

The Health of Women in Prison

Study Findings



Emma Plugge
Nicola Douglas
Ray Fitzpatrick

Department of Public Health
University of Oxford

2006

The authors

Emma Plugge, Senior Research Scientist, Department of Public Health, University of Oxford & Honorary Consultant in Public Health, Oxfordshire Primary Care Trust

Nicola Douglas, Research Officer, Department of Public Health, University of Oxford

Ray Fitzpatrick, Professor of Public Health and Primary Care, University of Oxford

For further enquiries please contact Dr Emma Plugge:
emma.plugge@dphpc.ox.ac.uk

Department of Public Health
University of Oxford
Old Road Campus
Old Road
Headington
Oxford
OX 3 7LF

Telephone: 01865 289225

Acknowledgements

A great number of individuals and organisations have been involved in this study and we are very grateful to them; we recognise that without their support this study could not have taken place. We especially wish to thank the governors, officers and healthcare staff in the two main fieldwork sites. To preserve the anonymity of participating prisons, we cannot identify individuals here but wanted to note our profound gratitude for their advice, help and support for this project. This not only facilitated the research but was often a welcome source of professional support and valuable insight.

In addition, we would also like to thank the many others who facilitated the project and made it possible:

Ms Sian West, former Governor of HMP Cookham Wood and all the staff and women prisoners of Cookham Wood who participated in the pilot study in 2003.

The study Steering Group: Ms Susan Bishop-Rowe, Ms Helen Dunford, Mr Steve Gannon, Professor Jan Keene, Dr Tish Laing-Morton, Mr Phil Morgan, Dr Mary Piper, Mr Simon Reeves, Mr Steve Tyman and Dr Janet Wilkinson.

The governors and the health care managers at:

- HMP Bronzefield
- HMP Brockhill
- HMP Buckley Hall
- HMP Bullwood Hall
- HMP Cookham Wood
- HMP Downview
- HMP Drake Hall
- HMP East Sutton Park
- HMP Eastwood Park
- HMP Foston Hall
- HMP Holloway
- HMP Morton Hall
- HMP New Hall
- HMP Send
- HMP Styal

and all the imprisoned women within these establishments who participated in the study

HMPS Women & Young People's Group particularly Steve Tyman and Jan Osborne

Dr Kimmett Edgar of the Prison Reform Trust

Ms Basia Rostworowska of HIBISCUS

Ms Mary Selwood and Dr Pat Yudkin, Department of Primary Care, Oxford University

The University of Oxford is grateful to the King's Fund for providing a grant to help with the cost of this study. Any views expressed in this publication are those of the authors and not necessarily those of the King's Fund, which is not responsible for them.

Executive Summary

This report details the findings of one of the largest studies examining the health of women prisoners in the England and Wales

The sample and methods

- ⇒ 505 women were recruited from 2 busy remand prisons in England over a 6 month period in 2004-05
- ⇒ There was an 82% response rate
- ⇒ Women were interviewed within 72 hours of being received into prison (Time 1) and then again one month (Time 2) and three months (Time 3) later
- ⇒ A sub-sample of women also participated in focus group discussions and one to one interviews
- ⇒ 256 women were still imprisoned at one month and 220 were interviewed again
- ⇒ 120 women were still imprisoned at 3 months and 112 were interviewed again
- ⇒ The sample of 505 women was of similar ethnicity, age and educational status as the female prison population as a whole, but they were less likely to have dependent children or to be employed or married
- ⇒ There were differences between the whole sample (505 women) and the sample who were still imprisoned at Time 2 and at Time 3. The sub-sample of women were still imprisoned at 3 months differed from the whole sample; they were older, more likely to have been born outside the United Kingdom, describe themselves as 'black', to have been employed before prison and to have stayed in education until they were 19 years old.

The findings

The questionnaire:

1. Subjective health status

The subjective health status of these women, as measured by the SF 36 and the GHQ 12, was much poorer than that of the general population.

Their health status as measured by the SF 36 and the GHQ 12 improved over the 3 month period spent in prison. However, this finding was confined to women who used drug before coming in to prison, and although improved, their health remains much poorer than the general population

2. Health related behaviours

⇒ Before coming into prison:

- 85% smoked cigarettes
- 42% drank alcohol in excess of the recommended amount
- 75% used illegal drugs in the 6 months prior to imprisonment
- 27% had been paid for sex
- 13% met the Government recommendations on exercise
- 13% met the Government recommendations on diet
- 16% self harmed in the month prior to imprisonment

⇒ Following imprisonment:

- The proportion of smokers remained the same but the amount they smoked decreased
- Alcohol consumption and drug use decreased
- Fewer women exchanged sex for goods or money
- Exercise and diet did not improve
- There was no statistically significant change in rates of self harm

3. Health service use

- ⇒ Before coming into prison:
 - women were less likely to be registered with a GP and more likely to make use of hospital services than the general population
 - 68% had a cervical smear in the last 5 years
 - 83% reported a longstanding illness
 - 73% were taking some form of prescribed medication
- ⇒ After 3 months in prison, women were less likely to be taking methadone and benzodiazepines and more likely to be taking antidepressants or antihypertensive medication.

The focus groups and interviews:

- ⇒ Women outlined the negative and positive ways in which prison had impacted on their health. Drug users highlighted the regular meals, shelter and protection from violence as particularly positive aspects of the prison regime.
- ⇒ Women were critical of aspects of the wider prison environment which they felt affected their health: poor hygiene, poor diet, few opportunities to exercise, and sometimes difficult relationships with custodial staff
- ⇒ Some women identified ways in which the health care services had helped them. Some appreciated the very difficult conditions in which these staff work. The aspects of health care provision that women were especially critical of were difficulties accessing care and medication, the attitude of staff and the lack of confidentiality

Discussion and conclusions

- ⇒ The emphasis of the report is on describing the findings; it is a tool for helping Primary Care Trusts to develop prison health services, not an evaluation of current services
- ⇒ The questionnaire survey achieved a good response rate (82%) although the sample of 505 women differs in some respects from the whole female prison population and therefore the findings should be generalized with caution
- ⇒ The findings highlight the very poor health status of women prisoners and show how, for some women, aspects of their health improve whilst in prison
- ⇒ Women perceive a number of problems with both the regime and the health care provision and these problems have a negative impact on their health
- ⇒ Prison health services have a considerable task in meeting their needs and providing '*compensatory care*' to these women

Contents

1. Introduction.....	13
1.1. Background.....	13
1.2. Scope of report.....	14
2. Methodology.....	15
2.1. The Questionnaire Survey.....	15
2.1.1. Sample size.....	15
2.1.2. Selection and recruitment of participants.....	15
2.1.3. Data collection.....	15
2.1.4. The content of the questionnaire.....	15
2.1.5. Data analysis.....	16
2.2. The Focus Groups and Interviews.....	17
2.2.1. Rationale.....	17
2.2.2. Enquiry techniques.....	17
2.2.3. Recruitment.....	17
2.2.4. Data analysis.....	17
3. Results: The Questionnaire Survey.....	18
3.1. Response rate.....	18
3.1.1. Initial Recruitment.....	18
3.1.2. Follow up at one and three months.....	18
3.2. Demographic information.....	21
3.2.1. The whole sample of 505 women.....	21
3.2.2. Comparison with whole population of women prisoners.....	23
3.2.3. Comparison with those women still in at one month and three months.....	23
3.3. Subjective health status.....	25
3.3.1. Short Form 36.....	25
3.3.2. The 12 item General Health Questionnaire.....	27
3.4. Health related behaviours.....	28
3.4.1. Smoking and alcohol.....	28
3.4.2. Illicit drug use.....	29
3.4.3. Sexual behaviour.....	31
3.4.4. Physical exercise and diet.....	33
3.4.5. Self-harm.....	36
3.5. Health service use.....	37
3.5.1. Community and hospital services.....	37
3.5.2. Uptake of preventive services.....	40
3.5.3. Women’s health issues.....	42
3.5.4. Longstanding illness and medication.....	43
3.6. Measurements.....	45
3.6.1. Blood pressure.....	45
3.6.2. Weight and body mass index.....	45

Contents

4. Results: The Focus Groups & Interviews.....	46
4.1. Participants.....	46
4.2. Contextual issues.....	46
4.3. Findings.....	47
4.3.1. Concepts of Health.....	47
4.3.2. Prior Health Status.....	47
4.3.3. Impact of Imprisonment.....	49
4.3.4. Impact of Imprisonment on Health Status.....	50
4.3.5. The Prison Environment.....	52
4.3.6. Mental Health.....	57
4.3.7. Substance Misuse.....	61
4.3.8. Sleep Disturbance.....	62
4.3.9. Relationships with Custodial Staff.....	63
4.3.10. Healthcare Services.....	64
5. Discussion.....	73
6. Recommendations.....	75
7. References.....	77

Notes on tables and figure

The row or column percentages may add to 99% or 101% because of rounding.

When a change between Time 1 (reception into prison) and Time 2 (one month after imprisonment) or Time 3 (3 months after imprisonment) is recorded in a figure or table, the data presented at Time 1 will only be that for those individuals whose data is presented at Time 2 or 3. Whole sample (n=505) data is not presented at Time 1 in these cases.

Summary text boxes are presented in the questionnaire findings comparing women prisoners with the general population. It should be noted that 'women prisoners' in this context are those women prisoners who participated in this study.

1. INTRODUCTION

1.1. Background

At the end of April 2006 there were almost 77,000 people in prison in England and Wales (1). Women make up a small but increasing proportion of this population, with the number of women imprisoned rising by 173% between 1992 and 2002 in contrast to just 50% for men (2). There are now almost 4,500 imprisoned women (1) and although they make up less than 6% of the prison population they do have specific health needs which differ from those of male prisoners.

The health needs of all prisoners, including women prisoners, in the United Kingdom (UK) have drawn increasing attention over the past decade. Historically their needs have been met within the Prison Service with little involvement of the National Health Service (NHS). However, there were a number of concerns about this arrangement, notably regarding equity, standards, professional isolation and whether the Prison Service had the capacity to carry out adequately its healthcare function (3). In 1999 the Prison Service and NHS Executive published their findings of a review of prison healthcare (4). Although this report did not recommend transfer of responsibility from the Prison Service to the NHS, it did introduce the concept of 'equivalence of care', that is that prisoners are entitled to the same standard of health care in prison as they would receive in the community. In order to achieve 'equivalence of care', the NHS and Prison Service were to work together to improve the provision of prison healthcare. At a local level this meant that Health Authorities (and now Primary Care Trusts (PCTs)) with a prison in their area worked with the prison to plan and commission services jointly, a process informed by health needs assessment of their prison population (5) and guided by the work of two newly created national bodies, the National Prison Health Task Force and the Prison Health Policy Unit. Although there was to be no immediate transfer of responsibility for health services from the Prison Service to the NHS, this co-operation has in fact lead to a gradual transfer of responsibility; from the 1st April 2006, PCTs have been responsible for providing and commissioning health care in prisons (6).

Health needs assessments of the prison population have played an important role in developing health care services in this setting but have been limited by a paucity of epidemiological research in this area in the UK. In particular there is little epidemiological data on the health of women prisoners. Existing research suggests that they experience more ill health with high levels of mental disorder, drug misuse, alcoholism and infectious diseases (7;8). However, there has been no systematic survey of women prisoners looking at the many aspects of health conducted in this country – unlike in other western countries. Thus there is little robust baseline data that can be used to inform service planning or monitor change in this population.

1.2. Scope of Report

The overall aim of the Health of Women in Prison study was to determine what happens to the health of women when they are imprisoned in order to provide essential information for improving health and health care within the prisons. The specific objectives of the study were:

- ⇒ To determine the health status of recently imprisoned women
- ⇒ To determine what aspects of women's health (physical, mental, and psychosocial) change during imprisonment and the extent of these changes
- ⇒ To examine and compare access to health services prior to imprisonment and during imprisonment
- ⇒ To determine whether the health needs of imprisoned female 'foreign nationals' differ from other female prisoners
- ⇒ To explore the health beliefs and attitudes of imprisoned women
- ⇒ To make evidence-based recommendations for the future planning and delivery of health care within the prison system

In order to achieve these objectives, the study involved both a questionnaire survey and qualitative research. This report details both the quantitative and qualitative findings and provides some discussion of how these findings may be interpreted. However, the emphasis of the report is on describing the findings as it should be viewed as a tool for helping PCTs to develop prison health care services, rather than a critical evaluation of current services which are changing at great pace.

2. METHODOLOGY

2.1. The Questionnaire Survey

2.1.1. Sample Size

Following the pilot study in February 2003, a statistician was involved in the calculation of the sample size for the main study and concluded that a final sample size (sample at Time 3) of 100 women was necessary.

Statistics from the Home Office indicated that less than one third of female remand prisoners would still be imprisoned at 3 months. Thus we needed to recruit at least three hundred and fifty women on remand (at Time 1). We assumed that at least 25% of the original sample may not agree or be unable to participate at Time 3, and therefore aimed to recruit 500 women into the study.

2.1.2. Selection and recruitment of participants

Each researcher recruited at one of the two women's prisons involved in the study. Any woman received into prison for the first time this custodial episode on a study day during the study period, 15th June 2004 to 15th December 2004, was eligible to participate. 'Study days' were pre-specified days of the week; as there was insufficient staffing to enable the researchers to see all new receptions in this time period, this method ensured they obtained a sample of those received into prison in this period. Women who were transferred into the study prison from another prison were excluded from the study as were prisoners who had mental health problems that precluded them from giving informed consent and those who posed a security risk.

The researchers approached all eligible imprisoned women within 72 hours of being received into prison. The women were asked if they wished to participate in the study and given an information sheet (translated appropriately if necessary). The researchers obtained written consent.

The researchers followed up the women at one month (Time 2) and three months (Time 3). Women who were still in prison at one month and three months were again given information on the study and asked for written consent. The researchers followed up all those women still in prison irrespective of prison, but did not follow up those women who had been released into the community.

2.1.3. Data Collection

Consenting women completed the questionnaire (see Section 2.5.). The researcher was usually present in the same room as the woman as she completed the questionnaire and assisted those women with reading difficulties. The questionnaire was translated into French and Spanish for women who did not speak English.

In addition the researcher measured the height, weight and blood pressure of each participant.

All questionnaires and measurements were anonymous and coded to ensure confidentiality but also enabling linkage to subsequent data.

2.1.4. The content of the questionnaire

The questionnaire was piloted in March 2003 at a closed women's prison in Kent and adjusted in the light of the findings. It comprised a combination of well-validated instruments to measure health status and questions from other surveys to examine lifestyles and health service use.

Health status: The Short Form 36 (SF-36) and the 12 item General Health Questionnaire (GHQ-12) are both well-validated instruments that have been widely used to measure health status and monitor the health of specific populations over time (9). The SF-36 is a short item questionnaire which measures eight dimensions: physical functioning, role limitations due to physical problems, role limitations due to emotional problems, social functioning, mental health, energy/vitality, pain and general health perception (10). It has been widely validated (content, criterion and construct) in the UK and USA (10) and has been used previously in prison populations (11-13).

The GHQ-12 is a 12-item questionnaire designed for use in the community and focusing on psychological well-being (14). It has been validated on a number of different populations nationally and internationally (14), and more specifically on women prisoners (15). Hurley and Dunne's study found that the GHQ-12 had a sensitivity of 88% (it correctly identified 88% of women with a psychological disturbance) and a specificity of 84% in a sample of female Australian prisoners (15). Thus not only is there evidence to support the validity of the GHQ-12 in a prison population, but it has the added advantage of being short and easy to administer in a population with poor basic skills (16).

Health-related behaviours: The questions contained within the questionnaire relating to diet, exercise, alcohol consumption, smoking habits and long-standing illness are from the Oxford Healthy Lifestyle Survey. This postal survey was run across the 4 counties of Berkshire, Buckinghamshire, Oxfordshire and Northamptonshire in 1985, 1991 and 1997. It has consistently achieved high response and completion rates across all sectors of the population, regardless of socio-economic status or ethnicity (17).

Questions relating to injecting drug use and sexual behaviour are those used in the 1997-1998 survey of prisoners in England and Wales undertaken by the Communicable Disease Surveillance Centre, London (18). The researchers reported only one major problem with their questionnaire, and this related to the question on length of time spent in prison rather than any of the questions on drug use or sexual behaviour.

The questions on self harm were used in the survey of psychiatric morbidity in prisoners in England and Wales by the Office for National Statistics (ONS) in 1997 (19)

Health service use: The questions within the questionnaire on health service use have been taken from the Oxford Healthy Lifestyle Survey, described above.

2.1.5. Data analysis

All data was entered onto a database within the Department of Public Health, University of Oxford, and analysed there using the software package, SPSS version 12. Specialist statistical advice was sought. The SF-36 and GHQ-12 were scored according to the developers' manuals (10;14). The scores for women prisoners obtained in this study were compared to normative data provided in the interpretation manual (10) and differences in scores for dimensions and for physical and mental component summary scores were assessed using the independent t-test for means. Significance was assumed at $p < 0.05$.

Differences between prisoners at Time 1 and Time 2 or Time 1 and Time 3 were assessed using a paired samples t-test (continuous variables such as age), or McNemar's test for matched samples (dichotomous variables such as whether or not the woman smoked). The sign test was used to examine changes in diet and exercise behaviour.

2.2. The focus groups and interviews

2.2.1. Rationale

The qualitative aspect of the study sought to explore the health beliefs and attitudes of imprisoned women. Such methods are the most appropriate means to explore and understand people's experiences, attitudes and views (20;21) and have been widely used to explore public understandings of health and illness (22). Focus groups are useful when exploring sensitive areas (22) and are a good exploratory method when investigating an area where there is scant research (23). One-to-one interviews are the most appropriate way of exploring the issues in greater depth (21;23). In addition, focus groups do not discriminate against those who cannot read or write and encourage participation from those reluctant to be interviewed on their own, or who feel they have nothing to say (22). These are key concerns in relation to research with women prisoners where basic skills acquisition has been shown to be relatively low and various other forms of social exclusion are common (24;25).

2.2.2. Enquiry techniques

Both focus groups and individual interviews were guided by the use of semi-structured schedules that allowed important issues to be explored but also retained sufficient flexibility to enable women to raise issues of interest or concern. All investigations were carried out by two female researchers (individually for interviews and in a pair for focus groups). Interviews and focus groups were recorded and transcribed. All participants gave written, informed consent and were advised of their right to withdraw at any time. The research was conducted in private within the two recruiting prisons; neither prison nor healthcare staff were present.

2.2.3. Recruitment

Purposive sampling whereby participants are selected according to who, in the researcher's judgement, may provide rich data related to the study question, was used to recruit women to specific focus groups to ensure that the perspectives of women from a range of different prison groupings were included. Although the groups were very different from each other, the members within a group were fairly homogenous in terms of background; this is the best way to identify a broad range of views from those from different backgrounds (23).

Convenience sampling involves choosing the nearest and most convenient persons to act as respondents (26) was used to recruit women who had completed a questionnaire to participate in individual interviews.

2.2.4. Data analysis

Systematic coding and categorisation of material using grounded theory techniques (27) was used to draw meaning from the data and generate conceptual insights. Coding was independently carried out by two researchers. NVivo 7 software was used to facilitate data coding. There were no significant incongruities between the thematic concepts identified as emerging from the material.

3. RESULTS: THE QUESTIONNAIRE SURVEY

3.1. Response rate

3.1.1. Initial recruitment

As previously noted in the methods section, the researchers approached the women within 72 hours of their reception into prison. The researchers were able to approach 613 of the 750 eligible women. Of these, 505 agreed to participate, giving a response rate of 82%. The researchers were unable to access 137 women within the 72 hour period. The most common reason for this was that the women (98 in total) had either been bailed or were in court at the time of the study. In the case of a further 37 women, the researcher did not have sufficient time to access the women. This may have been because of an unforeseen 'lock down' or because of the restricted hours for research – an inevitable consequence of the prison regime. Two women could not be accessed because they were on visits when the researcher was present.

Seventy nine women refused to participate in the study and we were unable to collect data on them. A further 12 were too unwell to participate. There were no appropriate translations for 17 foreign nationals as, because of financial constraints, the study materials were translated into French and Spanish only.

Figure 3.1. summarises to initial recruitment phase.

