's suggestions appear to have been effectively undermined by lack of proper resources and real commitment at ministerial level (Gould 2002), yet now many of his suggestions are bearing fruit.

For PCT's already bending under the weight of reform, targets, relentless scrutiny and expectations (locally, clinically and governmentally), this may be viewed as yet another burden and health responsibility. Yet as Dr Keavney (chair of the BMA civil service committee) has been reported as saying, it is 'with the practicalities rather than the principles that the difficulties lie'. It is interesting to speculate how the prison service will decide/know how much money to hand over to the PCT's.

It can, however, be only just and equitable for prison populations to be part of a coherent, unified NHS rather than a parallel, isolated, often inferior and relatively hidden health care system with different standards, and approaches to care. Many of the current actions and moves in prison health care are broadly welcomed by the

Howard League for Penal Reform. Its assistant director, Anita Dockley, has commented that the hope is that forging stronger and more systematic links with the NHS will also mean that continuity, access or transfer of treatment in their own home resettlement areas will be strengthened - thus reducing the ability of individual offenders to slip through the net leaving, as so often happens, health needs untreated once they return to the community.

4. Conclusion

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. The formal support of The Griffin Society and members of LSE for this Fellowship has opened many doors that might have otherwise been closed. I am indeed a little wiser. 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:

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 more deeply but time was not available. As a magistrate and nurse I have valued greatly the brief window of opportunity that I have been given to acquire a deeper insight and understanding of this special and distinct population with special and distinct health needs. Such a ‘special’ population requires sensitive, appropriate, and effective health care responses if there is to be any chance of impacting positively on the complex offender symbiotics of life experience, health consequences of imprisonment and patterns of offending.

Routes For Disseminating Findings

Routes for disseminating the outcomes of this study will be by personal contact with fellow Magistrates; writing for professional/practitioner national journals; and via conferences. Opportunities will be sought particularly in the West Suffolk area to consider the study's outcome in a multi-agency, community orientated way, especially in respect of the local Primary Care Trust and its commissioning of community health care services for the inmates at HMP Highpoint North.

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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)