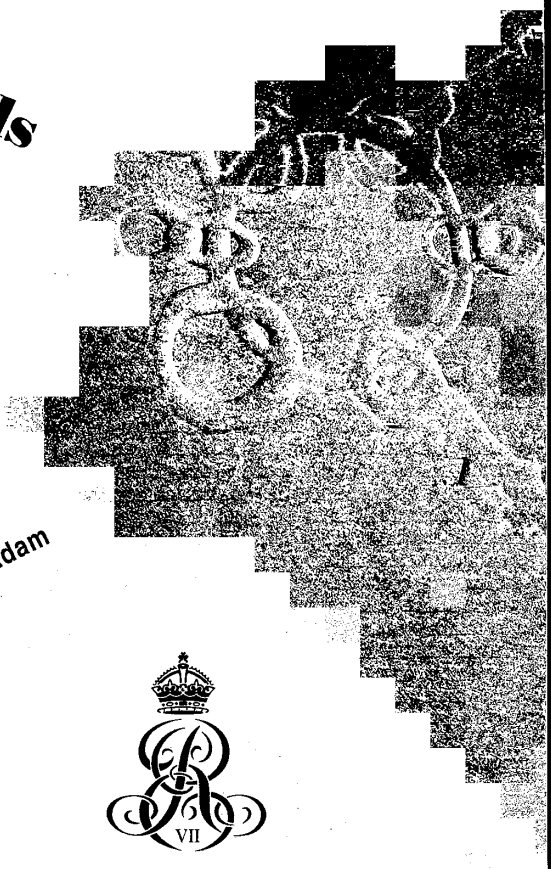
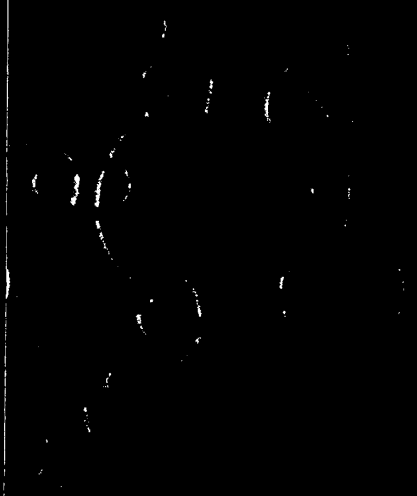
# learning across the walls

THE PRISON SERVICE AND THE NHS



Edited by Sheila Adam



# learning across the walls

## THE PRISON SERVICE AND THE NHS

EDITED BY SHEILA ADAM

Published by the King's Fund Centre
126 Albert Street
London
NW1 7NF

Tel: 071-267 6111



ISBN 1 873883 75 7

A CIP catalogue record for this book is available from the British Library

Distributed by
Bournemouth English Book Centre
(BEBC)
PO Box 1496
Poole
Dorset
BH12 3YD

# contents

# introduction

## Background

Like so many other things, this all began by a chance encounter – between Sarah Fielder, Deputy Governor of Pentonville Prison and John Mitchell, Fellow at the King's Fund College, who became the facilitator for the learning network.

A discussion about some of the difficulties in managing large institutions highlighted one specific issue, the relationship between prison managers and the doctors who provide health care within prisons. It became clear that, in order to understand and improve this interface, the relationship between prison health care staff and their colleagues within the NHS would need to be explored.

After a visit to Pentonville Prison, and discussions which included Bill Abbott, the Prison Governor, John Mitchell agreed to convene a preliminary meeting with prison staff and NHS staff across London. There was a wide range of stakeholders within both organisations, and a complex web of relationships, a significant proportion of which appeared to be to some extent.

The King's Fund and North West Thames Regional Health Authority (RHA) each agreed to fund £1,500 towards the costs of an initial series of five meetings which took place between July 1992 and February 1993.

The first meeting was well attended with representatives from Brixton, Holloway, Pentonville and Wandsworth Prisons and from the four Thames Regions (including providers, District Health Authority (DHA), Family Health Services Authority (FHSA) and RHA). The atmosphere felt tense, and it was difficult to establish either the key issues or a constructive approach to discussing them. There was understandable defensiveness among many of the participants, which was not surprising given the known difficulties and shortcomings in the provision of health care for prisoners, either within prison or within the NHS. For those in the NHS, which is not without its own reorganisations, the magnitude of impending change in the Prison Service felt daunting.

Despite all of this, or perhaps because of it, the group agreed to meet again, using the model of a learning network.

## What is a learning network?

The concept of a 'learning set' is now well established. Revans[1] has been responsible for popularising 'action learning' in the UK, and much of that thinking has led to the investment by senior NHS managers[2] and, more recently, senior professionals[3] in learning sets.

In essence, a learning set provides a secure setting within which the participants can engage in a process of peer review, support and criticism; and where feelings can be expressed openly about needs, failings, frustrations, anxieties and a sense of organisational loneliness and isolation. Within a learning set, both professional and personal issues can be addressed. The experience can be

fulfilling but it does require time, commitment and the development of trust.