3.1.2. Follow up at one and three months

All women still in prison were followed up one month (Time 2) and three months (Time 3) after being received into prison. Of the original 505 women, 256 were still in prison and of these 220 (86%) participated again. At 3 months (Time 3), 120 of those 256 were still imprisoned and 112 (93%) participated at this time.

At both Time 2 and Time 3, a small minority of women (8 women) who had earlier participated in the study refused to participate again. The majority of women who did not participate were unable to because the researcher could not access them during the study period. This was particularly so for women who had been transferred a long distance away from the original recruiting prison. Follow up of eligible women is summarised in Figures 3.2 and 3.3.

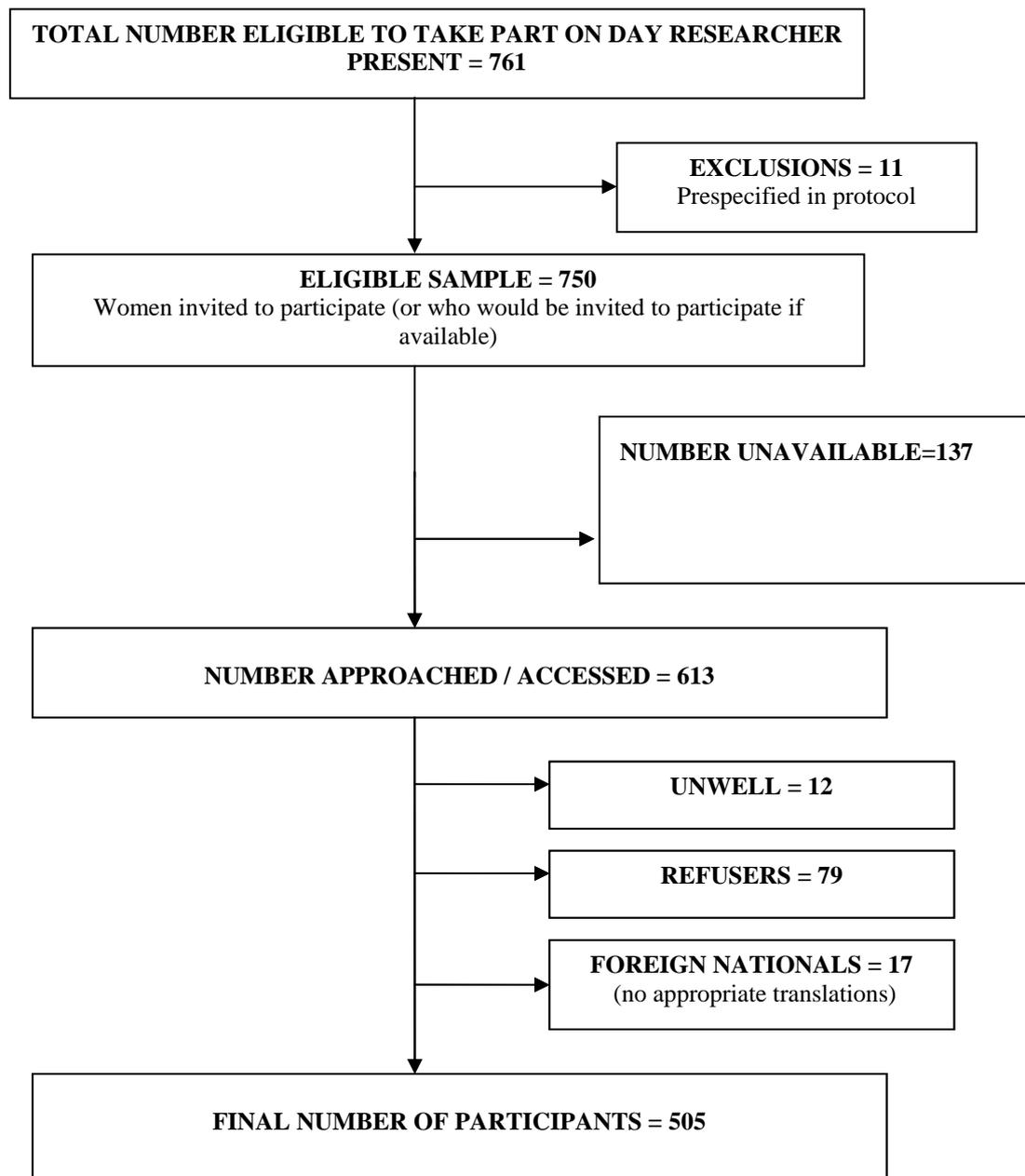
Figure 3.1. Recruitment of sample of 505 women prisoners.

Figure 3.2. Time 2 (one month) follow up

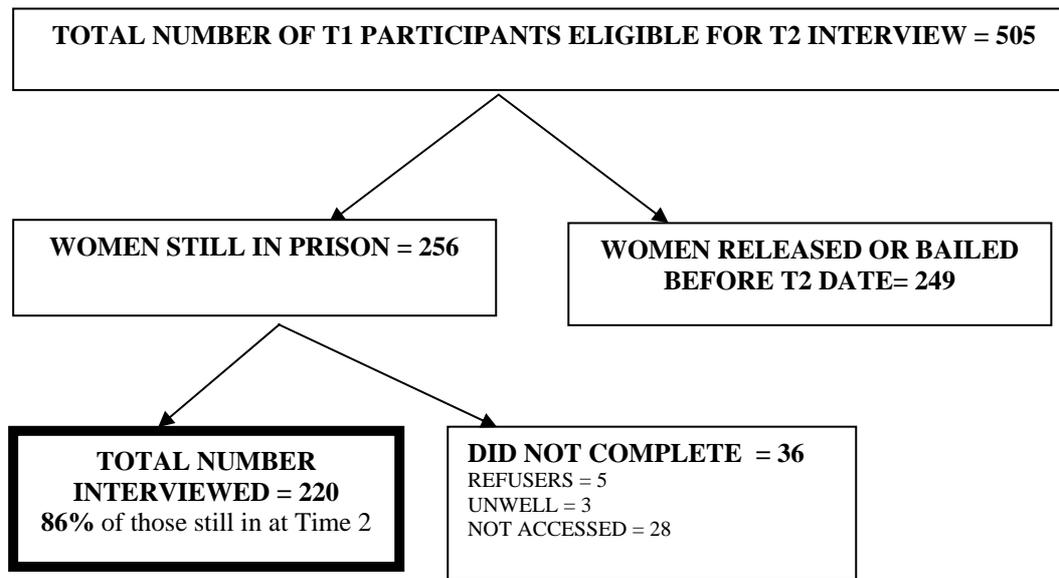
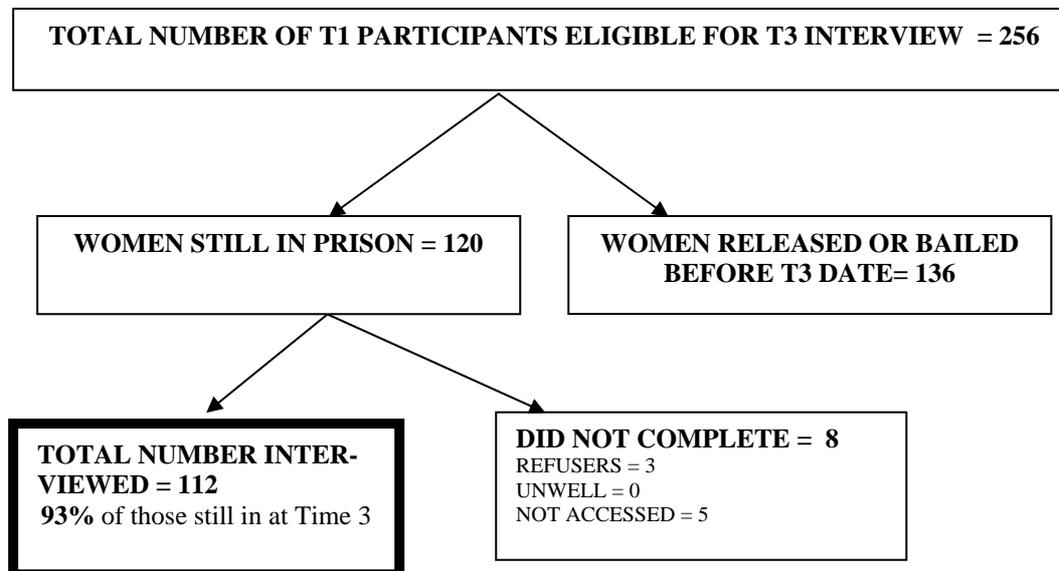


Figure 3.3. Time 3 (three month) follow up



3.2. Demographic information

3.2.1. The whole sample of 505 women

We asked the women to provide us with some general demographic data on themselves in the first questionnaire and this is presented in Table 3.1 below. The mean age of these women was 31.5 years. Almost 40% of them were sentenced and 60.4% were on remand. Further data on their sentence and prison history is given in Table 3.2. overleaf.

Table 3.1. Demographic information on all 505 women recruited into the study

	n	% of whole sample*
Born in the UK	410	83.3
Self reported ethnicity:		
⇒ White	355	72.6
⇒ Asian	12	2.5
⇒ Black	107	21.9
⇒ Other	15	3.1
Have spent 3 or more months outside the UK since the age of 16 years	94	19.0
Have resided for 3 or more months in:		
⇒ Northern Europe	38	7.7
⇒ Southern Europe	11	2.2
⇒ Africa	21	4.2
⇒ North America	11	2.2
⇒ West Indies	19	3.8
⇒ South America	9	1.8
⇒ Australia	3	0.6
⇒ Asia	11	2.2
Have at least one child	346	70.2
Marital status:		
⇒ married or living as married	176	35.8
⇒ divorced or separated	47	9.6
⇒ widowed	7	1.4
⇒ single	261	53.2
Age at leaving full time education		
⇒ 16 years or less	339	71.1
⇒ 17 or 18 years	108	22.6
⇒ 19 years or over	30	6.3
Employed before coming into prison	92	18.7

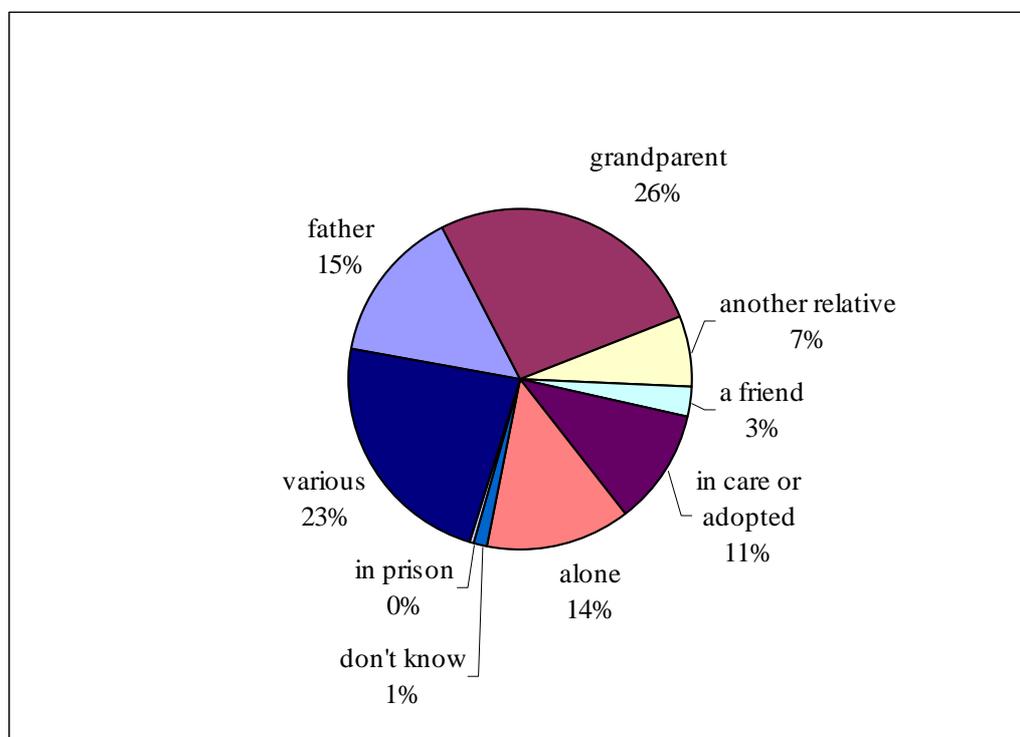
* Note: percentages based on number with complete data

Table 3.2. Information on current sentence and previous time in prison, whole sample, n=505

	Mean (95% CI)*	Range
If sentenced, length of sentence in weeks	26.5 (21.2 to 31.8)	2 days to 234 weeks
Time spent in prison in last 10 years in weeks	57.3 (48.3 to 66.4)	Less than 1 week to 400 weeks
Number of previous times in prison	3.6 (3.1 to 4.2)	0 to 45

* Note: percentages based on number with complete data

As highlighted in Table 3.1., over 70% of women have children. The figure below illustrates who then looks after these children when their mother is imprisoned. The ‘various’ category indicates that children of the same mother have been split up from their siblings and are being looked after by different people.

Figure 3.4. Pie chart showing who cares for children of imprisoned mothers immediately after their mother’s imprisonment, n=346

3.2.2. Comparison with whole population of women prisoners

The study was designed to recruit from two prisons in England. It is therefore important to determine how the study sample of 505 women compares to the whole female prison population and to comment on the generalisability of the findings. Table 3.3. summarises demographic information on the study sample and on all women prisoners. Data on all women prisoners was obtained from the Home Office published statistics on Women and the Criminal Justice System for 2003 (2).

Table 3.3. Demographic information for study sample and all women prisoners

	This sample % (95% CI)	All women prisoners (2) %
Self reported ethnicity: - white	72.6 (68.5 to 76.4)	71
Aged between 21 and 39 years old	70.9 (66.8 to 74.7)	69
Have at least one child under 18	42.2 (38.0 to 46.5)	56
Marital status: -married or living as married	35.8 (31.7 to 40.2)	25
Age at leaving full time education -16 years or less	71.1 (66.8 to 75.0)	74
Employed before coming into prison	18.7 (15.6 to 22.4)	29

3.2.3. Comparison with those women still in at one month and three months

The demographic characteristics of the sample changed over time as women were released back into the community. The demographics of the original sample and those interviewed at one month and three months is summarised in Table 3.4. overleaf. Those women still in at 3 months were more likely to have been born outside the UK, to describe their ethnicity as black, to be married, to have remained in education until they were at least 19 years old, and to have been employed before coming to prison. They were also likely to be older (mean age 33.5 years (95% CI 31.5 to 35.5) as opposed to 31.5 years (95% CI 30.7 to 32.3) for the whole sample).

Table 3.4. Demographic information for study samples

	Whole sample %* n=505	Sample interviewed at one month 'T2' %* n=220	Sample interviewed at three months 'T3' %* n=112
Born in the UK	83.3	78.1	70.4
Self reported ethnicity:			
-white	72.6	67.9	60.2
-Asian	2.5	2.8	4.6
-black	21.9	26.1	31.5
-other	3.1	3.3	3.7
Have at least one child	70.2	70.8	67.9
Marital status:			
-married or living as married	35.8	39.4	42.6
-divorced or separated	9.6	11.1	13.0
-widowed	1.4	1.9	1.9
-single	53.2	47.7	42.6
Age at leaving full time education			
-16 years or less	71.1	67.8	61.3
-17 or 18 years	22.6	26.5	29.2
-19 years or over	6.3	5.7	9.4
Employed before coming into prison	18.7	21.4	30.3
Have been in prison before	67.1	65.9	53.6

* Note: percentages based on number with complete data

Table 3.4. Demographic information for study samples

3.3. Subjective health status

3.3.1. Short form 36

As previously noted, the SF-36 measures subjective health status. The results in Table 3.5. highlight the very poor physical, psychological and social health of women in prison. Their health status is worse than that of women in social class V, the group within the general population who have the poorest health. The results detailed in Table 3.6. indicate that many domains of women's health apparently improve whilst in prison. In those women still in at 3 months, there is a statistically significant improvement in the mental component summary score but not the physical component summary score over the 3 months in prison. This suggests that while mental wellbeing improves, physical wellbeing does not. However, although improved, their subjective health remains poorer than the general population.

Table 3.5. Comparison of SF-36 dimension and summary scores for the study population and a population of women from social class V (or all women where indicated)

	Women Prisoners Mean n=467	Women Social Class V Mean n=167	Difference in the two means [95% confidence interval]	Significance
Physical functioning	71.8	83.8	12.0 [7.8 to 16.2]	<0.0001
Role physical	62.5	82.9	20.4 [14.5 to 26.3]	<0.0001
Role emotional	50.8	78.8	28.0 [21.7 to 34.3]	<0.0001
Social functioning	44.6	86.2	41.6 [37.3 to 45.9]	<0.0001
Mental health	43.0	69.4	26.4 [22.4 to 30.4]	<0.0001
Energy/vitality	39.0	56.9	17.9 [14.0 to 21.8]	<0.0001
Pain	51.3	78.9	27.6 [23.1 to 32.1]	<0.0001
General health perception	43.5	69.7	26.2 [22.0 to 30.4]	<0.0001
Mental Component Summary score	33.6	50.1 (all women)	15.3 [14.3 to 16.3]	<0.0001
Physical Component Summary score	41.7	49.7 9 (all women)	7.4 [6.4 to 8.4]	<0.0001

Table 3.6. Comparison of SF-36 dimension and summary scores at Time 1 and Time 3 for Women Prisoners still

	Women still in prison at three months, n=92		Difference in the two means [95% confidence interval]	Significance
	Time 1 Mean	Time 2 Mean		
Physical functioning	72.6	80.6	8.0 [2.0 to 13.0]	0.002
Role physical	69.9	74.9	5.0 [-1.5 to 11.5]	0.127
Role emotional	56.1	64.6	8.6 [1.8 to 15.4]	0.014
Social functioning	49.1	58.7	9.6 [2.8 to 16.4]	0.006
Mental health	45.6	51.6	6.0 [1.6 to 10.4]	0.008
Energy/vitality	42.0	48.1	6.1 [0.7 to 11.4]	0.027
Pain	58.0	63.4	5.5 [-1.0 to 11.9]	0.098
General health perception	49.8	58.2	8.4 [3.5 to 13.2]	0.001
Mental Component Summary score	35.5	40.1	4.6 [1.7 to 7.5]	0.002
Physical Component Summary score	44.3	46.3	1.9 [-0.6 to 4.4]	0.131

When we analysed the changes in mental component summary score (mcs) and physical component summary score (pcs) over the three month period according to whether women were drug users on the outside or not, we found that significant improvements in mental and physical well-being were found in the drug using group only.

Table 3.7. Comparison of SF-36 summary scores at Time 1 and Time 3 for Women Prisoners still in at three months (Time 3) – drug users and non drug users

		Time 1 Mean	Time 3 Mean	Difference in the two means [95% confidence interval]	Significance
Drug use in community n=50	Mental Component Summary score	32.5	38.8	6.3 [2.3 to 10.2]	0.002
	Physical Component Summary score	41.9	45.7	3.7 [0.3 to 7.1]	0.03
No drug use in community n=41	Mental Component Summary score	39.1	41.8	2.8 [-1.6 to 7.2]	0.213
	Physical Component Summary score	47.7	47.4	-0.3 [-4.1 to 3.6]	0.891

3.3.2. The 12 Item General Health Questionnaire

The GHQ 12 examines psychological well-being, and is used to divide subjects into ‘cases’, that is those with some level of psychological disturbance, and those who are not cases. The women’s responses were scored using the standard method (14) and those scoring 4 or above were classified as ‘cases’. At Time 1, 77.7% (95% CI 73.7 to 81.3) of women could be classified as cases. This indicates much higher levels of psychological disturbance than in the general population. The data in Table 3.8 compares the GHQ12 scores of women on reception into prison with those of adult women of all ages using data from the Health Survey for England 2003 (28). Whereas 15% of the adult female population score 4 or more, 78% of women on reception into prison scored 4 or more. However, the data does suggest that the proportion of women who are cases declines with time spent in prison and this is in accordance with the SF 36 results which show an improvement in mental wellbeing over time. However, 54% women still in at Time 3 remain ‘cases’ and thus although mental wellbeing of this population appears to improve over 3 months it does not return to a level comparable with the general population.

Table 3.8. Comparison of GHQ 12 scores: women prisoners and the general population of women.