In working with six health authorities involved in developing purchasing, the idea of the learning set evolved into a 'learning network'.[4] This involved up to three people from each authority. It was important to have a regular core of members, but the composition changed without harming the group's dynamics. The principles on which the group worked were similar to a learning set but instead of meeting in two- or three-day modules every couple of months, the learning network met for one day monthly, if possible. The agenda was determined by the participating authorities who took responsibility for introducing each issue and setting the scene. There was agreement on confidentiality ('Chatham House rules') and the facilitator's role was to draw out themes and make brief notes of any conclusions.

Participants' views were collected by a questionnaire. The learning network provided a number of clear benefits:

- 'a relatively safe, secure environment';
- 'an opportunity to network';
- 'an opportunity to keep up to date';
- 'creates much needed space for senior managers to talk among themselves';
- 'gives time for reflection and review, and thereby keeps morale high, as we can easily recognise that progress is being made'.

It was decided to develop a similar approach, with John Mitchell acting as facilitator.

## Our programme of work

We spent some time at the first and second meetings in mapping issues, and, taking these as our initial agenda, sought volunteers from within the group to kick-start a discussion at future meetings on a range of themes. Some of this work was done in pairs with one person working in the NHS and the other in a prison.

Our meetings lasted for four hours (preceded by lunch, and with drinks at the end) in order to leave plenty of time for discussion. The eating and drinking time allowed the opportunity for informal networking and provided a buffer from the demands of heavy jobs and over-committed diaries. John Mitchell took responsibility for circulating brief notes after each meeting, and for all the practical arrangements, as well as acting as facilitator.

This report illustrates some of the issues which we have covered and the conclusions which we reached.

# chapter 1
# the health of prisoners: a role for public health

*Sian Rees*

Prisoners are a disadvantaged population in terms of their social background, their health status and the health care that they receive.

The prison health service in this country has often been attacked for providing care that is considered substandard in comparison to the NHS. Its critics have been diverse; from government select committees, the Prison Reform Trust and the Government Inspector for Prisons, Judge Stephen Tummin.[5,6,7] There are a number of possible explanations for this apparent difficulty:

- prisons in Great Britain are overcrowded and their physical environment is often in a poor state of repair.
- the prison system directly employs a body of prison doctors. There is no formal training for this specialty, and it has low status within the medical profession.
- the social environment of prisons has been claimed to create conflict between the provision of health care and the maintenance of security.
- prisoners as a group have little voice or public/government priority.

The recent scrutiny report on prison medical services[8] recommended that the Health Care Service for Prisoners should replace the Prison Medical Service, and would act as a purchasing body for health care in prisons.

This paper reviews what is known about the health of prison populations and suggests ways in which public health departments may contribute to improving the health and the health care of prisoners. This would include new links with those providing and those purchasing health care.

## The health status of prisoners

The prison population in this country is predominantly male and young. The total population is in the region of 47,500 of whom about a quarter are unconvicted. Social classes IV and V and those without permanent accommodation or education past the age of 16 are all over-represented.[9] It is mandatory that all prisoners have a health assessment on entry to prison and are seen by a doctor within 24 hours. These assessments are not standardised and there is little central collection of information; even at a local level there are only sparse data. This, combined with the fact that there has been relatively little research on prisoners' health, means that there is a paucity of information on which to plan the provision of health care.

The majority of published research has been carried out in North America. There have been two broad approaches:

1. Direct assessment of health either through routine medical examination or through the use of specific research protocols;

2. Analysis of service utilisation data.

## Health assessments

*Physical health*

Many prisoners are admitted to prison with several active medical problems. A large study from New York Penitentiary[10] stated that 25 per cent of new prisoners report a health problem, while 60 per cent of them received at least one diagnosis from the prison doctor. The only comparable study published in this country (Bedford) reported that 46 per cent of new prisoners had a medical problem, again often not mentioned by the prisoner.[11]

A direct comparison of these studies is problematic, which may explain the differing proportions of prisoners receiving a diagnosis. The two populations are dissimilar, Bedford having a large number of remand prisoners. Diagnostic criteria may also differ. Despite this there was broad agreement on the health problems presenting. These varied from relatively minor ailments such as dental caries (9–18 per cent of the populations) and skin complaints (6–46 per cent), to more complex diagnoses, such as substance misuse and epilepsy.

A history of substance misuse was given by 41 per cent of the New York sample, with 36 per cent having an illicit drug found in urine samples. In Bedford, 16 per cent had a history of drug misuse. Alcohol problems were reported in 18 per cent of the New York prisoners and 24 per cent of the Bedford sample. In the general population, around 1.5 per cent of people might be expected to be defined as drinking to excess. Part of this higher rate can be explained by the fact that some sentences will be for alcohol-related offences.

Epilepsy was also reported more frequently in prisoners than would be expected, ranging from 1.2 to 4 per cent of admissions. This gives rates of between 12 and 40/1000 as compared to a rate in the community of 4.5/10000.

The relative prevalence of other medical problems such as hypertension is more difficult to assess from the literature, as age-related rates are not quoted.

However, prisoners' self-reported health status in Iowa[12] gave a 37 per cent prevalence of hypertension in 50–59-year-old men. This is higher than would be expected depending on the criteria used.

Abdominal disorders may also be more prevalent; a study from Tennessee[13] reported a three times higher rate of peptic ulceration and abdominal hernias, and a 14 times higher rate of chronic enteritis.

All these results suggest that prison populations have a significant excess of morbidity over the general population. What is not known, however, is how much of this excess can be explained by confounding and risk factors such as social class, smoking and substance misuse. The Bedford study reported that 86 per cent of new prisoners smoke as compared to 53 per cent of social classes IV and V in general. Excess hypertension and, if smoking was in combination with alcohol excess, peptic ulceration could be explained by this. Conditions deemed to

be related to self-neglect, such as skin infections and dental caries, may also be related to life-style factors such as deprivation and substance misuse. There need to be further epidemiological studies looking at how risk factors relate to disease prevalence.

The high prevalence of substance misuse has already been mentioned. Further in-depth studies give greater insight into the problem, which has implications for both prison health care and broader social policy. In Britain, a survey of 5 per cent of the prison population recorded pre-arrest illicit drug use by 43 per cent of prisoners, of which 34 per cent was cannabis.[14] Opiate usage varied considerably across the country from 25 per cent in Mersey to 3 per cent in the West Midlands.

This sort of local knowledge has clear implications for the organisation of health services in prisons, such as the provision of withdrawal or maintenance programmes. From a public health perspective, more relevant is the fact that 11 per cent of the sample reported injecting prior to arrest. The figures for Scotland are thought to be even higher, up to 27–35 per cent being quoted.[15]

Such risk behaviour will have an impact on the prevalence of conditions associated with needle usage such as hepatitis and HIV. Official statistics state that in 1992/3, 51 prisoners in England and Wales were HIV positive.[16] However, the Prison Reform Trust puts the figure at nearer 700.[17] This higher estimate is supported by a study which suggests a prevalence of infection in ex-prisoners of at least 0.6 per cent.[18] The carriage rate of hepatitis is not known, but in New York has been reported as 8 per cent.[19]

Other sexually transmitted diseases (STDs) are also thought to be common. Ten per cent of women prisoners on Riker's Island in New York were found to have untreated syphilis or gonorrhoea.[20] Reports from Holloway Prison, London, suggest high levels of cervical dysplasia.[21] There are important health implications to these figures, particularly HIV transmission within prisons, which is facilitated by coexisting STDs.

Compounding this, prisoners are known to participate in high-risk behaviours. Estimates of injecting in British prisons vary from zero to 27 per cent, with reports suggesting that a significant proportion of the people who inject would be sharing needles. Similarly, reports of sexual activity in prisons vary from being very low in Scotland to estimates of 20–30 per cent of long term prisoners engaging in homosexual activity. Unfortunately, the first formally documented case of prisoner-by-prisoner HIV transmission has already occurred.[22]

*Mental health*

It has long been recognised that there are a small but significant number of prisoners who suffer from *mental illness*. Such illness may or may not have contributed to their offence, but makes incarceration inappropriate. However, current health service provision within both the NHS and prisons has failed to provide adequate care for this group. The recent Reed Report tried to tackle this issue, although implementation of its many recommendations has yet to occur (see Chapter 5).

The scale of the problem is demonstrated by the fact that at Brixton Prison in 1984, over a 14-month period, 3184 psychiatric assessment reports were written for prisoners on remand.[23] It is generally considered that people should not be remanded simply for psychiatric assessment. This situation may have

improved since the introduction of court diversion schemes.

The morbidity in sentenced populations is not as high as in remand prisoners. However, a recent large-scale survey in this country suggests that 31 per cent of sentenced prisoners have a definable psychiatric disorder, 2 per cent of whom were suffering from psychosis.[24] This represents a prevalence not dissimilar to the 1–2 per cent of people suffering from psychosis in the general population. However, the majority of these cases (30 out of 34) were thought to be inadequately treated and to require transfer to hospital.

A further 15 per cent of the population were thought to require additional treatment within the prison system. The failure of current services is highlighted by the fact that, of those needing hospital transfer, 60 per cent had been recognised as being mentally disordered at the time of their offence.

Concern about suicide in prison has increased recently. The first document that suggested that prisoners had a high risk of suicide was produced early this century.[25] Since this time there have been a number of reports addressing ways of reducing the number of suicides in prisons. However, analysis of rates over the period 1972–87 suggests that the rate of suicide, particularly in young male prisoners, has been increasing, giving an overall rate of 91/100 000.[26] In order to make accurate comparisons with the general population where the annual suicide rate is 11/100 000, risk factors such as substance misuse and mental disorder must be taken into account. The fact that the rate in young men has also risen in the general population, re-emphasises the importance of comparing age-related rates.

## Service utilisation

Health status, both actual and perceived, is reflected in service utilisation. A number of studies have shown high rates of consultation in prisons, both with the prison doctor and with other hospital staff. The rates reported vary between studies, the annual rate in Bedford being 8.5 per cent of the population.[27] Rates in the general population for men under 50 would be expected to be 2–3 per cent per year.