GHQ 12 score	Women prisoners on reception into prison n=505 %	Women aged 16 years and over (Health Survey for England '03) n=7144 %
Score 0	5	60
Score 1-3	17	25
Score 4+	78	15

Table 3.9. Changes in GHQ 12 scores after three months in prison

	Proportion of cases* n=112		Difference [95% confidence interval]	Significance
	Time 1	Time 3		
GHQ 12 with standard scoring and a 4/5 cut off	70.5%	54.5%	16.1 [5.4 to 26.2]	0.009

* Note: percentage based on number with complete data

Women prisoners compared to the general population - GHQ 12

78% of women on reception into prison show some level of psychological disturbance as measured by the GHQ 12

54% of women prisoners show some level of psychological disturbance 3 months after imprisonment

15% of the general adult female population show some level of psychological disturbance (28)

3.4. Health related behaviours

3.4.1. Smoking and alcohol

When women were first interviewed they were asked about their smoking habits and alcohol consumption before they came into prison. Over 85% were smokers, compared to a national average for women of 24% (28). The mean age at which they had started smoking was 14.4 years (95% CI 13.9 to 14.9 years). On average they smoked 20.4g tobacco each day (95% CI 18.1 to 22.6), equivalent to 27 cigarettes.

Only 316 women (63.1%) drank alcohol before coming into prison. However, the great majority of these women (68.7%) drank more than the recommended 3 units of alcohol each day and the mean weekly intake was 16.8 units (95% CI 14.5 to 19.2).

Table 3.10. Smoking habits and alcohol consumption prior to imprisonment

Smoking and alcohol consumption prior to imprisonment	n (%)*
Smoking prior to imprisonment	428 (85.3%)
Drinking alcohol before coming into prison	316 (63.1%)
Of those drinking alcohol, those exceeding the Government guidelines of a maximum of 3 units per day	217 (42.2%)

* Note: percentages based on number with complete data

Women prisoners compared to the general population - SMOKING

85% of women prisoners smoke
23% of the general adult female population smoke (29)

Women prisoners compared to the general population - ALCOHOL

42% of women prisoners drank alcohol in excess of Government guidelines prior to imprisonment
22% of the general adult female population exceed these guidelines (29)

Although the proportion of women smoking during their time in prison did not change, the amount of tobacco they smoked decreased significantly. For those still in at one month, the mean amount of tobacco smoked each decreased from 19.9g to 11.7g at one month and this was significant, $p < 0.000$. For those still in at three months, the mean amount of tobacco smoked each decreased from 17.7g to 13.4g and this was also significant, $p < 0.000$.

The number of women drinking alcohol declined. It was not possible to calculate whether the few women who still accessed alcohol were consuming less; the questionnaire asked for *daily* alcohol intake and none of those women drank on a daily basis.

Table 3.11. Changes in smoking and alcohol consumption in the first month following imprisonment

	Time 1		Time 2		Difference % [95% confidence interval]	Significance p=
	n	% *	n	% *		
Women who smoke	173	81.19	175	80.28	0.92 [-1.63 to 3.53]	0.69
Women who drink alcohol	140	64.8	5	2.3	62.50 [55.32 to 68.68]	0.000

* Note: percentages based on number with complete data

3.4.2. Illicit drug use

Over three quarters of women coming into prison had used illicit drugs in the previous 6 months and 269 women (58%) had used drugs daily in this period. Crack cocaine, heroin, cannabis and benzodiazepines were the most widely used drugs (Tables 3.12. and 3.13.). Crack and heroin were the two drugs most likely to be used daily by 44.6% and 45.9% of this population respectively.

Table 3.12. Illicit drug use in the 6 months prior to imprisonment

Drug use	n (%)*
Have used drugs in the 6 months before coming into prison	348 (75.3)
Have used drugs daily in 6 months before prison	269 (58.0)
Have used the following drugs in the 6 months before prison	
Amphetamines	81 (16.6)
Barbiturates	164 (33.9)
Benzodiazepines	245 (49.8)
Cannabis	257 (52.0)
Cocaine	142 (29.2)
Crack	295 (59.5)
Ecstasy	63 (12.8)
Hallucinogens	21 (4.3)
Heroin	259 (52.2)
Other opiates	208 (42.1)

* Note: percentages based on number with complete data

Women prisoners compared to the general population – ILLICIT DRUG USE

75% of women prisoners had taken an illicit drug in the 6 months prior to imprisonment
12% of the general population had taken an illicit drug in the last 12 months (30)

Table 3.13. Daily drug use in the 6 months prior to imprisonment

Daily drug use	n (%)*
Of those using drugs, those women who have used the following drugs daily in the 6 months before prison	
Amphetamines	21 (4.3)
Barbiturates	83 (17.4)
Benzodiazepines	181 (37.6)
Cannabis	117 (24.4)
Cocaine	48 (10.2)
Crack	213 (44.6)
Ecstasy	5 (1.0)
Hallucinogens	1 (0.2)
Heroin	221 (45.9)
Other opiates	127 (26.6)

* Note: percentages based on number with complete data. Percentage is percentage of whole sample, not just drug users.

The pattern of drug use changed once women were imprisoned, with significantly fewer women using illegal drugs, in particular crack and heroin. However, 25% of women still in at one month said that they had taken an illegal drug since coming in to prison although only 3 out of the 220 women stated they had taken an illegal drug daily.

Table 3.14. Changes in drug use in the first month following imprisonment

	Time 1		Time 2		Difference % [95% confidence interval]	Significance
	n	% *	n	% *		
Taking any illegal drugs	129	67.5	48	25.1	42.4 [34.2 to 49.6]	0.000
Taking amphetamines	28	13.7	4	2.0	11.8 [6.6 to 17.4]	0.000
Taking barbiturates	67	33.2	38	18.8	13.3 [7.6 to 21.0]	0.000
Taking benzodiazepines	96	46.6	68	33.0	13.6 7.7 to 19.3]	0.000
Taking cannabis	95	45.7	19	9.1	36.54 [28.8 to 43.8]	0.000
Taking cocaine	52	25.7	4	2.0	23.8 17.8 to 30.2]	0.000
Taking crack	114	54.8	18	8.7	46.2 [38.9 to 52.8]	0.000
Taking ecstasy	21	10.2	1	0.5	9.7 [5.6 to 14.6]	0.000
Taking hallucinogens	6	2.9	3	1.5	1.5 [-1.7 to 4.9]	0.51
Taking heroin	96	46.2	22	10.6	35.6 [28.9 to 42.0]	0.000
Taking other opiates	78	37.9	51	24.8	13.1 [7.5 to 18.7]	0.000

* Note: percentages based on number with complete data

One hundred and ninety one women (38%) reported that they had ever injected drugs, and of those, 107 (56% of those who had ever injected) had done so within the month prior to coming into prison. The mean age when they first injected was 22.9 years (range 12 to 45 years). Only 37 women (20.6% of those who had ever injected) had ever sought treatment for their drug use. Many injectors (30.3%) had exchanged injecting equipment in the previous month whilst less than half of them (47.4%) had attempted to clean them. Thirteen women reported injecting in prison at some time in the past and all reported exchanging injecting equipment in this setting. Of note, none of the 13 women reported that they had first injected in prison. These findings are summarised in Table 3.15.

Table 3.15. Injecting drug use in the 6 months prior to imprisonment

Injecting drug use	n (% of injectors)*
Of those who had ever injected drugs, the last time they injected before coming into prison was:	
-on the day they came into prison	46 (24.3)
-in the week before	53 (28.0)
-less than 4 weeks before	8 (4.2)
-between 4 & 8 weeks before	12 (6.3)
-more than 8 weeks before	70 (37.0)
Exchanged injecting equipment in previous 4 weeks	57 (30.3)
Cleaned injecting equipment:	
Always	27 (47.4)
Sometimes	6 (10.5)
Never	24 (42.1)
Have sought help or treatment for drug use	37 (20.6)
Have injected drugs in prison	13 (6.9)
First injected in prison	0

* Note: percentages based on number with complete data

After one month in prison, 43 women who had previously injected remained in prison and of these 4 said they had injected in prison during that month but had not exchanged injecting equipment. At three months 25 women who had previously injected remained in prison but none had injected whilst in prison.

3.4.3. Sexual behaviour

Women were asked about aspects of their sexual behaviour in the year prior to coming into prison. The findings are summarised in Table 3.16. The majority of women had had 2 partners at most in the past 12 months. A small but significant minority of 58 women (11.8%) had had 10 partners or more. Of concern, 189 women (48.2% of those having sex with men) reported they never used a condom.

Seventy four women (15.7%) had had sex with a woman in the past 12 months. The majority of these women had only had one partner.

One hundred and thirty one women (26.8%) had been paid money, goods or drugs for sex at some time and a similar proportion had been treated for a sexually transmitted infection.

Table 3.16. Sexual behaviour in the 6 months prior to imprisonment

Sexual behaviour	n (%)*
Number of male sexual partners in the 12 months prior to coming into prison	
None	96 (19.5)
One	220 (44.7)
Two	71 (14.4)
3 to 9	47 (9.6)
10 or more	58 (11.8)
Of those having sex with men, those women who had used condoms	
Always	97 (24.8)
Sometimes	106 (27.0)
Never	189 (48.2)
Number of female sexual partners in the 12 months prior to coming into prison	
None	397 (84.3)
One	42 (8.9)
Two	22 (4.7)
3 to 9	7 (1.5)
10 or more	3 (0.6)
Of those having sex with women, those practising safe sex	
Always	10 (14.1)
Sometimes	7 (9.9)
Never	54 (76.1)
Have paid for sex	16 (3.3)
Have been paid for sex	131 (26.8)
Have been treated for a sexually transmitted infection (STI)	131 (26.8)

* Note: percentages based on number with complete data

Following the first month of imprisonment, there appeared to be changes in the women's sexual behaviour. Fewer women were sexually active. However, 18 women said they had sex with a man in the past month and 25 had had sex with a woman. Safe sex was not widely practised in prison with only one woman stating she had used a condom. Women continued to exchange sex for goods, money or drugs; four women said they had been paid for sex in the past month and one woman said she had paid for sex. Of the 220 women still imprisoned after one month, 46 had been diagnosed with an STI prior to coming into prison and a further five were diagnosed and treated for one in the first month.

Women prisoners compared to the general population – SEXUAL BEHAVIOUR

36% of women prisoners had more than one sexual partner in the year prior to imprisonment
10% of women aged 16-49 years had more than one sexual partner in the past year (31)

3.4.4. Physical exercise and diet

Women were asked about how much exercise they took and what their diet was like prior to imprisonment. The findings (Table 3.17) revealed low levels of physical activity with only 64 women (13.3%) meeting the Government guidelines on exercise - adults should take part in 30 minutes or more of moderate activity, at least five times a week.

Table 3.17. Exercise patterns prior to imprisonment

Exercise	n (%)
Frequency of undertaking vigorous sport or other activities	
Never/less than once per week	328 (66.9)
More than once a month but less once a week	41 (8.4)
1-2 times a week	52 (10.6)
3-4 times a week	24 (4.9)
5 or more times a week	45 (9.2)
Frequency of undertaking any sport or other activities that lasted for 30 minutes or more	
Never/less than once per week	314 (64.5)
More than once a month but less once a week	44 (9.0)
1-2 times a week	47 (9.7)
3-4 times a week	18 (3.7)
5 or more times a week	64 (13.1)

* Note: percentages based on number with complete data

Comparison of self reported exercise prior to imprisonment and in the month following imprisonment indicates that there are no significant changes in exercise patterns and women remain rather sedentary. The proportion of women meeting the national recommendations for exercise (30 minutes or more of moderate activity, at least five times a week) before imprisonment does not differ significantly from that one month after imprisonment (14.1% v 11.1%, difference =3.0% (-3.4 to 9.4) p=0.43).

Table 3.18. Changes in exercise patterns in the month following imprisonment

	Time 1		Time 2		Significance p=
	n	%	n	%	
Undertaking vigorous sport or other activities:					0.85
Never/less than once per week	125	61.6	119	58.6	
More than once a month, less once/week	20	9.9	30	14.8	
1-2 times a week	28	13.8	28	13.8	
3-4 times a week	10	4.9	11	5.4	
5 or more times a week	20	9.9	15	7.4	
Undertaking any sport or other activities that lasted for 30 minutes or more:					0.15
Never/less than once per week	121	60.8	105	52.8	
More than once a month, less once/week	21	10.6	29	14.6	
1-2 times a week	21	10.6	34	17.1	
3-4 times a week	8	4.0	9	4.5	
5 or more times a week	28	14.1	22	11.1	

* Note: percentages based on number with complete data

The diet of these women tended to be poor and the details are contained in Table 3.19. Only 63 women (12.7%) met the national recommendations for fruit and vegetable consumption, that adults should eat at least 5 pieces of fruit or vegetables each day. Only 22% of those eating bread ate wholemeal bread and only 41% of those drinking milk drank skimmed or semi-skimmed.

Table 3.19. Aspects of dietary intake prior to imprisonment

Diet prior to imprisonment	n	%
The frequency of consuming the following foods:		
Biscuits, cakes, sweets, chocolates		
Never	57	11.6
less than once a week	69	14.0
1-3 days a week	128	26.0
4-7 days a week	238	48.4
Fish		
Never	146	29.9
less than once a week	116	23.7
1-3 days a week	174	35.6
4-7 days a week	53	10.8
Poultry		
Never	66	13.5
less than once a week	85	17.4
1-3 days a week	222	45.4
4-7 days a week	116	23.7
Processed meats		
Never	107	22.2
less than once a week	119	24.7
1-3 days a week	170	35.3
4-7 days a week	86	17.8
Red meat		
Never	112	23.3
less than once a week	131	27.1
1-3 days a week	164	34.0
4-7 days a week	76	15.7
Chips		
Never	57	11.9
less than once a week	136	28.3
1-3 days a week	171	35.6
4-7 days a week	117	24.3
Pulses		
Never	126	26.1
less than once a week	95	19.7
1-3 days a week	164	34.0
4-7 days a week	97	20.1

* Note: percentages based on number with complete data

There were few dietary changes following imprisonment. Women were less likely to eat red meat or poultry and more likely to drink skimmed or semi-skimmed milk instead of full fat. After one month in prison, fewer women are eating the recommended 5 portions of fruit or vegetables each day (29 v 18). However this was not a statistically significant change, probably because of the small numbers.

Table 3.20. Changes in diet in the month following imprisonment

	Time 1		Time 2		Significance p=
	n	%	n	%	
Eating biscuits, cakes, sweets or chocolates					0.15
Never	25	11.7	21	9.9	
Less than once per week	32	15.0	39	18.3	
1-3 days per week	65	30.5	71	33.3	
4-7 days per week	91	42.7	82	38.5	
Eating fish					0.40
Never	60	28.4	50	23.7	
Less than once a week	44	20.9	65	30.8	
1-3 days per week	79	37.4	84	39.8	
4-7 days per week	28	13.3	12	5.7	
Eating poultry					0.000
Never	32	15.8	39	19.2	
Less than once a week	33	16.3	46	22.7	
1-3 days per week	87	42.9	104	51.2	
4-7 days per week	51	25.1	14	6.9	
Eating processed meats					0.15
Never	51	25.0	54	26.5	
Less than once a week	49	24.0	49	24.0	
1-3 days per week	74	36.3	82	40.2	
4-7 days per week	30	14.7	19	9.3	
Eating red meat					0.009
Never	56	27.6	74	36.5	
Less than once a week	58	28.6	62	30.5	
1-3 days per week	63	31.0	57	28.1	
4-7 days per week	26	12.8	10	4.9	
Eating chips					0.61
Never	25	12.2	42	20.5	
Less than once a week	51	24.9	35	17.1	
1-3 days per week	85	36.3	73	35.6	
4-7 days per week	44	14.7	55	26.8	
Eating pulses					0.39
Never	54	26.6	51	25.1	
Less than once a week	36	17.7	45	22.2	
1-3 days per week	73	36.0	66	32.5	
4-7 days per week	40	19.7	41	20.2	
Portions of fruit or vegetables eaten each day					0.79
Less than one	66	30.6	37	17.1	
1-2	78	36.1	132	61.1	
3-4	43	19.9	29	13.4	
5 or more	29	13.4	18	8.3	
Type of bread eaten:					0.79
Wholemeal	54	24.8	54	25.0	
Other brown bread	31	14.2	47	21.8	
White bread	106	48.6	94	43.5	
Other e.g. pitta, naan	9	4.1	0	0	
None	18	8.3	21	9.7	
Type of milk drunk:					0.000
Full cream	107	49.5	28	13.1	
Semi skimmed	71	32.9	96	45.1	
Skimmed	16	7.4	24	11.3	
Other	7	3.2	49	23.0	
None	15	6.9	16	7.5	

Note: percentages based on number with complete data

Women prisoners compared to the general population - EXERCISE

13% of women prisoners meet the Government guidelines on physical activity prior to imprisonment

11% of women prisoners meet these guidelines on physical activity one month after imprisonment

25% of the general adult female population meet these guidelines (32)

Women prisoners compared to the general population – DIET

13% of women prisoners meet the Government guidelines on fruit and vegetable consumption

8% of women prisoners meet these guidelines one month after imprisonment

27% of the general adult female population meet these guidelines (32)

3.4.5. Self -harm

Eighty three women said they had deliberately harmed themselves but without the intention of killing themselves in the month prior to coming into prison. The majority (78.3%) had done so to relieve feelings of anger, tension, anxiety or depression rather than attention seeking. The most common means of self harming was by cutting (59.0%).

Table 3.21. Self harm in the month prior to imprisonment

	n	%*
Self harming in month prior to prison	83	16.4
Of those self-harming		
Means of self-harm:		
Cutting	49	59.0
Burning	12	14.5
Swallowing objects	17	20.5
Ligature tying	12	14.5
Other (not specified)	35	42.2
Reason for the self-harm:		
To draw attention to or change their situation	24	28.9
To relieve feelings of anger, tension, anxiety or depression	65	78.3
Received medical attention whilst in prison for self-harming	27	32.5
Have seen a psychiatrist, psychologist or counsellor in prison because of self-harm	26	31.1

* Note: percentages based on number with complete data

In the month following imprisonment, fewer women said they had harmed themselves compared to the month prior to imprisonment (23 (10.6%) v 35 (16.1%)). However this did not reach statistical significance ($p=0.43$), probably because of the small numbers involved.