The majority of attendances seem to be for new minor ailments such as headache, toothache, upper respiratory tract infections and skin complaints. This, however, leaves at least a third of consultations for the follow-up of established conditions, a figure not dissimilar to that seen in general practice.

Prison consultations are more likely than those in general practice to result in a prescription being given. In Bedford, 60 per cent of attenders were given drugs, whereas only 45 per cent of a similar group in general practice were.[28] A large study across a number of prisons in Canada showed that consultation with the hospital officer was even more likely to result in a prescription (91 per cent).[29]

The high consultation rates described can be accounted for in a number of ways. Access to over-the-counter medications is only available in a small number of prisons in this country, mainly as pilot studies. Self-medication is not possible. This is reflected in the high rate of prescription of analgesics and magnesium trisilicate in the Bedford study.[30]

High rates for specific conditions, such as trauma and skin infection, may reflect the prison environment; violence and overcrowding are problems and access to means of personal hygiene is restricted.

The social environment is also likely to play a part. One of the few rights a prisoner has is to see a doctor. In a situation of restricted freedoms, this may represent the exercise of a sense of personal control.

The actual stress of incarceration may also produce health problems; psychosomatic conditions, such as headache and non-specific abdominal pain are common reasons for attendance. The fact that consultation rates on Riker's Island were reported to have risen in the weeks before the riot in the late 1970s may testify to the potential influence of stress on illness behaviour. This idea is further supported by the fact that consultations are reportedly highest early and late in a sentence, perhaps when stress levels are greatest. However, none of these variables has been investigated in any depth. Further research is needed.

## The role for public health

Public health departments play a major role in epidemiological and health service research, and are also involved in the planning and evaluation of services and in environmental health issues. There is currently no organised public health function within the prison health care service. Expertise within the NHS could be used in a number of ways to help improve the health of prisoners.

### Research

The evidence summarised here shows that prisoners have greater health problems than a comparable group of the general population and engage in high-risk behaviours for future illness. Their utilisation of health services is relatively high, and represents a complex interaction of illness with social and environmental factors.

Public health departments in conjunction with clinicians could describe more clearly the prevalence of disease and its relationship to risk factors. The impact of the physical and social environment on health and illness behaviour also needs to be assessed and related to the health beliefs of this particular population.

Further to this is the need to determine how likely health care improvements are to increase health status and how much penal reform, for instance to change overcrowding and long lock-up periods, could have an impact. The very act of increasing research in prisons could generate interest in the service, which in itself may improve quality.

### Information

The planning of NHS services has often suffered from poor routine information. The prison service has even further to go in order to collate simple statistics as a basis for planning. At a national level, there needs to be a common set of data; locally, service providers need to review their own practice. The development of prison audit has been recently prioritised by the NHSME.[31] The establishment of audit is a slow process that has often been facilitated by public health departments. The sharing of this experience alongside the development of comprehensive information systems must be a priority.

## Purchasing

Fundamental to the concept of purchasing is needs assessment. This has largely been carried out by public health departments. The development of quality indicators and the contracting process in general have also been helped by public health. It would be very wasteful if the new health service for prisoners did not draw heavily on this body of knowledge.

## Health promotion

Prisoners are a captive population, and historically it has been apparently difficult to encourage them to adopt health promotion messages. However, there are a number of areas which would merit the development of innovative programmes. Smoking and drugs education are two possibilities: the need for the latter was highlighted by a study from Switzerland which suggested that the increased mortality seen in the six months after release could be related to renewed drug misuse after a period of abstinence.[32]

Such programmes would need to be combined with sexual health provision to tackle the issues of injecting and sexual activity within prisons. Other countries have introduced access to needle cleaning equipment and condoms. Screening programmes for cervical cancer and hypertension would also be appropriate.

The development of suicide prevention strategies must also be a priority as must programmes that address the acknowledged stress of prisons as a workplace.

chapter 2

# creating a health promotion and disease prevention service for wandsworth prison

*Judy Hague and Roy Burrows*

This is part of a pilot project being developed by the Prison Health Care Directorate to provide HIV and genito-urinary medicine services via NHS staff for three central London prisons (Brixton, Wandsworth and Wormwood Scrubs).

From the prison perspective, the aim is:

- to achieve the same standard of health care inside prisons as outside
- to prevent spread of HIV
- to increase health promotion initiatives to prisoners
- to raise awareness of staff of HIV issues and increase their ability to be involved in health promotion
- to avoid professional isolation and improve educational opportunities for staff
- to improve audit of care and interdisciplinary working to provide multidisciplinary care.

From the NHS perspective, the aim is:

- to respond to 'market' opportunities
- to understand the prison setting and health care needs of prisoners
- to share expertise with colleagues in prisons
- to create models of good practice in prison setting for HIV prevention and care of people with AIDS or who are HIV positive
- to be involved in educational initiatives and interdisciplinary working
- to provide opportunities for self-development to interested staff.

## Draft aims of service specification as prepared for pilot project

- To provide a more comprehensive service for the screening, diagnosis, treatment and prevention of sexually transmitted diseases (STDs) including HIV/AIDS, to involve partner notification and follow-up where possible, through provision of GUM clinics in the three establishments.
- To ensure that the standard of care and treatment of prisoners will be the same as in the NHS, having due regard to the health care policy statements and guidance issued by the Directorate of Health Care and recognising that the care and treatment of prisoners will normally be undertaken in conjunction with the prison's health care staff.
- To actively promote and co-ordinate, as an integral part of the service, the health education and health promotion of prisoners in respect of STDs, including HIV/AIDS.

## Barriers

- Not understanding respective cultures and language.
- Time required to overcome the above.
- Process is 'driven' by political imperatives.
- Expertise in purchasing for clinical (as opposed to non-clinical) services in the Prison Service not yet fully developed.
- Understandable concern from prison professionals about the influx of NHS professionals.
- Sensitivity of HIV as an issue in prisons.
- Dealing with three prisons with different cultures at once.

## Cultural issues

- Language – both organisations have their own jargon and cultural perspectives.
- National policy over key issues in HIV (e.g. confidentiality, condom use, sharing needles, and sexual acts in prison setting).
- Health care needs versus 'legal' issues (e.g. court appearances).
- Difficulties in continuity of care.
- Developing understanding of new roles (e.g. 'What is a health care officer?' 'What is a purchaser?').
- Ensuring direct access to the service.

## Hints and tips

- Take meetings initially at slow pace, do not expect mutual trust and understanding will emerge overnight.
- Set up visits for groups of managers/professionals in both directions.
- Take your 'lead' staff with you: imposing these arrangements will inhibit fruitful collaboration.
- Look for the 'positive': what can the individuals involved gain both personally and professionally from these arrangements? Identify what you have in common.
- As an outsider, you do not have all the answers, come to learn not to impart wisdom.
- Set up a full induction programme before the project starts.
- Ensure that 'audit' and 'evaluation' processes are shared.

*Postscript: the contracts for these services have since been let to the NHS. King's Healthcare NHS Trust provides services for Brixton and Wandsworth; Chelsea & Westminster NHS Trust provides services for Wormwood Scrubs.*

# chapter 3
# mentally ill prisoners: a mismatch of agendas

*Martin Bould and Maazu Yase*

Both the NHS and the prisons recognise there is a problem concerning prisoners with a mental illness. Since the network members did not have a ready example of joint work or good practice, they heard two accounts of the current situation, one from an RHA, and the other from a prison medical officer. These accounts showed starkly how the policy agenda diverged from day-to-day practice. This mismatch meant that the system was failing both prisoners and its own staff.

The philosophy is clear and underpinned by the Reed Report: mentally disordered offenders who need care and treatment should receive it from health and personal social services, not in prison.

In pursuit of this goal, action at regional level by the NHS included:

- a needs assessment conducted at the request of the Department of Health
- planned expansion of regional secure provision (so-called medium secure)
- steps to align arrangements for medium-secure provision with the NHS purchaser/provider division (different RHAs had taken different steps).

On the prison side, the main concern is for prompt disposal of prisoners who are mentally ill, by transferring them to hospital under the provisions of the Mental Health Act. Delays are exceptionally difficult for the prison health service, which might require up to six transfers a week. Mentally ill prisoners are kept in conditions which are not appropriate for their care and treatment. They require intensive staff time which must be diverted from other prison health needs. Doctors cannot treat under the Mental Health Act.

Finding a hospital to accept a mentally ill person from prison is a recurrent difficulty. The prison health service draws lessons from these experiences, and may perceive visiting psychiatrists as failing to agree, hospitals as not wanting difficult patients, and the service solution as more locked wards.

Focusing on the most difficult patients in the most extreme situations can be disabling when attempting to improve services across the board. The situation of prisoners awaiting transfer must be vigorously tackled, but so must the full spectrum of mental health needs. The NHS faces challenges at every level in providing appropriate care to mentally disordered offenders, from homeless people who are mentally ill and commit minor offences, to people who require treatment in special hospitals for many years. Equally, the prison service has to deal with over one third of its constantly shifting population who have one or more psychiatric disorders.

In addition, both NHS and prison services are operating against the background of recent policy changes in contracting. Where new practices and procedures do not address the day-to-day reality of a system under stress, they can increase frustration. For the NHS, the Reed Report has drawn attention to the disincentives operating in one part of the system (whereby DHAs have to pay for people moved out of special hospitals but not for residents). From the viewpoint of the prison service, a local hospital or purchaser has no incentive to accept a difficult patient who is currently being maintained in prison at no cost to them.

Hence the learning network had to face a situation where each party needed the full and active engagement of the other, but

- prisoners were not getting transferred
- the wider policy agenda was log-jammed
- the financial reforms were not providing an incentive for change.

An underlying issue was a feeling that all the responsibility for movement was with the NHS. This was summed up by a comment made when the network heard of the Department of Health funds for building new medium-secure units. One prison governor remarked, 'You've got the money, but we've still got the people'. And indeed there is a valid question about who is responsible for monitoring how this new investment in the health service actually reduces the burden on the prison service. Or will it be another case of resource drift?

Not surprisingly, the network could not unblock this problem. But without the network all that might have happened would have been a ritual exchange of letters in tones of accusation and denial.