Women prisoners compared to the general population – SELF HARM

16% of women prisoners self-harmed in the MONTH prior to imprisonment

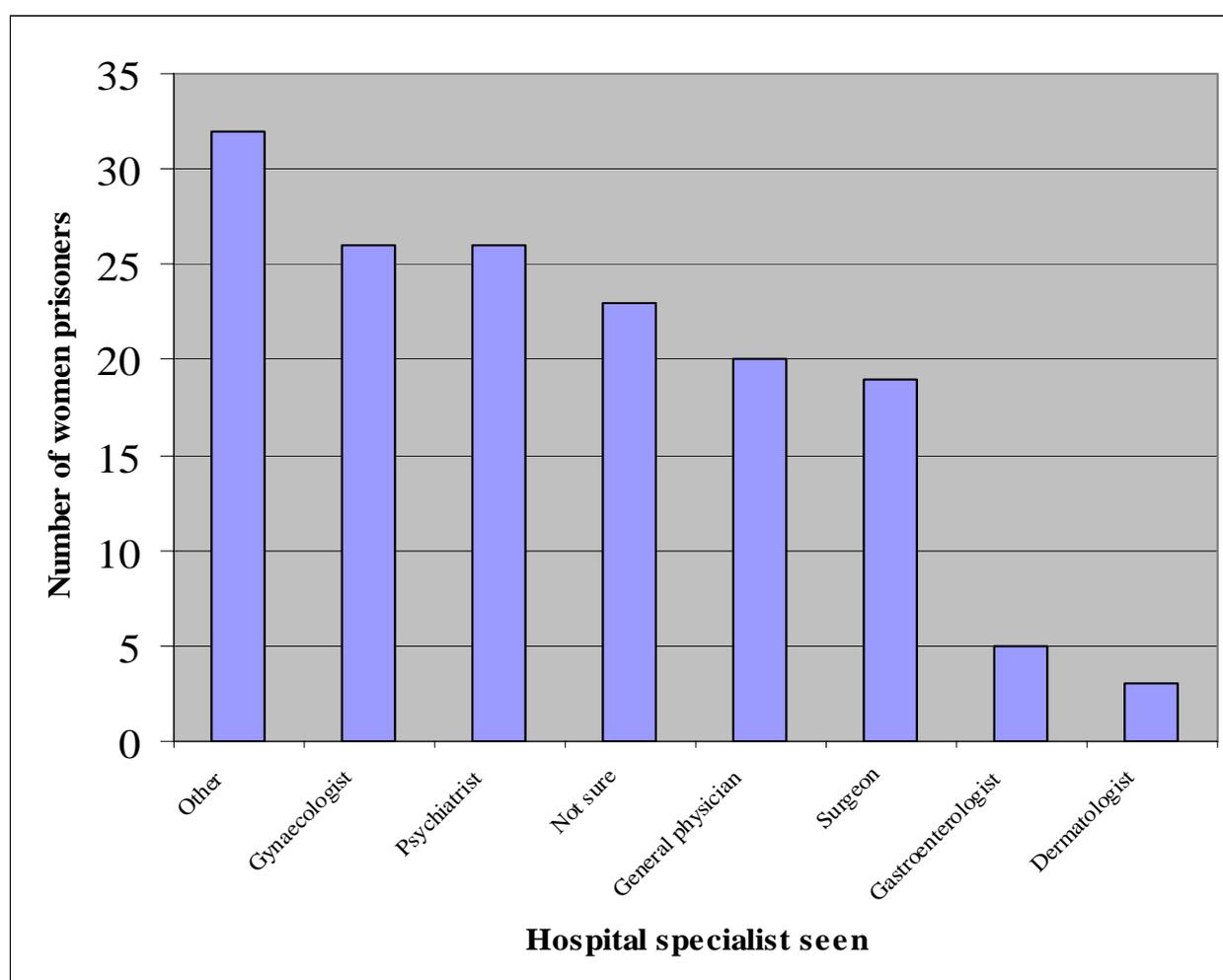
Little is known about the prevalence of self-harm in the general population, but the highest rates are seen in adolescent females; in this group 11% have self harmed in the past YEAR (33)

3.5. Health Service use

3.5.1. Community and hospital services

Women were asked a number of questions about their use of health services in the three months before they came into prison. Only 377 women (76.2%) were registered with a general practitioner (GP) and had on average visited the GP 2.4 times (standard deviation 2.9, range 0 to 24) in the three months prior to imprisonment. In the same time period, 157 women (33.1%) had visited the Accident and Emergency Department of a hospital (on average 0.7 times) and 94 (20.0%) had visited Outpatients. In all, 181 women (39.2%) had visited either outpatients or A&E. Most visits to outpatients were to see either a gynaecologist (26 women) or a psychiatrist (26 women). Figure 3.5 details the specialist seen. Women were also using other community health services in addition to the GP, most notably drug and alcohol services. Two hundred and seventy women (53.5%) had been in contact with such services at some time in their life.

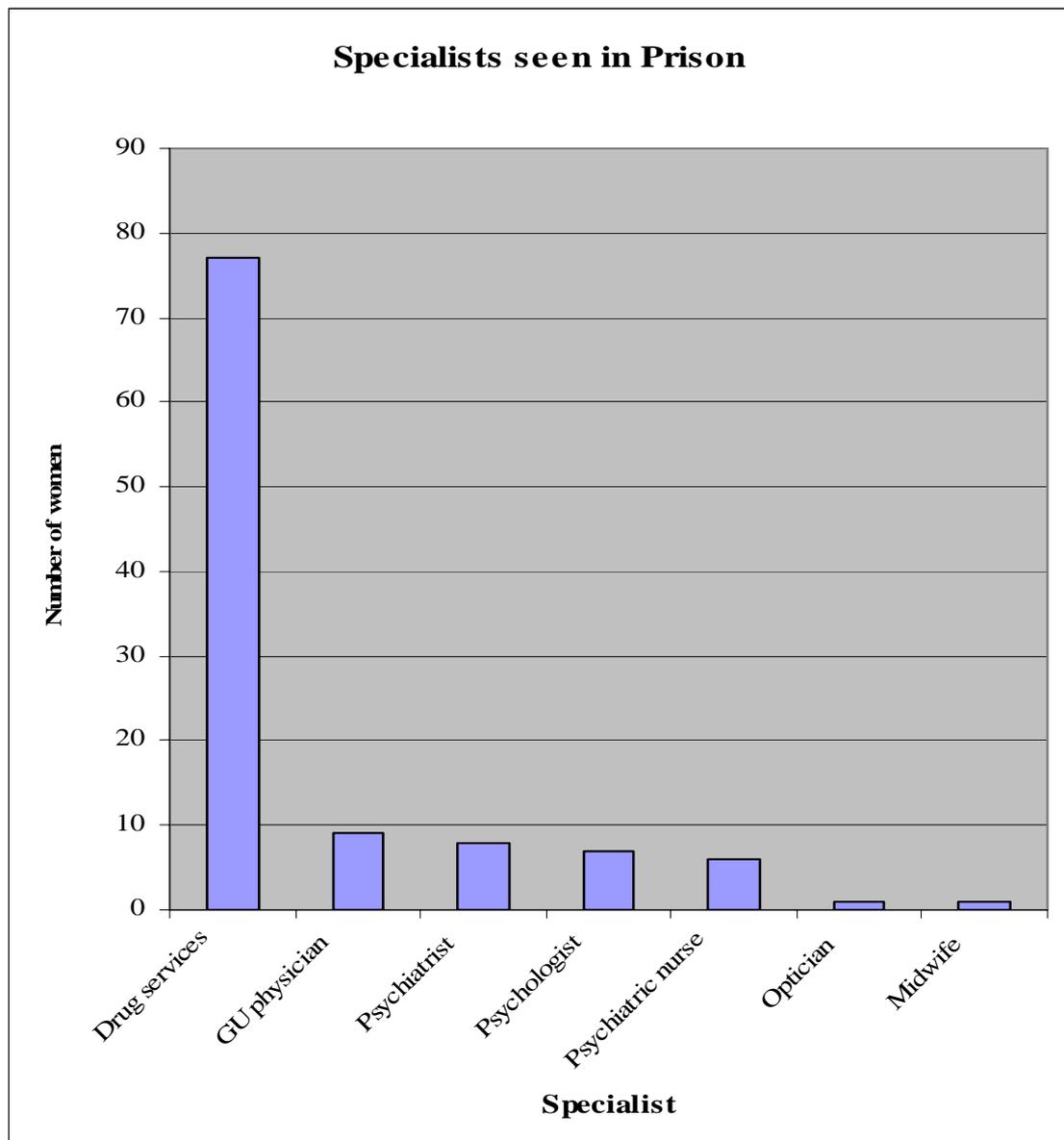
Figure 3.5 Outpatient visits to hospital in 3 months prior to imprisonment



N.B. some women saw more than one specialist

Women who were still in prison at one month were asked what specialist health services they had accessed within the prison since coming in. Out of 220 women, 77 had accessed drug services (the CARATS Team). Women had also used psychiatric and/or psychological services, and attended the genito-urinary clinics.

Figure 3.6 Specialist health services accessed within the prison during first month of imprisonment



For those who remained in prison at three months, there were differences in the use of health services in the three months before prison and the three months following imprisonment. Women were more likely to be registered with a GP and to be in contact with drug treatment services, and less likely to have visited A&E, stayed overnight in hospital or visited outpatients.

	Time 1		Time 3		Significance p=
	n	%*	n	%*	
Registered with GP	82	74.5	110	100	0.00
Visited the Accident & Emergency Department	37	33.0	13	11.6	0.00
Visited outpatients	29	25.9	16	14.3	0.04
Stayed overnight in hospital	40	35.7	16	14.3	0.00
In contact with drug or alcohol services	10	9.3	51	47.2	0.00

*Note: percentages based on number with complete data

Table 3.22. Changes in use of hospital & community health services in the three months prior to imprisonment compared to the three months after

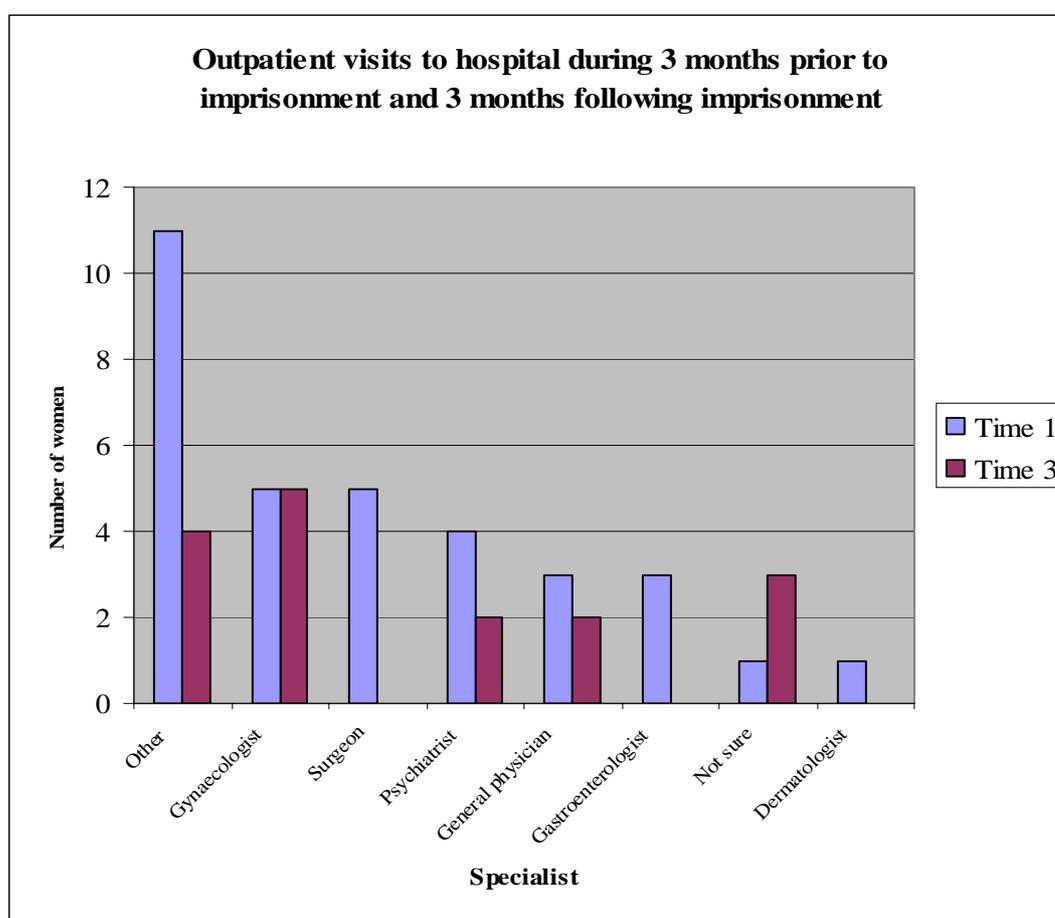


Figure 3.7. Outpatient visits to hospital in 3 months prior to imprisonment

Women prisoners compared to the general population – HOSPITAL USE

39% of women prisoners had visited outpatients or A&E in the 3 months prior to imprisonment

19% of women prisoners had visited outpatients or A&E in the 3 months following imprisonment

15% of the general female population had visited these hospital departments in this time period (29)

3.5.2. Update of preventive services

3.5.2.1. Blood borne viruses: testing and vaccination

Women were asked whether they had been tested for HIV, Hepatitis B and Hepatitis C, and whether they had been vaccinated against Hepatitis B before coming into prison this time. The majority of women had been tested before; 293 (59.2%) for HIV and 248 (50.6%) for Hepatitis B, although only 228 women (46.8%) could remember being tested for Hepatitis C. Two hundred and forty eight women (20.6%) had had at least one injection for Hepatitis B. Women who were drug users or those who had been in prison before were more likely to have been tested for these blood borne viruses and vaccinated against Hepatitis B. Women who were registered with a GP in the community were no more likely to have been tested than those who were not. Those who had been in contact with drug or alcohol services in the community were more likely to have been vaccinated against Hepatitis B and tested for Hepatitis B and C, but not HIV. Age did not affect testing or vaccination status.

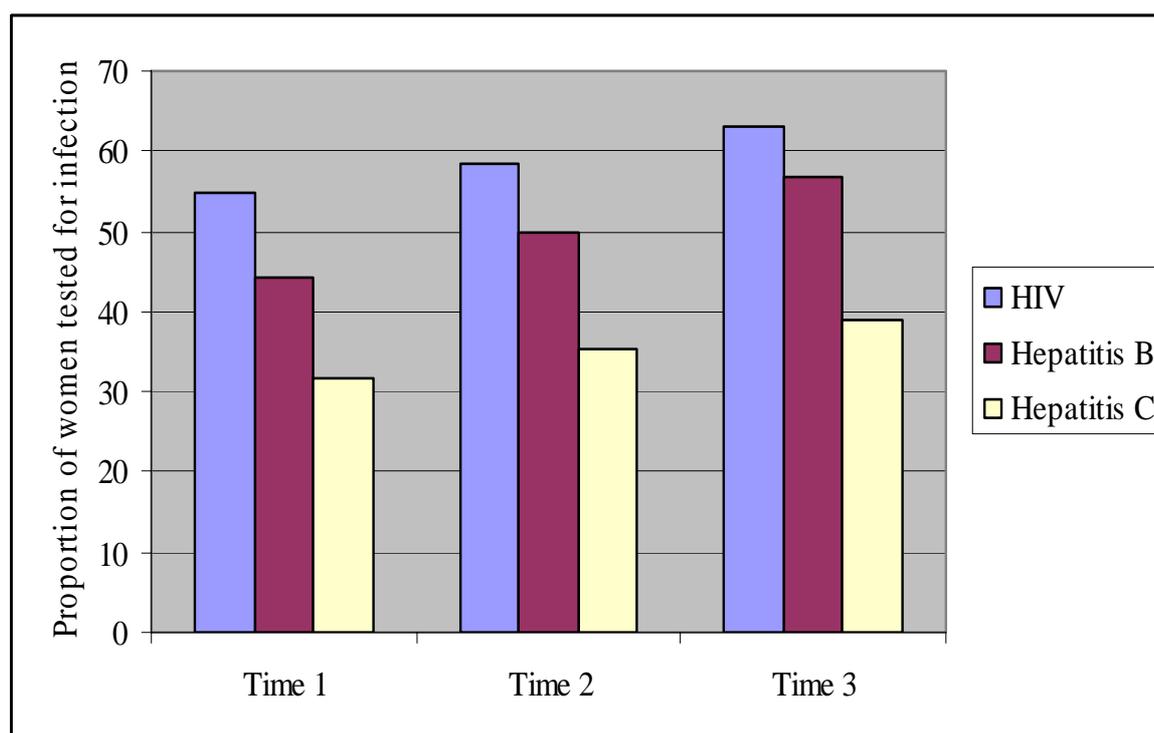
Table 3.23. Testing for HIV, Hepatitis B and Hepatitis C and for vaccination against Hepatitis B prior to imprisonment by drug use in the six months prior to imprisonment, previous experience of prison and registration with GP in the community.

	Drug use in the 6 months prior to imprisonment			Previous experience of prison			Registration with GP prior to imprisonment		
	% Drug users* n=345	% Non drug users* n=111	p=	% of those in prison before* n=330	% of those in prison for first time* n=165	p=	% of those registered with a GP* n=375	% of those not registered with a GP* n=117	p=
Tested for HIV	64.3	41.4	0.000	67.0	43.6	0.000	64.1	57.9	0.28
Tested for Hepatitis B	54.9	24.8	0.000	62.1	27.6	0.000	52.1	50.1	0.79
Tested for Hepatitis C	46.3	13.0	0.000	49.4	17.9	0.000	41.4	38.0	0.59
Vaccinated against Hepatitis B	54.9	24.8	0.000	59.9	20.9	0.000	53.8	44.4	0.09

*Note: percentages based on number with complete data

Given that those who had been imprisoned before were more likely to have been tested and to have received at least one vaccination against hepatitis B, it is not surprising that the proportion of women tested increased over time. These findings are detailed in Figure 3.8. Forty six women (54.8%) of those still in at three months had been tested for HIV prior to this imprisonment and a further seven were tested for HIV. A further 11 women were tested for Hepatitis B and six for Hepatitis C. Thirty five women (31.3%) of those still in at three months had had at least one vaccination against Hepatitis B prior to this imprisonment and a further 21 received at least one vaccination over the three month period in prison.

Figure 3.8. Changes in testing status for HIV, Hepatitis B and Hepatitis C over during 3 months imprisonment



3.5.2.2. Routine screening

Cervical screening

During the study there were major policy changes in the age and frequency of screening for cervical cancer (34). Currently all women between the ages of 25 and 49 should be screened every three years and those aged 50 to 64 years every five years. However the questions in the questionnaire were based on the previous recommendations that all women aged 21 to 64 years should be screened every 5 years. The results therefore look at a five year interval rather than the 3 year interval which is now considered appropriate for women. There were 362 women who were aged 25 years or more and who therefore were eligible for screening. Of these, 313 (88.2%) had been screened for cervical cancer at some stage and 216 (68.0%) had had a test in the last 5 years. This compares poorly with the national average of 80.3% (34). Cervical screening was being undertaken in prison. However of the 86 eligible women still in at three months, 23 (26.7%) had not had a smear in the last five years and during the three months of imprisonment, only three of these actually received tests.

Women prisoners compared to the general population – CERVICAL SCREENING

68% of women prisoners had been screened for cervical cancer in the last 5 years

80% of the general female population have been screened in the last 5 years (34)

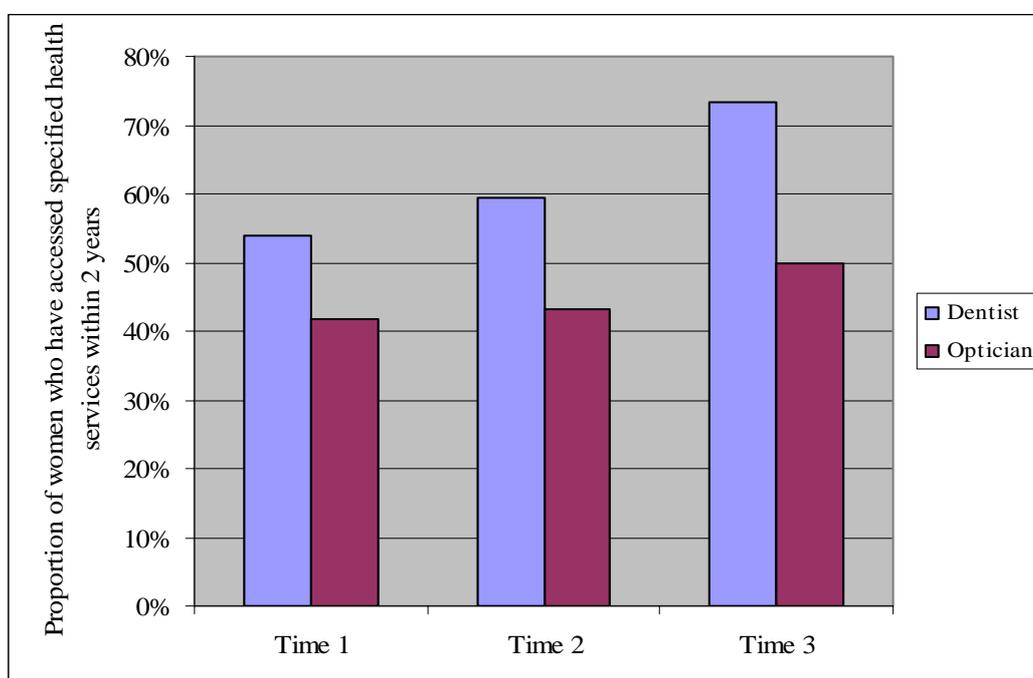
Breast screening

Only 21 women were aged 50 years or more and were therefore eligible for breast screening by mammography. Only 10 of these women had ever had a mammogram, and 7 of these women were still in at 3 months. None had had a mammogram during these 3 months of imprisonment.