In fact, the network ensured that key players understood the severity of the problem, and took some limited action. The prison service arranged for monitoring information to be provided in such a way that regional medical officers could intervene promptly in individual cases and receive data about the length of time mentally ill prisoners waited before transfer. (This and other responses to the Reed Report are dealt with in more detail in Chapter 5).

The network also provided a foundation for further work outside its own meetings. This enabled RHA officers to visit Pentonville (the first time at least one had been inside a prison) and meant that a prison medical officer could present a paper to the region's purchaser development network. In addition, there were opportunities to use other events to work in partnership to get the issue of mentally disordered offenders higher on the agenda, for example, at the Mental Health Foundation's conferences on this subject.

The purchasers' meeting (bringing together FHSA and DHA purchasers) set an agenda for future work which is a useful by-product of the prison and health network. Concerns included:

- the need for a better understanding of numbers and costs of medium-secure patients
- up-to-date bed availability information was inadequate
- more work to define needs and dependency was required
- future needs must be addressed with providers
- the high cost of services for this group will fall differentially, and this

must be reflected in resource allocation

- develop a vision of services for mentally disordered offenders, including a view of what should be provided locally.

As a result of its participation in the learning network, North East Thames Regional Health Authority has been enabled to:

- write targets on mentally disordered offenders into the planning guidelines issued to districts
- encourage bids for pump-priming and pilot schemes to the Department of Health
- take a more active approach to the development of diversion schemes at magistrates' courts, including organising a day workshop.

There undoubtedly remains a lot to do, but the learning network has been a solid contribution to interagency working.

# chapter 4
# medical ethics in prison

*Graham Clark*

The session was based on a paper by Jacques Bernheim, Professor of Forensic Medicine at Geneva University, former Director of Medical Services, Champ-Dollon Prison General, and Vice President of the European Committee for the Prevention of Torture (Strasbourg).[33]

We addressed some of the dilemmas faced by doctors working within the prison system, especially those employed by and accountable to the prison service. There are inevitably ethical problems for the doctor in the tension between the relationship with the patient and the relationship with the employer.

The prison medical officer is required by the prison governor to:

- provide medical care for prisoners
- sanction the treatment of prisoners by the discipline staff
- prepare reports for the courts
- monitor the prison environment from a health perspective
- provide medical advice to the governor.

Medical care in prison should equate to that within the NHS. Indeed there is an extra aspect of 'duty of care' because of the prisoner's powerless state. Usually, patients are free to choose their doctor, and the doctor–patient relationship is based on mutual consent. But prisoners are not free to select a doctor, are dependent and are therefore vulnerable. Specific dilemmas include:

- the extent and limits of confidentiality
- the role of the doctor within the multidisciplinary team
- issues which are either unique to the custodial setting (e.g. hunger strikes) or special due to the custodial setting (e.g. HIV and suicide).

This poses a number of very real questions about the nature of the relationship between doctor and governor, questions which will persist even if there is a new framework for delivering health care within prisons.

# chapter 5
# the reed report and implementation

We decided to discuss the Reed Report as an example of:

- an area where we all agreed that present practice was unsatisfactory and resources were being poorly applied
- development work (through the Reed Committee) which had involved both the prison service and the NHS
- an area where the learning network could add value.

We reviewed the report and agreed that, as a policy document, it represented a comprehensive review which took account of the needs of individuals and small groups, as well as the overall needs. There was no dissent from the principles which informed the recommendations.

However, the implementation of a report with 276 recommendations poses enormous problems, especially when many organisations are involved, and some of the recommendations apply to more than one organisation.

Although there appears to be ministerial commitment, this does not, for example, appear to be reflected in the priorities guidance to the NHS.

One approach would be to select a small number of recommendations which can be justified as having very high priority, and make them core elements of the NHS corporate contract in 1994/95.

The network suggested an initial tranche of three issues:

- the management of mentally ill offenders in prison
- the development of court diversion schemes
- the diversion of mentally ill people from police custody.

We agreed to pursue this in the following ways.

*Mentally ill offenders in prison*

- The four RHAs would establish targets for London and the South East in order to ensure that those mentally ill offenders in prison would be assessed for NHS care and transferred to the NHS if appropriate.
- The prison health care directorate would liaise with local staff to explore the monitoring information which would need to be provided, including the number of inmates awaiting assessment or transfer by health district.
- Arrangements would be established to ensure the more effective management of those instances where particular problems arise.

*Court diversion schemes*

- NHS staff would carry out an initial assessment of the progress made on court diversion schemes, the present gaps and any change required.
- The learning network would return to this and agree the necessary action.

*Ensuring the assessment and transfer if necessary of people in police custody*

- Again more information needs to be collected before an action plan can be agreed.

This work highlighted several important points:

- The need for better information in order to inform priority setting, and monitor change and progress.
- The consequences of selecting priorities, which can include ramifications for other organisations. For example, a greater emphasis on the criminal justice system could result in the NHS being less responsive to the Special Hospital Services Authority (SHSA). Likewise, the needs of prison inmates with alcohol and drug problems could be marginalised if greater attention were given to mental illness.
- The problems for managers and professionals when policy is dislocated from implementation.
- The temptation in our discussion to talk about 'the problem' rather than to develop 'a solution'.

Further, longer-term work is also necessary. Both the prison service and the NHS need to manage upwards on issues such as this, sending consistent messages to their ministers and government departments. It is too easy for those on the ground to behave competitively rather than collaboratively when addressing the needs of a vulnerable group of people which involve a range of different organisations.

# conclusions

Through our discussions a number of themes emerged:

- The difficulties for two very different and similarly complex organisations working together when their mutual understanding is imperfect, but where unjustified assumptions may nevertheless be made, 'like landing in a foreign country without any currency'. It is essential to spend time learning about the other, their different but overlapping priorities and their organisational cultures.
- There were some similarities between the two worlds – for example, the tension between the field and the centre; the potential conflict between those who give priority to an individual as opposed to those who focus on the overall needs of a community, and the different perspectives of those who engage day to day in dealing with problems as opposed to those who focus primarily on policy development and evaluation.
- The predictability from the initial sessions of the nature of the problems, and the recognition that an intellectual and rational understanding does not of itself ensure that appropriate action is taken.
- Mentally disordered offenders and their complicated and resource-intensive needs remained a recurring issue through our work. The continuing failure of our organisations to meet these needs is an indictment of all of us, and the irritation which is caused undermines any broader efforts to work collaboratively.

It is planned to continue network meetings, ensuring the effective representation of all Prison Service and NHS stakeholders. For further information contact:

Sheila Adam
North Thames RHA
40 Eastbourne Terrace
London
W2 3QR

# references


1. Revans RW. The Origins and Growth of Action Learning. Bromley: Chartwell Bratt, 1984.
2. Parston G. Ways and means of managers learning to manage. Health Service Journal 1986; 1452–4.
3. King's Fund College. Submission to the Department of Health for Management Education for Consultants. London: King's Fund College, 1989.
4. King's Fund College. The Commissioning Experience: Learning the art of purchasing. London: King's Fund College, 1992.
5. Smith, R. Prison medicine: beginning again. BMJ 1992; 304:134–5.
6. House of Commons Social Services Committee. Prison Medical Service. London: HMSO, 1986.
7. Her Majesty's Chief Inspector of Prisons. Report January 1990-March 1991. London: HMSO, 1991.
8. Government Efficiency Unit. Report on an Efficiency Scrutiny of the Prison Medical Service. Oct 1990.
9. The National Prison Survey 1991. Main findings. Home Office Research Study 128. London: HMSO, 1992.
10. Novick LF *et al.* Health status of the New York prison population. Medical Care 1977; 15:205–16.
11. Martin E, Colebrook M, Gray A. Health of prisoners admitted to and discharged from Bedford prison. BMJ 1984; 289:965–8.
12. Colsher PL *et al.* Health status of older male prisoners: a comprehensive survey. Am J Pub Health 1992; 82:881–4.
13. Quoted in: Smith R. The physical health of prisoners. BMJ 1984; 288:129–32.
14. Maden A, Swinton M, Gunn J. A survey of pre-arrest drug use in sentenced prisoners. Br J Addiction 1992; 87:27–33.
15. Farrel M, Strang J. Drugs, HIV and prisons. BMJ 1991; 302:1477–8.
16. HM Prison Service. Report of the Director of Health Care for Prisoners. April 1992–March 1993. London: HM Prison Service, 1994.
17. Smith R. Failure of prison HIV policies. BMJ 1991; 302:371-2.
18. Turnbull PJ, Stimson GV, Dolan KA. Prevalence of HIV infection among ex-prisoners in England. BMJ 1992; 304:90–1 .
19. See 10.
20. See 13.
21. See 16.
22. Power KG *et al.* Sexual behaviour in Scottish prisons. BMJ 1991; 302:1507–8.
23. Smith R. Mrs Short's recipe for better prison health. BMJ 1986; 293:226.
24. Gunn J, Madden A, Sinton M. Treatment needs of prisoners with psychiatric disorders. BMJ 1991; 303:338–41.

25. Smith R. 'Taken from this place and hanged by the neck...'. BMJ 1991; 302:64–5.

26. Dooley E. Prison suicide in England and Wales, 1972–87. Br J Psyche 1990; 156:40–5.

27. Martin E. Comparison of medical care in prison and in general practice. BMJ 1984; 289:967–9.

28. See 27.

29. Sheps S *et al*. Prison health services: a utilization study. J Comm Health 1987; 12:4–22.

30. See 27.

31. NHS Management Executive. Priorities for Audit. Leeds: NHSME, 1993.

32. Harding-Pink D, Fryc O. Risk of death after release from prison: a duty to warn. BMJ 1988; 297:596.

33. Bernheim J. Ethique en Médécine Penitentiaire. Geneva: Médécine et Hygiene, 1991.

# appendix 1
# list of participants

Bill Abbott
Governor,
HM Prison Pentonville

Sheila Adam
Director of Public Health,
North West Thames RHA

Roy Burrows
Head of Health Care,
HM Prison Wandsworth

Graham Clark
Governor,
HM Prison Wandsworth

Jeremy Coid
Senior Lecturer,
Forensic Psychiatry,
Hackney Hospital

Andrew Coyle
Governor,
HM Prison Brixton

Nigel Eastman
Senior Lecturer,
Forensic Psychiatry,
St George's Hospital Medical School