Dental & optical visits

National guidelines recommend that adults visit the dentist and the optician at least every 2 years (35;36). Four hundred and forty three women (90.2%) had seen a dentist at some stage but only 246 (50.1%) had visited the dentist in the last 2 years and whilst 373 women (76.1%) had seen an optician at some stage, only 165 (46.2%) had visited in the last 2 years. Women were able to access these services whilst in prison. There was a significant increase in the proportion of women who had seen a dentist within 2 years after 3 months in prison (54.7% at Time 1 v 73.3% at Time 3, $p=0.000$); the increase for those visiting the optician did not reach statistical significance (43.2% v 50.0%, $p=0.06$).

Figure 3.9. Changes in access to dental and optical services during 3 months of imprisonment



3.5.3. Women's health issues

Pregnancy

Of the sample of 505 women, 28 (5.6%) were pregnant on reception into prison. The mean gestational age was 13.9 weeks (standard deviation 7.8, range 4 to 33 weeks). Twelve of these women were in the second or third trimester of pregnancy but only 5 (41.7%) had registered with a midwife ('booked') in the community before coming into prison. At three months, 7 pregnant women remained in prison.

Periods

Two hundred and fifty eight women in the study (52.2%) said that they had problems with their periods. The main problems were that their periods had stopped (103 women) or that they were irregular (103 women). Women who had used drugs before coming into prison were significantly more likely to have problems with their periods than those who did not (57.2% v 32.5%, $p=0.000$).

There was no significant change in the prevalence of self reported problems with periods over a three month period of imprisonment; 44 of the 112 women still in at three months reported that they had had problems with their periods before coming into prison, and 50 women reported problems at 3 months (39.3% v 44.6%, $p=0.39$).

3.5.4. Longstanding illness and medication

Longstanding illness

Four hundred and twenty one women (83.4%) said they had a longstanding illness or disability. The most commonly reported problems were depression (56.6%) and anxiety and panic attacks (42.4%). The prevalence of physical illness was also much higher than in the general community. The prevalence of asthma was 37.7% and migraine and headache 34.2%. Sixty women (12.2%) said they had epilepsy and this is 10 times higher than the prevalence in the general community and appears to contradict other evidence which indicates the prevalence of epilepsy is not significantly greater in imprisoned populations (7). It may be that what women describe as ‘epilepsy’ is in fact a fit because of either alcohol or benzodiazepine withdrawal. Only 3.0% of women were taking antiepileptic medication on reception into prison (see following section)

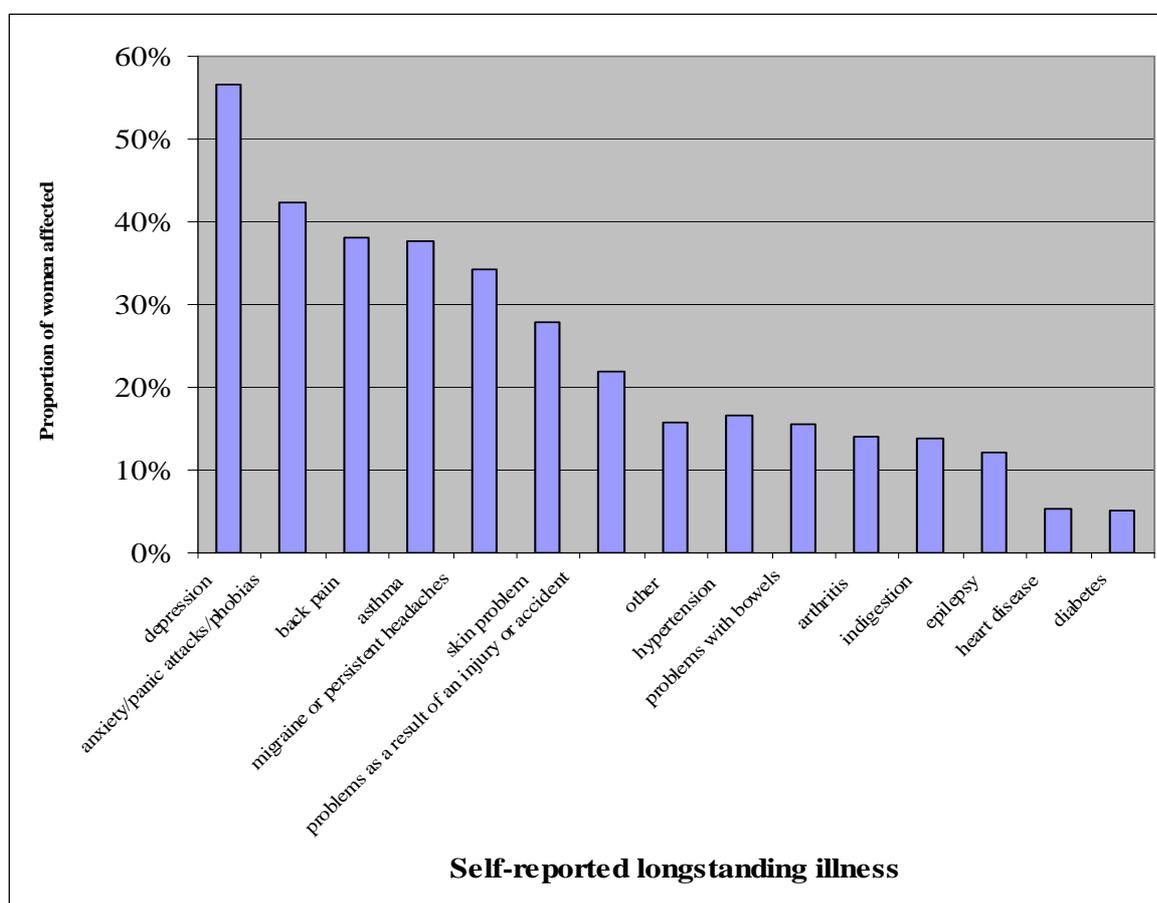
There was no significant change in the prevalence of self reported longstanding illness over a three month period of imprisonment; 84 of the 112 women still in at 3 months reported that they had at least one longstanding illness before coming into prison, and 83 women reported a longstanding illness at 3 months.

Women prisoners compared to the general population –LONGSTANDING ILLNESS

83% of women prisoners said they had a longstanding illness

32% of the general female population have a longstanding illness (29)

Figure 3.10. Longstanding illness in women prisoners on reception into prison.

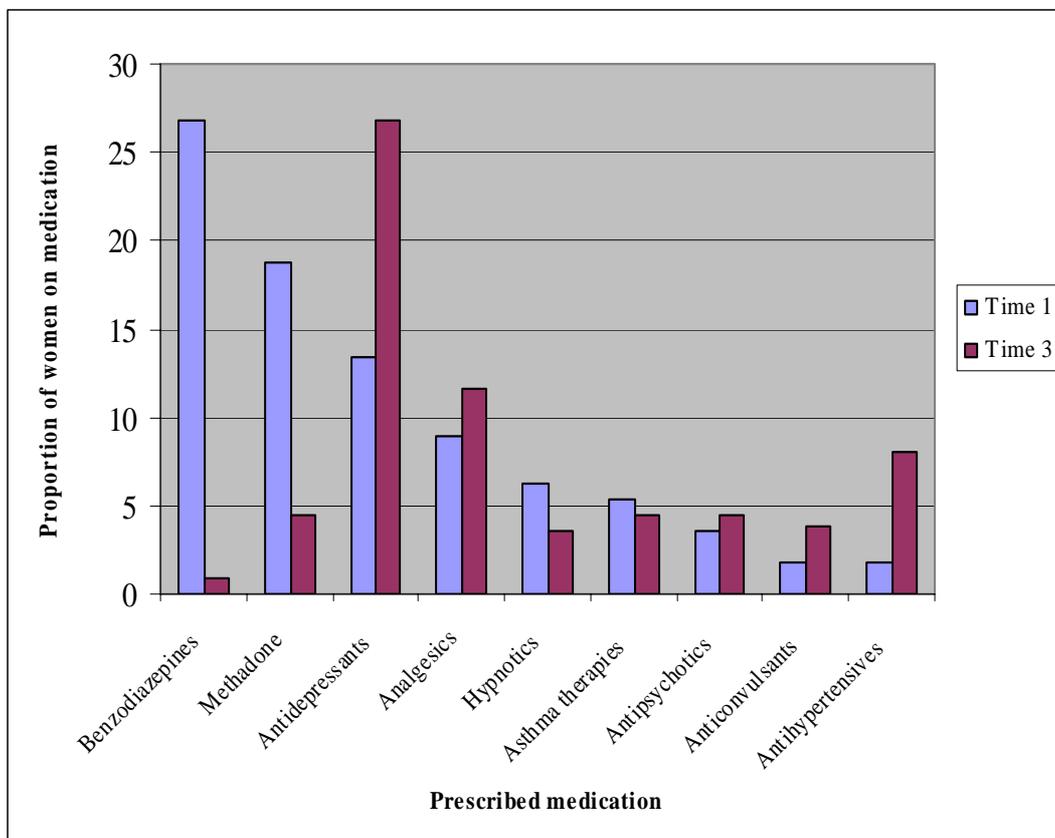


Medication

When women were interviewed within 72 hours of coming into prison, 73.2% of them reported being on medication. The most commonly prescribed drugs were benzodiazepines (41.8%), methadone (36.2%), antidepressants (13.5%), sleeping pills (10.1%), analgesics (8.3%), asthma treatments (6.9%), antipsychotics (3.6%) and anticonvulsants (3.0%).

Overall, the proportion of women taking some sort of medication did not significantly change over time. Of those women still in at one month, 74.2% were on medication at Time 1 and 71.3% at Time 2 ($p=0.4$). Of those 112 women still in at 3 months, 62.0% were on medication at Time 1 and 60.2% at Time 3 ($p=0.9$). However, there were changes in the prescribing of individual medicines. Three months after imprisonment women were significantly less likely to be taking methadone and benzodiazepines but more likely to be taking antidepressants and antihypertensive medication. These findings are detailed in Figure 3.11.

Figure 3.11. Changes in prescribed medication on reception into prison (Time 1) compared with three months later (Time 3)



3.6. Measurements

3.6.1. Blood Pressure

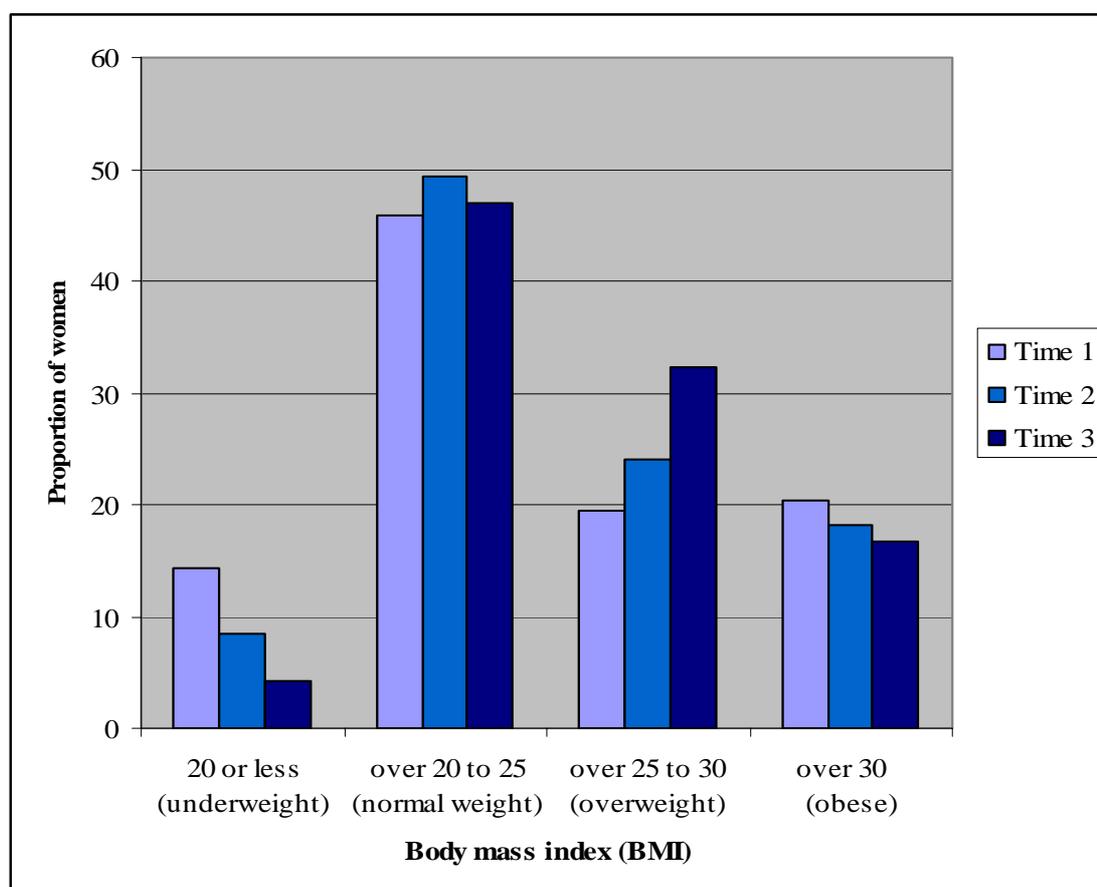
On reception into prison mean blood pressure was 112/68 mmHg, which lies within normal limits. There were no significant changes in blood pressure over the three months in prison; for those women still in at Time 3, their mean blood pressure on reception was 118/73 mmHg and three months later it was 116/71 mmHg, $p=0.15$.

3.6.2. Weight and Body Mass Index

Women were weighed each time they were interviewed and their height was measured on the first meeting with the researcher. From these measurements their body mass index was calculated and women could thus be categorised as underweight (BMI <20*), normal or healthy weight (BMI 20-25), overweight (BMI 25 -30) or obese (BMI >30). When women were received into prison, over one quarter ($n= 114$, 26.5%) were underweight and 189 women (44.0%) were a healthy weight. The remaining women could be classified as overweight or obese.

Women tended to gain weight in prison. There was a statistically significant gain in weight in the first month; mean BMI on reception was 24.5 and one month later it was 25.0 (difference=0.6, 95% CI 0.3 to 0.6, $p=0.000$). The BMI of the 112 women still in at three months changed over that period too; mean BMI on reception was 25.1 and three months later it was 26.1 (difference=1.0, 95% CI 0.6 to 1.4, $p=0.000$). Figure 3.12 below shows how the proportion of women who were underweight decreased but the proportion of overweight (but not obese) women increased.

Figure 3.12. Changes in body mass index following imprisonment



* Some consider a healthy BMI to be between 18.5 to 24.9 , others 20.0 to 24.9

4. RESULTS: THE FOCUS GROUPS AND INTERVIEWS

4.1. Participants

Six focus groups were run involving thirty-seven women in total. This is summarised in Table 4.1. Twelve individual interviews were carried out in total. Eleven interviewees were British born, one was Irish. Four were Black (African or African-Caribbean), the remainder were white. They ranged in age from 19 to 46.

Table 4.1. Focus Group Composition

Group	Number of Participants
Group One: Young Women's Group, Under 21	11
Group Two: Black British Women's Group	5
Group Three: Jamaican Women's Group	3
Group Four: Sentenced Prisoners Group	6
Group Five: African Women's Group	7
Group Six: Drug Using Women's Group	5
Total	37

4.2. Contextual Issues

Before presenting the findings from the interviews and focus groups, it is important to set the material in context. Firstly, we did not include any prison staff (healthcare, custodial or managerial) in any of our interviews, although we did consult one group of healthcare staff on emerging findings.

This aspect of the study was designed to explore the perceptions and experiences of women prisoners and this was an appropriate focus for inquiry given the study aims. Nevertheless, this can therefore only be regarded as partial perspective on the health of women in prison. While women's accounts were credible and key themes were repeated across interviews and focus groups, it remains a partial account. Had the resources and time been available to include prison professionals, they no doubt would have had much to say that would have explained, contradicted, and expanded upon that which women prisoners contributed. There are always multiple meanings and interpretations that can be made of any social process, including the provision of healthcare. For example, as the findings will show, women perceived that healthcare providers were unreasonably withholding anti-depressant and sleeping medication. Does this denote an uncaring staff attitude that is indifferent to women's needs, or does it instead indicate a healthcare system that is responsive to previous criticisms that women prisoners have historically been an overmedicated population and is keen to follow best practice from community settings?

Secondly, prisons are socially contested sites. While we have no evidence or reason to believe that we were given deceptive or misleading accounts, the fact that prisoners were being asked, in part, to discuss institutions and individuals who were involved in the processes of detaining them against their will must be given due accord.

Finally, this research took place during a period of considerable change in the organisation and delivery of prison healthcare in England and Wales, with the transfer of responsibility at the local level from individual prisons to primary care trusts. It therefore represents a particular historical moment, and we can only speculate whether the advance of this process has significantly altered the impact of imprisonment on women's health and their perspective on key issues.

With these important caveats outlined, the following sections present the significant themes and issues that emerged from the interviews and focus groups carried out with women prisoners.

4.3. The Findings

4.3.1. Concepts of Health

Interviewees were asked to describe individuals they regarded as healthy to generate discussion about their own concepts of health. Responses indicated that women's constructions of healthiness were not limited only to notions of the lack of disease. Family members or popular sports figures were frequently regarded as healthy because of their obvious physical strength and stamina and the apparent positive health behaviours, but women also emphasised good mental health, social integration, resilience and inner 'strength' as important dimensions of good health.

'If you're unhealthy then you're going to withdraw yourself from social circles and you're not going to be associated with if you're unhealthy.' (Young Women's Group).

'After what she's [singer Tina Turner] been through, considering what her husband put her through alone for so many countless years, mentally as well as physically abused her, she has come through it. A lot of them would have been in and out of rehab like a yo-yo but she is physically and mentally a strong women and she's still out there projecting and giving peer positivity.' (Young Women's Group).

4.3.2. Prior Health Status

Women's assessments of their health status prior to imprisonment were complex. Some women were able to describe ways in which they had previously enjoyed good health. Their perceptions were related to reports of balanced nutrition, good mental health, physical activity and the absence of behaviours such as excessive smoking or drinking which might have an adverse consequence on health.

'Before I came in here it [health] was good because I had a good diet, I was eating quite healthy and mentally I was all right as well so I was okay. I wasn't going to the gym but I was eating right and I stayed fit. I was alright.' (Black British Women's Group)

'Well I was working full-time so I was more active. Also I played squash twice a week, you know, and I mean, I didn't really drink an awful lot, only when I went out, like weekends. Because I was working in the day, I wasn't smoking.' (Sentenced Prisoners Group)

However, descriptions such as this were in the minority. More commonly, women reported a range of factors that had compromised their health prior to imprisonment. Women reporting problematic drug use discussed in stark terms the way in which drug dependency had led them to neglect their health

'I didn't have an appetite to eat because drugs suppress your appetite. My partner used to cry, literally cry, to try and make me – I was really skeletal, terrible, terrible, really bad, and I knew it myself but I was just so deep into it, I just didn't give a fuck. And when you're not eating as well, you're not feeding your brain and your mind starts to go funny and you're not sleeping. You start getting paranoid and all sorts of other things come with it.' (Interviewee 11)

Women described the way in which acquiring drugs and maintaining their addiction took precedence in their lives to the detriment of almost everything else, including their health. A sense of denial or delusion enabled women to ignore or minimise the profound impact of chronic addiction.

'I was like this matchstick. I was really skinny and I looked really awful but at the time I didn't think so. I didn't think I looked that bad but I see a picture of it now and I think "oh my god".' (Young Women's Group)

'You don't really notice because you can have ten people telling you how bad you look, but when you look in that mirror you don't see what they see. That's the thing, people that use drugs have got to cross that boundary to see what other people see. You can have not slept all week but you don't notice the black circles under your eyes, the anaemic look in your face, how hollow your face looks – you don't notice that.' (Interviewee 7)

In contrast to the 'social drinkers' quoted previously, a number of women also reported chronic problems with excessive alcohol use and its associated impact upon health.

'Alcohol is my main drug. I can drink about twelve cans of Kestrel [in a session]. I mix my drinks and that's dangerous. I do vomit a lot because I only drink on an empty stomach and that's not good...My doctor was really shocked. He's scared for me. Like, my insides is fucked. Now with the drink, I have to wake up to a drink. And if I haven't got that drink, I've got problems.' (Interviewee 10)

'I did want to get off it because, I mean, it was getting to the stage where I was getting cramps, I was getting the shakes, and you do get to the stage where you drink so much that you don't even get drunk.' (Interviewee 13)

Poor mental health was a common and significant feature of women's descriptions of their prior health status. Most accounts were related to reported histories of depressive illness. Anxiety also featured strongly.

'The doctors just put me on Prozac that was all. I wasn't actually having any therapy or anything like that. I was literally just on the tablets. I was only ever taking one a day but they weren't working, it wasn't doing any good but I just couldn't be bothered to go back to the doctors - but then that's the depression, you can't be bothered to do nothing.' (Interviewee 9)

'I just panic a lot. I used to suffer a lot of panic attacks before I come in here. I used to rely on my daughter and my son to take me to the shops and back.' (Interviewee 13)

Prior experience of domestic violence, which was in some cases explicitly linked with poor mental health, was also a feature of many women's lives prior to imprisonment.

'He [first husband] was a wife beater so to speak and, er, that's it basically. I started suffering from depression. I spilt up with him and I was left with, like, three boys all under five.' (Interviewee 9)

'We was living at my boyfriend's mum's house, so, like, it was a stable home and that. I was alright to a certain extent. He used to beat me a lot though so I wasn't really that healthy.' (Black British Women's Group)

It became clear that for many of these women, their prior health status was directly linked to their offending, so that acquisitive crime was engaged in to finance chronic addiction or mental health problems were directly linked to offences. In this account, a woman who was accused of an arson offence, and who had in her words suffered a 'breakdown', reflected on whether she would have been imprisoned if she had been able to obtain the mental health treatment that she needed.

'Being in here is waking up to face things that I've got to face up to, because if I'd done that beforehand then I probably wouldn't have been here. So in a way I'm sort of like, blaming myself and wishing that I'd got this sorted, otherwise I wouldn't be here now.' (Interviewee 13)

4.3.3. Impact of Imprisonment

There were key ways in which the deprivations of prison impacted upon all women but most significant in terms of mental health was separation from family, most especially children. One of the women reported the psychological deterioration she had observed in a cell-mate whose child was being looked after by social services.

'She's always depressed. She'll be alright this minute and then it's there on her conscience. [She's] just crying herself away. You understand me? She's just gone mental, worse than how she was before. Just taking the mere fact that she never ever see her child.' (Jamaican Women's Group)

Women found it especially stressful if there were family problems such as relatives becoming ill or uncertainty about the care of children or other vulnerable relatives. In such cases, feelings of powerlessness to intervene could become intolerable. In the latter account, a woman had recently learned that her son-in-law had been murdered. Her inability to comfort and support her daughter was causing significant anguish.

'I worry a hell of a lot more about my mum through the fact she is ill. So when I don't get her at home or I can't get hold of my daughter, you know, I do panic. Because when I'm in prison my mum's my main carer for my daughter, so it kind of puts my head into turmoil.' (Interviewee 7)

'Nobody would tell me nothing. When I phoned my daughter the third day she goes "John's dead you know mum" and I said "what!" and she goes "John's dead" but I didn't know...My daughter's strong but I just wish I was there to support her.' (Black British Women's Group)

In many cases the support of families was a significant factor in enabling women to tolerate imprisonment and to psychologically cope with the experience. However, for many foreign national women, it was especially difficult to maintain links with family and the effects of separation took a significant emotional toll.

'When I wake up and I think of my dad I just smile because I know that when I come out of this hole that he's going to be there and everything's going to be all right. Without my dad I wouldn't know what to do.' (African Women's Group)

'I can't get someone that I'm used to speaking to, to comfort me. If I could call my mum in Jamaica or talk to my son, that would change the way I'd be. You understand me? At least I get to talk to somebody I love, you understand me? I'd feel much better speaking to them and getting some encouragement.' (Jamaican Women's Group)

As well as separation from family, women also recounted the stress that came from newly encountering the prison environment. Crowding, noise and the threatening atmosphere were the most immediate factors.

'The first few minutes I'm in the room and I'm like, hearing people shouting on the landing, I'm hearing people say "yeah I'm going to bang you up tomorrow", like fighting and it's like threats and then there's people shouting "help, help"...it's frightening.' (Young Women's Group)

Other women discussed the initial emotional impact of confronting the fact that they were in prison. This included the initial sense of shock, which for some women developed into a longer lasting sense of emotional distress.

'I just couldn't take in what was happening. It's like people are talking to you but you're not listening because all you can think is like prison, prison, prison. And it's like, "get away, go away." I was so distraught I didn't want no one near me...I just sat and sobbed my heart out for ages.' (Interviewee 13)

'I won't say it didn't make me feel suicidal but I could never ever do that because I think I have a child out there that I have to live for. Do you understand me? And if I should do that I would be just being selfish and just thinking about myself and how I feel for the moment... for the first two weeks, three weeks, four weeks, I didn't know if I would be here right now.' (Jamaican Women's Group)

Women also recounted their shock at some of the situations that they found themselves encountering in prison. Women recounted their alarm and concern at finding themselves sharing cells with women with mental health problems including self harm. They were frightened and unprepared when confronted with women who were suffering severe drug withdrawal or seizures.

'I don't take drugs personally so I'm not used to seeing things - but then I saw her [cell mate] in the bed next to me and I saw her having sweats and shaking and I got the officer and I said "what the hell's happening to her!" and like, I was pushing her "wake up, wake up, wake up" and she wouldn't wake up and in the morning I was saying "what was wrong with you, what did you take?" and she was like "I didn't take anything I was withdrawing".' (Young Women's Group)

'The girl who had fits in my room - I didn't have a clue what happens. [I] just pressed the bell and then she [officer] goes "just hold her on the bed". I had to be holding this girl on the bed.' (Black British Women's Group)

Conversely, there were women for whom the profoundly chaotic and stressful nature of their lives outside prison meant that prison represented a respite. These tended to be women with long-term histories of problematic drug use and/or women juggling the demands of managing families in a context of poverty and social exclusion.

'Personally, I see prison as a false environment. You haven't got nothing to worry about in here. But when you go back outside, you have to start juggling all these hot potatoes and deal with all this stress that you haven't had for the last few months.' (Interviewee 7)

'You're not under the stresses that you would be under outside. Like outside say, you've got a house to run or you haven't even got a house, you know. You've got to get money for drugs every day, you've got to feed yourself, you've got to clothe yourself, you're wanted by the police, you've got court cases. It's like stress, stress, stress, stress, stress, stress.' (Interviewee 13)

4.3.4. Impact of Imprisonment on Health Status

Women were asked to consider what they felt the impact of imprisonment had been on their health. The responses were complex, in that there appeared to be a sharp distinction between the women who had histories of problematic drug misuse and those who did not. Non-drug using women tended to report that imprisonment had led to a decline in their health. They reported being less active, having poorer nutrition and greater incidence of illness.

'I think my health has gone down a lot since I've been in here...and it wasn't like that when I was out there. That's in five months.' (Sentenced Prisoners Group)

'I probably only went to see the doctor once a year, maybe once every two years when I was outside, apart from going with the kids. I've been in prison three-and-a-half-months and I've had four appointments with the doctor, about different things, like a kidney infection, urinary tract infection, skin problem and something's happening with me even today.' (Sentenced Prisoners Group)

Such women also felt particularly keenly the restrictions of the regime on their ability to self-care and to maintain their own health.

'Because obviously you haven't got no access to buy nothing, no little personal stuff and for some women that is really hard.' (Black British Women's Group)

For drug using women, the situation was more complex in that, as noted, they were often in denial themselves about the extent of the harm that drug misuse had previously caused to their health. There was also a profound sense of fear and dread surrounding detoxification. One woman gave a powerful and graphic account that is worth quoting at length in order to convey the experience of drug withdrawal symptoms.

'Every pore, every sweat gland of your body is screaming out. You are perspiring and that perspiration then gets very cold and then you're cold to the bone and then the next minute the heat will overtake so rapidly that you won't know what hit you. The heat will then cause you to convulse, convulse, convulse, you are shaking and that's why they call it 'clucking' because you are vibrating all over physically. Mentally, don't even go there! You are isolated, you are in a black box, no one can touch you, no one can – the only person who can talk to you medically is a drug dealer...Your whole body has gone into self destruct mode, your bones, your muscles are aching, screaming, your stomach is in cramp, you are twisted and doubled up...you are violently vomiting and vomiting and it is yellow and it is just pure bile so your throat is on fire.' (Black British Women's Group)

Understandably, given the extreme reactions that many women had regarding drug detoxification, this concern was uppermost in the minds of women with drug problems when entering prison, and a small number of women reported that they had been able to continue to use drugs in prison. This could have the effect of numbing them to the boredom of the prison experience.

'What I've used in prison is heroin and crack, because quite a lot of people do use heroin when they're in prison because it helps kill your 'bird' - it [the sentence] goes quicker if you use, somehow it just speeds things up for you.' (Interviewee 7)

However, over time, those women who underwent detoxification noted the real benefits to their health as a result. Women described improvements in their mood, eating and sleeping patterns and in their weight. For many women with chronic addiction problems, imprisonment provided housing, regular meals and a respite from the drug use and associated violence. The extent of the impact was often a surprise to the women themselves.

'I no longer wake up "clucking" anymore and I can sleep through. You know, before you worry about going to sleep unless you've got heroin there to wake up to because you know you're going to be sick, so I'm normal now.' (Black British Women's Group)

'I've put weight on. Because I'm not smoking crack my chest has cleared up. You know, I can bounce out of bed now instead of dragging myself out of bed and thinking, "I've got to get a bit of gear, I can't function without it". I can function, I can get out of bed and function, and it sounds like a little thing but it's not, it is a really big thing.' (Interviewee 11)

4.3.5. The Prison Environment

4.3.5.1. Hygiene

While the impact of imprisonment was variable for women, almost all agreed that the physical prison environment did little to promote health. Women complained that the prison environment was dirty with unhygienic sharing of facilities. For example, women reported that five women in a dormitory could be sharing one in-cell sink, which would be used for personal washing as well as cleaning eating utensils. There was also crowding with a lack of fresh air and ventilation. Enforced sharing of rooms with smokers was especially problematic for non-smokers.

'They use the same sink to wash...like you're living together and we wash in that sink to wash our plates.' (Black British Women's Group)

'There's a toilet in the room. There's five of us in the room. There's no air coming in...the food is there and it's just too, too much. People get all hot and bothered.' (Interviewee 10)

The women also gave vivid accounts of vermin in the prison. While stories of mice unexpectedly encountered in shoes and wardrobes were often told with resigned humour, it was clear that the women were disgusted by the evidence of vermin present in the areas where they ate, slept and stored their personal food items.

Participant 1: There's rats.

Participant 2: There's mice in all the rooms.

Participant 3: Yeah and they come at us and they're big fat bastards as well, they are massive!

Participant 2: There was one dead one in my room the other day.
(Drug Using Women's Group)

'This pigeon was flapping about [in the dining room]. It wasn't the same pigeon because I think that one was still in my room. When I went back in there, it'd crapped all over the floor and everything.' (Interviewee 12)

Women were also concerned about parasitic infections, and thought that the prison system could do more to prevent their spread.

'Imagine every different people come in and come out, you don't know what [they've got]. Some people come in and get scabies, all kind of things.' (Jamaican Women's Group)

'I don't comb my hair because I have mine in dreadlocks so I can't. There's no Derbac or Lyclear. You know, if I was at home and I thought the kids had nits, I'd just give myself a treatment just to make sure that I didn't have them.' (Sentenced Prisoners Group)

In one establishment, there were no in-cell sanitation facilities. One group recounted a process whereby they would have to wait until the morning to be let out to use the toilet facilities, with buckets used during the night. On one occasion, a woman was reportedly without an empty bucket and was told by an officer to urinate on the floor of her cell. The woman was present in the focus group while her story was recounted by her friend. The observer went on to speculate about the impact of delaying access to toilet facilities on women's genito-urinary health.

'She told one of the officers right, she went "well I haven't got another little potty, I haven't got a bucket in here so I can do a wee", she said "I'm dying for the toilet" and she got told to actually piss on the floor! That was what they said to her. She [officer] said "use the floor then"... You can imagine that you don't want to piss on the floor in your cell where you live, so then you have to hold urine for an hour and a half. It's not good for your urinary tract is it? I have suffered from cystitis quite a lot since I've been in prison and I think it's totally due to that.' (Sentenced Prisoners Group)

The lack of in-cell sanitation was especially unpleasant when women woke to find that their periods had started and that they would have to wait, sometimes for hours, to be unlocked to access a toilet.

'If you wake up in the morning and you've just come on - you don't know that you're going to come on sometimes do you? So you wake up in the morning, it's a normal thing for women, "oh shit period, got to get out", then you can't get out for two hours.' (Sentenced Prisoners Group)

Women indicated that prison facilities hindered them from maintaining self-care in other ways. While the women were highly critical of others who did not maintain personal hygiene, they also acknowledged that it could be a struggle. Some women complained that the prison regime unnecessarily limited access to personal hygiene products and there were times when restricted access to bathing and shower facilities was a problem. Women reported that the facilities that were available were often dirty.

'Sometimes two days straight, I can't have a shower. It would make you depressed and being locked up, it does.' (Interviewee 8)

'The bath wing is disgusting...we clean the bathrooms every day and then the next day when we get there, after just an hour, it's horrible; water all over, the mop is stinking, [used] sanitary towels, tampons, oh it's horrible.' (Young Women's Group)

Despite their reluctance, women made use of in-cell sinks where available to 'strip-wash' but this was less than ideal.

'You have to use a bowl to be washing yourself and anything that you take off, the sanitary towels, everything, you have to keep in the room. You know, you can't get to put them outside in the bin. It's just not nice.' (Interviewee 8)

Women were also critical of the fact that they were not allowed materials to clean the facilities they had to use. While there was some recognition that this related to security concerns, they felt disempowered to have to rely on other designated prisoners to carry out cleaning tasks, whose standards were not to their own. This example relates to washing machines but women were also concerned about their inability to clean toilets and washing facilities.

'They should have washing machine that allow you to wash your [own] clothes and your sheets, because you [have to] ask some prisoner... One on our landing, when she walk, she leave a smell behind her...[her clothes are] washed with the other people's clothes on the landing and that's not right. Your pillowcase, you have to put your face on it and stuff like that, they should allow you to wash your things.' (Jamaican Women's Group)

4.3.5.2. Nutrition and Activity

As noted, there were women, particularly those with histories of problematic drug misuse, for whom the consumption of regular meals represented a significant improvement on previous eating patterns. While it was not universal, women tended to report that their prior eating patterns included going without food for long periods, reliance on 'junk-food', overeating and/or bingeing.

'I would be on the cocaine and so I wouldn't eat like for three days or whatever. And, then for two days I would like, pig out, do you know what I mean? Get the munchies for two days after. I mean, it weren't doing me no favours.' (Interviewee 9)

'I've always had bad eating pattern. I used to throw Nik-Naks [crisps] down my throat at home.' (Interviewee 13)

Despite poor eating patterns, women were vociferous in their condemnation of prison nutrition. A number of women criticised the prison diet as being overly rich in carbohydrates, which they perceived was designed to make them put on weight (whether they needed to or not).

'[It] doesn't seem like a healthy diet at all. Like, I've not once had salad since I've been here. Not once in this prison. I think it's potatoes every day. They feed us stodge all the time. Some of the girls when they come in on drugs and that, it builds them up and it's alright for them.' (Interviewee 2)

As well as being too carbohydrate rich, women complained that the food that they did receive was limited in choice with a small range of options being frequently revisited.

'It's the same thing every day, like you get a set menu for one week and it's the same the next week and the next week and the next week and the next week. There's kind of, no variety, even though there is variety, like you can have rice or potatoes, you can have fish or meat, it's like, it gets pretty boring after a while.' (Interviewee 11)

Women also complained about the preparation of the food, which they experienced as tasteless and poorly cooked.

'And everything's kind of bland, like it has salt in it but like, no pepper - you can't have pepper on the wings in case you chuck it in someone's eyes. So everything is bland. It's palatable but bland. You kind of have to tell your head that it's eating something else.' (Interviewee 7)

'Like the potatoes are hard. Even the roast potatoes, they look really, really brown. And when you put a fork in them, you can even hear the crunch of a hard potato. Honestly, if I threw one at you, it would knock you out.' (Interviewee 12)

Despite complaints about the quality of the food, many women found that comfort eating, or eating to cope with boredom became a pattern.

'All the time you just sit on the bed and eat, I think that's what makes me feel not healthy... I don't sit there on my bed at home and eat my food and I don't feel tired with eating because, do you know what I mean, I would want to do something instead of just lying in bed.' (Interviewee 1)

'When I'm down as well, I comfort eat, I'm a comfort eater. So, with being pissed off most of the time, well I'm just eating everything that's in sight.' (Interviewee 9)

Women were also asked about opportunities to be active. There were accounts in one establishment in particular where women praised the exercise facilities, whether or not they personally chose to use them. This was one area where there appeared to be a distinction between establishments. Women who used the exercise facilities in this prison praised the quality of the instruction and reported the benefit for their general wellbeing and ability to cope with imprisonment.

'They've got everything, different varieties you can choose from, you know, games, there's a lot you can do...[The instructors], they're excellent. I've done one gym course and I've got really close to my gym officer.' (Interviewee 6)

'If you go down to exercise it's like you get out, you get a bit of fresh air, you talk to people, it lifts you a little bit, and then you come back and you feel a bit more rejuvenated, do you know what I mean?...when I go, I'm glad that I went and I feel better when I come back.' (Interviewee 11)

This contrasted sharply with the other establishment where women criticised an apparently barren concrete exercise yard and the organisational regime, which they felt forced them to choose between exercise and work. Because work provided money needed to buy personal items, women who had the opportunity chose work.

'If you're in prison for a long period of time, you can't afford not to have a job, unless you've got like, people on the outside supporting you. But you do need at least fifteen or twenty pound a week in prison, just to live, just for phone calls and toiletries and stuff. Therefore you have to work. If you have to work or take education classes, you cannot go to the gym.' (Sentenced Prisoners Group)

Even in the prison with good facilities, the organisation of the regime could act as a disincentive to use them.

'A lot of the time, people don't go to exercise because they need to get ready for work, they need to get ready for education, visit, whatever. And they want to have their little bit of breakfast, because if you don't have it at that time you're not having it at all, so that exercise, a lot of the time, goes out the window for people.' (Interviewee 11)

A perhaps greater disincentive was the boredom and apathy that women experienced in prison. In one account, a woman details how she was obliged by the prison regime to leave her room because she was a convicted prisoner. Other women had the option of remaining in bed all day. The sense of disempowerment and despair that could lead to this pattern was clear in women's accounts. For at least one young woman, there was literally nothing worth getting out of bed for.

'I have to work or go to education because I'm convicted. The other four girls [in the dormitory] don't because they're [on] remand. They can choose to stay in their room if they like. Most choose to stay in their room and stay in their beds.' (Interviewee 11)

'Come out of my room for what? To line up in a queue and then go in a room and look at the clock [to see] what time I'm coming back and then come back again, for what?...The first two months I was ill, I used to go out but now it reminds me more that I'm in jail when I go out so it's just better I don't go out... I've got no interest in here or anything to do with people; my aim is just getting out of here.' (Drug using women's group)

Women with mobility difficulties or disabilities experienced the opposite problem. They reported wanting to participate in activities but found either that the environment was not suitably adapted, or that it required additional staff resources, which were not available. For example, one woman reported that she had been prevented from attending an activity because she had to be escorted in order to use an alternative exit. She had apparently been encouraged by an officer who had also found the situation unacceptable to make a complaint, but she remained angry that her needs were not being met. Another woman detailed the impact of the prison's inability to meet her needs, which was isolation.

'They've given me a wheelchair that's punctured. I'd like to go into education. I can't get in the ed' because they've got no facilities for disabled people...I have to go all the way around the prison. We have specialist officers come with me and they can't find the officers to do that, they haven't got enough. So I have to give it a miss for the day, and the next day and the next day. There's an officer to escort me down to the [punishment] block - they'd soon fucking find me one.' (Interviewee 12)

'I'm sitting in my cell all day, no TV and I'm not even a convicted prisoner. I can't read a book because like, the pain in my leg does my head in and I can't concentrate. I'm just fucking sick of it to be honest with you and no one's taking no notice.' (Drug Using Women's Group)

Disabled women reported feeling that it was wrong for them to be sent to prison establishments that could not allow them to participate equally and function with dignity.