David Gbeckor Kove
Managing Medical Officer,
HM Prison Wormwood Scrubs

Dick Gooch
Health Care Directorate,
Home Office

Judy Hague
HIV/AIDS Manager,
Riverside Hospitals

Peter Mason
Substance Misuse Development Manager,
North West Thames RHA
(until August 1992)

Stephen Mitson
Head of Custody,
HM Prison Pentonville

Howard Osborne
Business Manager, Forensic Psychiatry,
St George's Hospital

Sue Osborne
General Manager,
Lambeth, Southwark & Lewisham FHSA
(until April 1993)

Michael O'Sullivan
Governor,
HM Prison Holloway

Sian Rees
Senior Registrar in Public Health,
North West Thames RHA

Liz Robin
Registrar in Public Health,
North East Thames RHA

John Sinclair
Health Care Directorate,
Home Office

V Somasundaram
Managing Medical Officer,
HM Prison Brixton

Paul Turnbull
Centre for Research on Drugs
and Health Behaviour

Dayananda Wanigaratne
Senior Medical Officer,
HM Prison Holloway

Richard Weatherill
Health Care Directorate,
Home Office

Doreen Williams
Principal Nursing Sister,
HM Prison Holloway

Mahazu Yisa
Managing Medical Officer,
HM Prison Pentonville

*Facilitator*

John Mitchell
King's Fund College

# appendix 2
# views of participants

Those participants who continued to attend found the network useful; those who dropped out presumably derived less benefit. The following quotes illustrate some of the positive aspects of the network:

'The network has produced a forum where areas of conflict can be discussed openly and compromises sought. It is good to be able to do this away from the area of conflict and the associated emotions.'

*Prison governor*

'The meetings provided wonderful opportunities for each side to understand the concerns and problems of the other.'

*Prison doctor*

'Outside agencies wishing to participate in the health care developments of prisoners should not settle for anything less than an equivalent standard to the NHS. Their ability to contribute will be greatly enhanced if they are aware of the problems.'

*Prison doctor*

'We no longer see each other as remote 'faceless bureaucrats' but as individuals who are anxious to work together creatively.'

*Prison governor*

'This was my first experience of a learning network, and I found it both intellectually stimulating and enjoyable.'

*Prison doctor*

'Genuine understanding and respect has been gained through the process. Being involved has been one of the most enjoyable aspects of the last year. It has taught me again the value of listening, reviewing my own prejudices, and thinking carefully before saying things.'

*Public health doctor*

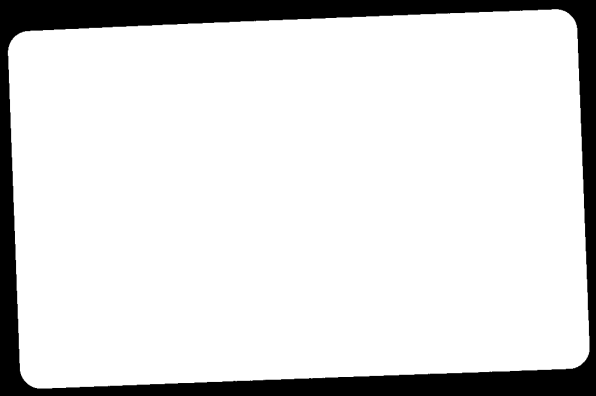
'My experience over 22 years has been of constant problems in all the areas where prison/prison medical service/ NHS overlap. This has been one of the best aids to overcoming some of these problems that I have found.'

*Prison governor*

'The NHS is, increasingly, a fragmented organisation which it is not very easy for the prison service to become involved with, particularly at local level. Yet the message in the prison service is ever greater delegation, in health care as in other areas of activity. The responsibility and accountability for health care will increasingly fall on the shoulders of prison governors, not just of health care professionals, in the prison service. And governors and health care professionals will increasingly turn outwards to the NHS rather than upwards to headquarters in seeking to develop health care services for prisoners. Hence the importance of

the network. It provides a forum where people from very different backgrounds in the two services can come together, on a basis of equality, to discuss matters of common concern, to listen, to learn and, we hope, to find new answers to the old problems of providing a decent standard of health care in the prison setting.'

*Civil servant*




048572 020000

**Over the past two years, a group of representatives from prison staff and NHS staff across London has worked together, using the model of a 'learning network', to develop a better understanding of the health needs of prisoners, and to explore new ways of meeting those needs.**

**This report**

- **reviews the health status of prisoners in the UK**
- **presents an innovative approach to strengthen the link between the Prison Service and the Health Service**
- **highlights the areas where the two services need to collaborate in order to ensure health improvement.**

**Of great interest to staff in the Prison Service, health care purchasers and providers, this report will also be relevant to those involved in the development of learning networks.**

ISBN 1-873883-75-7