'I shouldn't be even in here. I can't bath myself, I can't go in the shower, I feel degraded. I don't know any woman that has to ask them "oh please can you come and give me a bath" so what do I do? I have try and find some ways and means to do it, so obviously because I can't stand up for long, I can't wash myself properly.' (African Women's Group)

The obvious impact of a carbohydrate rich diet and inactivity for many women was weight gain. As noted, some women valued this because prior problematic drug misuse had led to under nourishment.

'I'm bloating up because initially I was seven-and-a-half stone. The other week I was thirteen-stone-something and when I come into prison I was only seven-and-a-half stone.' (Sentenced Prisoners Group)

'I'm glad I put on weight, I needed to put on weight. But I don't want to put any more weight on. I'm sure you've seen that people are bouncing round here like Teletubbies.' (Interviewee 11)

Even women who welcomed their weight gain were concerned that it was the 'wrong sort' of weight and there were references to the impact of obesity on self-esteem and mood.

'In jail, it's a different kind of weight. The food that they give us is like, pumped up with water and stodgy and it's meant to fill you up and it's meant to fill you out a bit. So it's that kind of heavy "wooooh" weight. I don't think it's the healthiest of weight and I see a lot of people getting grossly overweight in here. I wouldn't like to go down that road.' (Interviewee 11)

'If you don't feel right in yourself weight-wise, you feel low in yourself...now I've put on some weight, I lie on that bed and I think "oh my god" and I really do feel myself going down.' (Sentenced Prisoners Group)

One woman was explicitly critical of the prison health regime for failing to address excessive weight gain among prisoners, which she juxtaposed with her experience in the community.

'There's no supervision of your diet... if you'd put on three stone and you were outside and you went to see your doctor, your doctor would say "you're putting on a bit of weight, you need to address it. You need to like, take more exercise or you need to analyse where you're putting on weight." But [here] there's nobody supervising your weight.' (Sentenced Prisoners Group)

4.3.6. Mental Health

As noted above, reception into prison could precipitate feelings of shock and depression. A number of women also discussed their prior mental health problems outside of prison, particularly depression. Interestingly, some of the women with drug problems explained that their drug use acted as a form of 'self-medication'. Reception into prison and detoxification could therefore mean the powerful and unwelcome emergence of disturbing thoughts and feelings.

'For me like, because I've come to prison, I've come off drugs. All my emotions and everything have come back to me.' (Sentenced Prisoners Group)

'I suffer with depression. When I'm outside and on the drugs I can kind of keep a barrier in front of it. Coming into prison takes away the vices that keep that barrier in position. I suppose a lot of people do end up seeing a psychiatrist to give you that medication that you should have been taking on the outside.' (Interviewee 7)

The obvious fact that there were significant numbers of prisoners with serious mental health problems was frequently remarked upon by the women. One young woman housed in the young offender's unit described her experiences of hearing apparently delusional or psychotic prisoners in distress.

'They scream and shout out their windows at night, they talk to themselves, basically they have a conversation with themselves and they sit there...They're mental aren't they?' (Young Women's Group)

Women's own disturbing accounts of their emotional distress sometimes included references to suicidal feelings and attempts.

'There was one time during detox, I did try and hang myself off the top of a bed but it fell down and I was too embarrassed to say anything. So I just thought, "oh fuck it". I don't know what happened. I don't know whether somebody heard or someone was looking through the hatch or what but they moved me to strip cell that afternoon and I was in there for a week.' (Interviewee 12)

A number of other women had reportedly witnessed incidents where successful suicides had occurred. Where incidents were described in detail, a common feature of accounts was the perception that officers had been callous or indifferent in their treatment of vulnerable prisoners prior to the event taking place. In one account, the observer reported that an officer had ignored warnings that something was wrong when a woman was extensively delayed in returning from a toilet visit. In another reported instance, a woman who was undergoing an apparently severe reaction to detoxification and who had vomited on herself was denied a bath.

'They took us both down the block. She needed her medication ...There's no toilets in the actual cell, she's got to ring [to be allowed to go the toilet]. She goes to the toilet and I said to the officer "she's been in the toilet too long". [He replied] "oh shut up, stop concerning yourself with things that don't concern you". Twenty minutes later they've realised she's not back in the cells, she's dead.' (Drug Using Women's Group)

'She'd been sick all the night before but they refused to give her a bath...She was hanging by her window like this. The officer screamed, I dropped everything what I was doing in the kitchen and run in to the room, the officers – and we - literally had to hold her up, she had gone.' (African Women's Group)

Women giving accounts of suicides were angry about what they perceived as negligent care on the part of officers. A further feature of such accounts was that officers were reportedly ill-equipped in practice to cope with emergency suicide situations, which women had found themselves responding to.

'She's swinging from the window and two of the staff panicked. Me and two other ladies – not two officers that were on - me and two other ladies had to pick her up. The officers panicked. The keys are attached to the scissors; the scissors couldn't get behind the ligature - too tight. [There's] officers panicking, I had to go and press the 'aggi-bell' to get more staff because they're just flapping, standing there flapping.' (Black British Women's Group)

One woman described the way in which she was traumatised by the incident. Another reported what she perceived as an inadequate response to her distress and anger, which was to transfer her to another prison. Women giving such accounts were angry at the lack of emotional support that they were offered following such incidents.

'I was mad, I hated the officers, I hated the nurses, I hated – I just went mad, I wouldn't eat, I didn't sleep well all month... the thing is I was the last person she asked – she goes "[name removed] just help, get them to give me a bath, tell them I really need a bath" and I told them!' (African Women's Group)

'That's how I ended up in [establishment name removed]. They shipped me out to the furthest prison they could...I feel fucking angry but do you know what, the officers got counselling!' (Drug Using Women's Group)

Women also reported that they were used by officers to act as unofficial supervisors for women who were thought to be vulnerable. While women were keen to show their concern for vulnerable prisoners, being allocated to this role could be stressful and difficult and women felt unprepared for such a responsibility.

'You see this person this minute, they'll go in their room, and they'll start cutting themselves, trying to kill themselves, so you can't know...you can't read the mind. You don't know. Their face might be showing one expression but inside her, they're having a different feeling.' (Jamaican Women's Group)

'If you're in a room with a self-harmer the officers will always tell you, or you usually know because they're on a 20/52, [suicide and self-harm observation] and they'll say, "oh keep an eye on her for us", which you'll do because you don't want to see no one hurt themselves. But at the same time it is a lot of responsibility on you. I don't get paid to watch prisoners, whereas they do, and it's like, you're constantly watching that person.' (Interviewee 11)

Women also discussed their own motivations for non-suicidal self harm. Women's accounts related this behaviour to attempts to alleviate intolerable feelings of stress, anxiety and depression. This was discussed by other women who observed it as something that caused them anxiety but which was so common that they had to try to adapt to witnessing the behaviour.

'For me it was easier just to pick up a knife or a razor blade and go like that [motions cutting] and feel all the tension come out of my body. It was a very blissful and calming experience. I've even planned before I've done it and [if] you've seen me after I've cut my wrists, I've got this smile on my face. It's like all of a sudden all this energy and all this negativity has come out, and I'm feeling, yeah, I'm on top of the world again.' (Interviewee 7)

'I've been in five months and you kind of get used to it. You kind of do get used to it. I did see my friend cutting up once, but I've really got to live with it.' (Interviewee 7)

Women's accounts of the responses of prison professionals to self-harming behaviour were mixed. There were accounts where officers were said to have been sympathetic and vigilant in their responses.

'Because now, sometimes the staff are a bit compassionate. They will sit there, especially like, if you're saying "look, I feel like I'm going to self-harm and I need to talk" – and so nowadays it's got better like that.' (Interviewee 7)

'I was leaning on the landing one day and I was just, you know, very tearful, crying and I said you know, "I'd fucking top myself if I had the chance". And then the officer obviously overheard and they decided to put me on a 20/52 to keep an eye on me because they could see, I mean I just wasn't myself.' (Interviewee 9)

Other women perceived that the prison system was indifferent to women who self-harmed and that more should have been done to help them.

'Nobody cares, nobody tries to find out what's going on, what they can do to help... If they have one problem, they go to three different officers, three different answers... If you are stressed, they don't have to come to you and speak to you and give you encouragement. Nobody don't care about no-one.' (Jamaican Women's Group)

'They [self-harmers] need more counselling, maybe they need to be on the healthcare unit...it's not about just banging you up in your room, you know what I mean? They need counselling and help with it and obviously you need to treat them a little bit with kid gloves, maybe [more] than you would other inmates because they're that [much] more vulnerable.' (Interviewee 11)

In one establishment, women also gave accounts where the segregation unit had been used inappropriately to hold women with mental health problems for long periods of time.

'They said that they couldn't find her a hospital bed so they kept her. She was down in the seg' here for six months and then they finally found her a bed, at six months!' (Sentenced Prisoners Group)

'Since I've been here, I've seen two women go to the seg' who've got mental health problems that they can't contain. They don't know how to deal with that on the wing and they do then put those women in the seg'. (Sentenced Prisoners Group)

In the other establishment, a women who had a job as a cleaner on a unit where women with mental health problems were located discussed the treatment of prisoners that she had reportedly witnessed.

'I've seen the way they're treated and it really depresses me...Where they piss on their mattress, they take their mattress out and make them sit and they tell them they're not mad they're just bad and all things like that...I was askin' to clean out one of the rooms and they said "leave their room they can go back in it. If they want to mess up their rooms let them stay in it" and things like that. But the thing is they're not normal people...They shouldn't be in prison and if they are they shouldn't be treated like the rest of us – do you know I mean, they're mad, they don't know what they do.' (Interviewee 11)

Women who were not suffering severe mental illness but who needed support in adjusting to imprisonment found that emotional support was not forthcoming.

'If you went to the doctor at home and you were feeling sad or depressed, you were upset about something, they normally would refer you to counselling in the surgery or they might say you could have counselling support at a therapy centre, which I've had on the outside. And then you come into prison, which is the most stressful environment that most women will ever encounter. Honestly and truly I haven't been offered any counselling or anybody to talk to in health care, in a nursing capacity' (Sentenced Prisoners Group)

Women with diagnosed mental health problems also complained that help and treatment was often difficult to obtain. They indicated that the response of mental health services needed to be considerably more responsive and pro-active.

'Say you've got psychosis and you're a bit freaked out, you shouldn't have to put an app' in to see a psychiatrist. It should automatically be done. If you do suffer with depression, you should be seen virtually, if not the next day then the next day after that so you haven't got to wait for all that madness to start in your head - before you start cutting up. And it's like, after you've cut up, "oh, you're going to see a psychiatrist love". It's always after the horse has bolted in this place.' (Interviewee 7)

One woman who had been diagnosed in the community with severe personality disorder discussed her problems obtaining an assessment in prison. Three visiting psychiatrists were reportedly sent to see her but she refused to see one of them because she overheard him expressing fear at being left alone with her. This was reportedly confirmed by an officer.

'I heard him say to the officer, "I'm afraid to be left alone with her"...And the officer told me, the officer actually said [it] to me...And if that don't make me fucking paranoid, what does? It made me feel terrible. I hadn't threatened to do anything to him, nothing.' (Interviewee 12)

Another of the psychiatrists wanted to interview her through the hatch, which the officer on duty disallowed because she thought it was 'unprofessional'.

'And she [the psychiatrist] then wanted to deal with me through the hatch, and the officer said like, that is really unprofessional. You know, how can you talk about mental health problems through the hatch, where the whole landing can hear?...And the officer said, "Well sorry, I can't be in the office and the dining room with you and it's meant to be confidential, I'm not meant to know what [name removed] is saying. I'm nothing to do with that part of it." And, she just said it was out of order.' (Interviewee 12)

Another woman undergoing psychiatric care also reported that on occasion, she refused to participate in consultations because the psychiatrist allowed the presence of other staff, to whom the woman objected.

'Every time I see a psychiatrist there's a nurse sitting in this very room...I'm very funny with groups of people that I don't know and I won't talk. And sometimes the psychiatrist will be in here with five other people as well as the nurse and me and I won't see them...I prefer to talk to my psychiatrist one-on-one. I don't want one of these nurses sitting in on it, but they never ever dismiss the nurses, never.' (Sentenced Prisoners Group)

Despite the difficulties with mental health provision that women described, it is important to emphasise that there were examples where women regarded the mental health support they received favourably and reported that they had been helped by it. Sympathetic staff who seemed to genuinely care about the welfare of women with mental health problems was of crucial importance.

'I see a counsellor, I see a psychiatrist, I've been on special watch, I've been in hospital... they treat me and they don't judge me...the watch nurses when they come down to my hatch at night time they're like, "oh hi, how are you today" they're generally interested or they give me their impression that they are and they're genuinely concerned.' (Young Women's Group)

4.3.7. Substance Misuse

As noted, many women described in detail their prior substance use problems, whereby obtaining drugs and maintaining their addiction took priority over almost everything else in their lives, including their health. In this account, a woman describes how, having drugs available is regarded as essential to everyday living for such women and how poor health is simply explained away as the effects of drug withdrawal, with more or better quality drugs posed as the 'treatment'.

'When you're a drug addict then you're just living to support your habit, do you know when I mean? You're not taking care of yourself really, you're not...Any form of like snuffle or anything like that you just think it's to do with the gram; "I need some gear, the gear's not good enough"...You've got to make sure those bits [drugs] are there before you can do anything to start your day.' (Black British Women's Group)

Also noted above, women powerfully expressed their fear and anxiety about undergoing detoxification. As well as being physically gruelling (and frightening for unfamiliar observers), withdrawal could mean the emergence of powerful negative emotions that had previously been suppressed by drugs. This made women undergoing detoxification especially emotionally vulnerable.

'It's horrible because you're so used to being 'well' [lacking withdrawal symptoms] – you're unwell and you're craving for the drug and you're in prison and you're missing your family. Everything, everything you can possibly think of is hard when you're coming off drugs; it's ten times worse.' (Young Women's Group)

Some women reported that they continued to use drugs in prison but this appeared to be the minority experience, with the impression given that such use was not widespread.

'Yeah, I did smuggle [in] controlled drugs but for my own use. (Interviewee 5)

Women who had undergone detoxification and for whom the worst effects had passed, reported considerable improvements in their emotional and physical health. Some women reported that they benefited from the respite from drug addiction that prison enforced upon them. This could also extend to women with alcohol problems.

'I'm glad I got three years because I know I'd have just have gone straight back on the gear. That's why I'm glad I'm in here because I've only been in three weeks and it's sorted my head out a lot of more.' (Interviewee 1)

'In one way it's [imprisonment] done me a favour because I was starting to drink a lot. I mean it was every other day and I'm talking a bottle of vodka, you know, and that's a lot.' (Interviewee 9)

Women were asked about the support available to them to address their substance use problems. Some women were keen to take up the offer of drug treatment interventions in prison and were sometimes frustrated that more provision was not available, recognising that services were considerably stretched by sheer demand. However, the services women had accessed were on the whole favourably regarded. One woman described the process of interacting with the CARAT service (Counselling, Advice, Referral, Assessment and Throughcare).

'You get to have a first assessment done with them, and then they come round and see you at first once a week and then like, if you're going backwards and forwards to court, [they] find out what's going on, like, if you need a letter written from them saying that you are seeing them...It's been okay, they've been helpful – they always have been and my CARAT worker, she's known me for ages ...they help me have my assessments, advise me of which rehabs to go to, to which ones not to go to and which ones would be good for me.' (Interviewee 7)

Other women had participated in the drug-treatment groupwork interventions that had been offered. Again, this was regarded as helpful.

'I'm on a drugs course and that is helping me. I'm twenty-six and I've got two lovely boys. I don't want to be coming here when I'm fifty.' (Interviewee 10)

'The course was good. I think it should actually be longer because four weeks I don't think is enough. But yes, it was really good. Because I've done rehab before - I've done rehab three times - and for me it was just putting myself back in that mindset, learning stuff again, you know, like a refresher course, because I knew it all but you forget it, don't you? So it was just like, yes putting me in the right mindset so that I can go on and carry on the same path.' (Interviewee 11)

Where women were considerably more critical was in the availability of community rehabilitation services and aftercare. Women felt strongly that there was insufficient availability of rehabilitation places and that not enough was done to help them build lives that could sustain abstinence. Often they were obliged to return to lives and communities where the pressures and temptations to use drugs were regarded as overwhelming. Without comprehensive and effective aftercare services women reported that they were highly vulnerable to the 'revolving door syndrome' of relapse, crime and imprisonment.

'Don't put someone in prison for three years and then say "right, your release date is tomorrow", open the door, "bye, bye, see you later".' (Drug Using Women's Group)

'I came back to [large city], basically I was fucked back out on the street and nowhere to live. They gave me somewhere to live at the end of my licence but in between time I had to sell crack to survive. At least in [other prison] you got aftercare...They've got people who take you though and meet you and give you jobs and somewhere to live.' (Drug Using Women's Group)

4.3.8. Sleep Disturbance

As issue that emerged with regularity was around sleep disturbance. For some women this related to difficulties in adjusting to the stress of imprisonment and the noisy prison environment. For other women, this related to prior histories of drug misuse where drugs had previously been used to 'self-medicate' for sleep problems and/or had left women's sleep patterns profoundly disrupted.

'Like I can stay up for a few days. No more than three days. I need to go to sleep. But if I'm up constant, then I go for three days.' (Interviewee 10)

Women complained bitterly when they felt that they should have had access to sleeping medication, which was denied them. They often perceived that this was related to efforts on the part of the medical staff to deny sleeping medication to drug using women who were perceived to be using it to compensate for enforced abstinence from street drugs. One woman rehearsed the dialogue that she experienced with prison healthcare providers over the issue.

'They know that you're a drug addict. They think it's to do with drugs. "I can't sleep properly." "Well, you'll get your pattern back". Yeah, yeah, yeah. I've been here fucking four months!... "But can you just help me out with some sleeping tablets?" No, they've stopped doing sleeping tablets.' (Interviewee 10)

'When I was coming off my detox, they're supposed to give you sleeping medication, because after you come off your methadone you don't sleep. I hadn't slept for about seven days and I was wing cleaning and doing the drug course, so I was proper frazzled. I was like, "listen I need some medication, I need to sleep at night." And he [doctor] was like, "No we're not giving out medication."' (Interviewee 11)

For some women, it was the case that following detoxification and adjustment to the prison routine, normal sleeping patterns resumed.

'I feel good. I'm not dependent and I'm now sleeping normally and I'm not getting any sleepers from the doctors, whereas before I wouldn't be sleeping.' (Black British Women's Group)

However, for other women, problems sleeping remained and left them feeling tired and low. When asked about the impact of sleep problems, one young woman put it in graphically.

'You don't have any energy and you feel like shit.' (Young Women's Group)

4.3.9. Relationships with Custodial Staff

Among a number of factors that determined how well women coped with the prison environment was the quality of relationships with custodial staff. Some women reported that interaction with certain members of the custodial staff had a positive impact on their wellbeing in prison. Officers who made themselves available and gave opportunities to talk about issues of concern were especially appreciated.

'They were marvellous, they were really good. They were ever so nice on that landing where I was. I could go and talk to them anytime and you could talk to them about anything...they was as good as gold...They always gave you time, they never said, "oh I can't talk to you at the moment I'm busy". If they knew you were really pissed off like that they would find the time for you no matter how busy they were.' (Interviewee 9)

Officers who helped women solve problems or showed that they were concerned about their welfare were noted and praised. Women particularly praised those officers who were proactive in identifying when women had emotional problems or needed support.

'For me, one officer, Miss [name removed], anytime she asks you, on our landing, she'll see that you're stressed, you don't have to say nothing. She knows, she'll be checking.' (Jamaican Women's Group)

One disabled woman, who felt that her needs were not being met, particularly appreciated how an officer had taken on an advocacy role for her in attempt to encourage the establishment to respond more effectively.

'I didn't even think of putting in a complaint. And she said, "no, I want you to fill in a complaint form because I want these people [prison managers] to know. I don't want these people to say that it [information] wasn't there, that you didn't have a decent wheelchair and you couldn't get down to exercise". She says, "I want it known that everybody was made aware of it".' (Interviewee 12)

However, such accounts were in the minority, and the majority of women regarded officers as callous and indifferent to women's needs.

'I think that the only thing they have to have, the criteria they have to have, to be an officer, you don't have to have no heart. They don't have a heart.' (Jamaican Women's Group)

One woman was distressed because she had been unable to obtain medication for a serious eye complaint that was causing her considerable anxiety. She recounted what happened when she had threatened to commit suicide within the earshot of an officer.

'I lost confidence in them altogether. I've even told them I would swing because I came for my medication, medication wasn't there...So they used to come round and do the watch and all of that...I was expecting, from me saying that, like, some attention, to try and get help off them. I said "what about me". They [the officer] went "swing quietly".' (Sentenced Prisoners Group)

Some women recognised that being a prison officer was a stressful and difficult job and felt that officers were not given sufficient training to enable them to do the job well. It was perceived that officers were equipped to carry out security-related tasks but not to respond to the broader welfare needs of prisoners.

'They need to be trained for this type of job. It's not an easy job for them either, no. I understand it's not an easy job to cope with because it's not as if everybody's the same.' (Jamaican Women's Group)

'They're not trained for any of this, they're just trained to lock the door, let them out, make sure no one escapes or nothing like that. Even me, I think I've got more training than they have got. Even the officers told me that, "[name removed] you've got more training than we get to deal with this". When I became a listener they trained me how to support, counselling and all that stuff so that's part of my listening training but they haven't got anything like that.' (African Women's Group)

4.3.10. Healthcare Services

4.3.10.1. Positive Perceptions of Care

The healthcare service was just one topic among a number that were explored in interviews and focus groups. However, it was often a subject that women were keen to focus on. There were examples given of good quality care given that women valued and appreciated. This related to specific services that women had used such as the women's health clinic, dental services or in some cases general primary care.

'The treatment here is good, similar to my dentist back home, the equipment and everything. The women's health clinic, the doctors take time with you and do everything – smears, everything. They called me back when they got the results and spoke everything [through] and she said it's all clear and there's no problems. They take their time and they don't watch you or anything and make you feel comfortable with what you confide to them and the doctor is the same.' (Young Women's Group)

What women valued about these encounters was that they were seen promptly and they could see for themselves that some action had been taken about their problem.

'The nurses are always there anyway if there's any problem and you always get to see the doctor in the end if you're not feeling too good. It doesn't take ages, it doesn't take forever to see the doctor and you get your medication.' (Young Women's Group)

'Well, once I spoke to the nurse down there. She seems nice, and I was telling her about my medication and even she was like, "oh it's just terrible. It's just no good."...and she said, "I'm going down to speak to the doctor" to sort us out.' (Interviewee 13)

It was also important that healthcare providers demonstrated a caring and compassionate approach and that the woman perceived that the provider gave time and attention to her needs and was genuinely concerned for her welfare.

'It [the women's clinic] was just like the outside surgery. There's a women in there with short hair, I can't remember her name. She's "old school". She's lovely...They always see me, they're alright with me and I'm alright with them.' (Interviewee 10)

Nurse [name removed] is wicked! It's not because she's just helped me but she helps a lot of people. It's not just because she's there as a nurse, she does take time out, she will listen. She is a genuine person.' (Interviewee 13)

The notion of respectful treatment was central to this perception and women expected that they would be respectfully treated by healthcare providers, even if this was not always forthcoming from other staff.

'Even though you might be in prison, you're still treated with some respect. You might not get it totally from the officers. [If] the officers are in a pissed-off mood, you're guaranteed that you say the wrong word to them, that's it, they're going to jump down your throat. But with the doctor, he has to hold up some professional respect for you, which is good.' (Interviewee 7)

As well as primary and secondary care services, women also appreciated opportunities to benefit from complimentary therapies when available. In this account, the woman noted the value of making acupuncture available (provided on a voluntary basis by a visiting practitioner) and relaxation for women who were undergoing detoxification.

'You do get acupuncture and you do get to do a bit of relaxation – movement – if you can. But the acupuncture I find is very, very good...everything from your big toe all the way up to your ear hole hurts. You're throwing up at one end, diarrhoea out the other, so it does help the body kind of, calm down and starts opening up some of these things that is just shut down, it eases the pain a bit.' (Interviewee 7)

4.3.10.2. Negative Perceptions of Care

While such positive accounts were forthcoming, it was more frequently the case that women used the opportunity presented by the interviews and focus groups to detail their complaints about their reported experiences of healthcare services. This effect has been observed elsewhere, so that when patients are asked about health service quality, they are more likely to focus on perceived shortcomings than positive aspects, and it is widely acknowledged that gauging patient satisfaction in health care is problematic (37;38). Women's concerns were centred on five key problem areas:

- ⇒ Access
- ⇒ Staff attitudes and interactions
- ⇒ Confidentiality
- ⇒ Access to medication
- ⇒ Professional competence

(i) Access

Issues of access emerged frequently during discussions. Many women were aware that they had neglected to access services in the community (in some cases due to problematic drug use) and regarded the fact of imprisonment as an opportunity to redress the problem.

'I've been to the women's health clinic, I've been to the dentist and I've been to the doctor. Because when I came here I said "you know what, I don't want to be here but then I cannot do nothing about being here, and whatever facilities they have I'm going to use it".' (Young Women's Group)

In each establishment, a system was operated whereby women were required to submit a written application to their unit office for assessment by a nurse in order to access care. This system was almost universally detested by the women. As noted above, women with diagnosed mental health problems perceived that their care should be automatically arranged for them. Other women disliked the application system because they felt that it was ineffective (multiple applications appeared to be ignored) and took too long to be responded to.

'They're no good the doctors here - people queuing for the doctor, "He'll see you within the next two days."...You're waiting and waiting and waiting...I put in applications. They came down and they said that they haven't got the application. I did four applications! I know that I did four.' (Interviewee 2)

'They should work on the applications. If you have a system of application forms you should really stick to it. You shouldn't be stuck in a pile, you know, down to the trash, into the bin. I mean six months [ago] my first application must have been. If you haven't seen my application [for ophthalmic services], the first application, then the system is not working.' (Interviewee 6)

The perceived lack of responsiveness in healthcare services left women feeling ignored and dismissed.

'And I'm saying to them, "please, can you put me down to see the doctor?" And I asked and asked and asked and asked, and it was only because [named officer] come on [duty], that she got me put down to see them on doctor's orders. Yet I fucking begged the nurses. Who you'd think would write me down.' (Interviewee 12)

Such treatment reportedly fuelled angry and frustrated responses, which contributed to an atmosphere of tension between prisoners and healthcare staff, leading to confrontational scenes.

'Some people have to curse and run from one corner to the other corner and tell them dirty words and then they pay them attention.' (Jamaican Women's Group)

'In the end, you just get so frustrated that you just end up having a go at them or shouting at them and they'll say, "oh get out of my office, I don't want to see you." So it's like you sit down - because I do go in there and think, "right, let me be diplomatic with him." You want to get what you want, so you've got to be nice. It doesn't work, then you speak from the other side of the coin, that don't work.' (Interviewee 11)

As well as complaining that multiple applications were ignored, some women objected to the system itself. Applications were submitted to officers and screened by nurses. Some women felt that this provided too many opportunities for their applications to be delayed or fail to be processed and that it compromised their confidentiality.

'I think that's not right at all. Because you can hand an officer an application, doesn't mean that they get passed over right away. But then, by the time you get down to the doctor, he's probably going add a couple of more days and by the time they're wanting to see you, people could die in here.' (Interviewee 8)

'The nursing staff decide when you're eligible to go to the doctor or not...you have to hand it [application] in to the wing box, and then the wing officers sort that out. So, prison officers, and you know, they could be male members of staff as well, sort through your application and decide, you know, to prioritise it or not and I really object to that. I think it's not confidential.' (Sentenced Prisoners Group)

Women further objected to the fact that nursing staff appeared to them to act as gatekeepers to services. They did not understand why in order to see the doctor for example, they first had to convince a nurse that it was necessary.

'When you're needing to see the doctor, they let you put in an app'. You have a nurse come before you see the doctor, and say "why you want to see the doctor?". You have to explain to she, and I don't see the reason why you have to explain to she that you need to see the doctor.' (Jamaican Women's Group)

Some women further objected to what they saw as the extension of this gatekeeper role into their consultations with doctors, whereby nurses were reportedly present in consultations and intervened in unwelcome ways.

'You've got your "bodyguard" nurse with you while you're talking to the doctor, who interprets your symptoms for you, as if you're not capable of explaining to the doctor in your own words.' (Sentenced Prisoners Group)

'Listen, if you want to see a doctor here you have to wait until the nurse slips out the room and quickly say all you've got to say to the doctor and they can write down your meds because the nurse will stop you getting anything, you know, and that's wrong – that's wrong.' (Black British Women's Group)

One aspect of accessing care that women particularly dreaded was the security arrangements that were put in place for external hospital appointments. While women anxiously awaited external treatment that they needed, there were humiliated by being handcuffed to officers when attending community facilities and resented those occasions when external healthcare providers did not insist (or officers refused) that handcuffs be removed during consultations.

'You would be in handcuffs. You get taken by two officers and basically you're treated like a real criminal. It's horrible.' (Jamaican Women's Group)

'They come in to take me to the hospital, two officers come, go be strip searched down in reception, put in handcuffs to go into the minibus. We go into the hospital, handcuffed again. And you know what a hospital waiting room's like. You get walked through with two officers...I just felt ashamed, it's terrible...everyone's staring at you. It's just embarrassing but they keep you cuffed all the time.' (Sentenced Prisoners Group)

(ii) Staff Attitudes and Interactions

Women also complained bitterly about what they regarded as care that was dismissive or lacked compassion, particularly on the part of nursing staff.

Participant 1: Two girls in my dorm they're drug users and I remember one night she got up with toothache and the nurse abused her. The nurse turn to her, said "what you want [is] drugs, I ain't got no drugs for you." They're rude man.

Participant 2: Why would you say something like that? She's in prison trying to get over the fact that she was taking drugs and you're going to rub it in her face.

Participant 3: Yeah they're really rude the nurses. (Black British Women's Group)

One woman recounted an incident that she had observed of the response of an officer and a nurse to a disabled woman who had fallen out of bed during the night and was unable to return. She recounted the story as an example of the lack of compassionate care that she had observed.

'They said "oh, do you want us to put a mattress on the floor?" but she couldn't move and this nurse said, "I can't help to move you because I've got a bad back." So she then said, "can I have a bed-pan? I need to go to the toilet?" Not one bed-pan could they find in the prison. She was like, urinating and she was lying in her own urine. You wouldn't treat an animal like that.' (Interviewee 11)

Another prisoner recounted an incident where she was incapacitated by a serious leg injury and a nurse had had to throw pain medication to her through the hatch in her cell door.

'He just saw me crying, literally, and he goes "what's the matter?" and I said "I'm in pain but I can't walk to the door to get that medication because I can't walk, the leg is too much, I can't make it to the door". He couldn't open the door...he hasn't got keys and he felt bad and he didn't know what to do, so he said he can chuck one of the tablets. So he literally threw it – he put it in a plastic thing and threw it on my bed but I've got no water to swallow it. I didn't swallow it I just left it on the side.' (African Women's Group)

Women were often emotionally devastated by such treatment, in part because they regarded themselves as especially vulnerable. Not only because they were unwell but also because they were prisoners. One young woman recounted her reaction to a dispute that she had had with a nurse over obtaining pain medication for a toothache. Another woman explained that prisoners expected compassion from nurses and were especially disappointed when it was not forthcoming.

'It made me feel bad. I'm not worth anything, not even for painkiller. And it's for my pain not her pain that I'm taking it.' (Interviewee 6)

'You're so low, you're in prison and you're feeling unwell and somebody that you associate with an image of care and kindness and compassion, a nurse, a woman as well - like, you expect it. I think I have higher expectations of women than men to be kind to me when I'm unwell. But when these women are so cold and disrespectful, it really harms you.' (Sentenced Prisoners Group)

In some cases, a lack of compassionate care was attributed to healthcare staff being jaded and lacking the accountability that would prevent what women saw as rude or abusive treatment.

'Because we're in prison, they can treat you like any way they want. Then, when we say anything about it, we get nicked for it.' (Interviewee 4)

'I think just a lot of the nurses they've been here too long. They're just so stuck in their ways and they've been so used to taking liberties with people and fucking people off that they're just a law unto themselves.' (Interviewee 11)

More commonly, women saw such treatment by healthcare providers as rooted in stigmatising attitudes held about them as prisoners. Women who were known to be drug users were said to be particularly stigmatised but lack of compassionate care was reportedly not limited only to these prisoners. Women believed that holding such attitudes meant that staff did not feel compelled to treat them with compassion or respect.

Participant 1: As far as they're concerned we're shit on their shoes man, they don't even bother.

Participant 2: We're criminals, we're still criminals. (Young Women's Group)

'He [the dentist] was the worst one. He asked me what I was in for and I told him and he was like really, really arsey with me. I thought, "well, what do you want me to tell you? Do you want me say I'm in for shoplifting or whatever, just like, keep the doctors happy?" Because his attitude changed when I told him what I was here for.' (Interviewee 2)

Women found it particularly offensive when they perceived that diminished quality of care was related to stigmatising attitudes because they strongly believed that this should not be the case. In their view, the fact that they were prisoners was irrelevant and therefore, their healthcare should be commensurate with that provided in the community.

'We should be treated the same when you're in prison because we're not all bad people. Some of us haven't even been convicted guilty yet so we shouldn't be treated any different than they should outside. I don't think that's fair.' (Young Women's Group)

Moreover, women found it difficult to understand why healthcare staff who seemed to them to have distaste for working with prisoners would choose to be employed in the prison environment.

'The doctors come from outside to work in prison and they know what they're coming here to do, they're coming to work with prisoners so I don't see how they can treat people different because they know it.' (Young Women's Group)

'The way I see it is you're here to do a job, you get paid to do it. I would have thought to work here, to be a nurse and to work in the prison system you would have to have some kind of form of caring, some form of compassion for people. It's not there. If you don't like your job or you don't want to do what you're paid to do, don't work here. Simple as that!' (Interviewee 11)

(iii) Confidentiality

One issue that informed women's assessments of poor quality care was lack of respect for confidentiality. As noted, in the section on mental health, some practitioners apparently thought it acceptable to attempt to consult with women about private health matters through the hatches in cell doors, within earshot of staff and other prisoners.

'There's no privacy. Every time we go to discuss something it has to be through the hatch. Now when someone else round the corner is having a discussion with the nurse I can hear what they're saying and what's going on, there's no privacy one-to-one like, to explain. So no wonder when you come out on the landing everyone's looking at you. You should have privacy to speak to the nurse if you want to speak to her.' (Drug Using Women's Group)

The woman involved in the incident with the psychiatrists reported in the section on mental health described her reaction.

'Just to ask a 'screw' to come and sit in while they talk to me about my mental health and all the things I've been through as a child, my abuse and everything, when it's supposed to be strictly confidential between me and them...and not even to ask my permission do I mind one of them sitting in there, I've never fucking heard of that in my life!' (Interviewee 12)

Again, women contrasted the treatment they received from prison healthcare providers with that in community settings and found it lacking.

'The nurses come up to you in the corridor, talk to you about your medical problem that you've reported. They've no consideration how you might find that embarrassing. Or you might not want everybody on your wing to know that you've got a urine infection. I mean well, there's this assumption that it's ok. You wouldn't get a nurse outside coming up to you in a public place and discussing what is wrong with you. I find that really upsetting.' (Sentenced Prisoners Group)

(iv) Access to medication

A key issue of conflict between prisoners and healthcare providers was around access to medication. As noted above, women perceived that there was an assumption made on the part of healthcare providers that they were trying to obtain drugs (particularly anti-depressants and sleep medication) as a way to compensate for the enforced withdrawal from street drugs. Some prisoners agreed that this did occur, with women seeking to obtain unwarranted medication. This therefore created an environment of mistrust between healthcare providers and prisoners, so that women who genuinely believed they needed medication felt that they were being unreasonably denied, as this focus group exchange demonstrates.

Participant 1: Right, how many people do you get going to the doctors just wanting to some drugs to get them out their heads? That's what they've got to take into consideration.

Participant 2: But I don't want drugs to get out of my head, I want drugs to cure my illness.

Participant 1: But I'm saying, some people do do that, that's why they've got to be careful. (Young Women's Group)

While in some cases women understood, even if they felt aggrieved by the fact, that access to mood altering medication was contested terrain between prisoners and healthcare staff, they found it less easy to understand why staff were reluctant to give medication that was easily and legally available in the community and which was not open to abuse.

'You can't even get Ibuprofen. You can go to the shop - you're child could go to a shop and buy Ibuprofen but the nurses are going on like it's cocaine to give it to you.' (Black British Women's Group)

'My friend, she had some shoulder pain and stuff and she was having the flu and she went to the nurse and she was like, "wait until medication time", which will be I don't know how long. If you're in pain, why can't they just give you something to take?'. (Jamaican Women's Group)

One explanation put forward, and which was thought especially to apply to requests for medication from women with histories of drug misuse, was that their illnesses (whether physical or psychological) were regarded as self-inflicted and that they were therefore less deserving of treatment.

'I think they say like, it's self inflicted. So their attitude for people coming off the drugs is like "you brought it on yourself, tough shit" and don't care.' (Drug Using Women's Group)

Even those without histories of drug misuse found that such judgements were also applied to them, as this young woman's account of a consultation with a doctor indicated.

'I saw the doctor last week and it was a lady doctor I've never seen before. I've gone in there and I said I was really ill and she said "well that's what you get from coming off buckets of drugs". For starters, she should have read my file and she didn't read my file. When I came in I wasn't on drugs...she didn't apologise to me and she just assumed that I was on "buckets of drugs" because everyone else is on drugs, I'm not on drugs.' (Young Women's Group)

In contrast, other women found that they were too readily given mild painkillers, which they suspected was a way to placate them and to prevent them being disruptive then their healthcare needs were not being met.

'That's their answer to everything, Ibuprofen. "Have a couple of Ibuprofen". (Young Women's Group)

(v) Professional Competence

The difficulties that some women had in their interactions with healthcare providers led some to question their professional competence.

'First of all, these nurses are unprofessional. I don't know where they get them from. I'd like to see some of them, qualification, trust me, because they don't even interact with you on a professional basis.' (Jamaican Women's Group)

'I don't rate them that they're qualified doctors, I reckon they just fucking got them off the street.' (Young Women's Group)

The phrase 'NHS rejects' came to be used, which was understood to mean that healthcare staff were obliged to work in prisons because they were not competent to work in the community. Whatever the truth of the matter, the concept was used sufficiently often and was sufficiently well understood to have taken on shared meaning among prisoners. When asked to elucidate why women held these views, as well as the quality of their interactions, examples were given that women felt demonstrated that the ability of healthcare staff to accurately diagnose and treat illness was questionable. One woman who had been diagnosed with sickle cell anaemia was puzzled to have her diagnosis contradicted by a prison doctor. Another woman with damaged veins felt that the prison doctor was negligent in not recognising the boundaries of his professional competence and making an appropriate referral.

'I told a doctor when I came in here I'm sickle cell and he's telling me I'm not sickle cell. How can he tell me that? He said I'm too fat to be sickle cell? He said "oh you can't tell me [that]" he said "everybody who has sickle cell is skinnier.' (Black British Women's Group)

'They should be sending me out. He's saying "oh you've probably done damage injecting", well fucking obviously I've done damage injecting, that's why I'm walking like a fucking freak do you know what I mean? But at the end of the day, why aren't you sending me out to check out what the damage is? Because he's telling me "oh, it's past repairable". "How do you know, what are you Superman?" (Drug Using Women's Group)

It was in what they perceived to be poor responses to emergency situations that women most questioned the competence of healthcare staff. One woman gave a detailed account of a reportedly life-threatening two-hour delay in being taken to hospital with an ectopic pregnancy, because the nurse misdiagnosed her symptoms. This was apparently despite the fact that the woman informed the nurse that she had suffered from the condition previously. Another woman reported that she had acquired food poisoning while in prison, which eventually necessitated hospital treatment.

'I was proper sick and it was four days before anybody came to see me. All they wanted to do is give me anti-sickness pills, anti-sickness pills, anti-sickness pills to stop me from being sick but it was still making me feel sick because something was wrong. And all they put it down to was "you're withdrawing from methadone or you've had drugs in your system". (Black British Women's Group)

As well as problems with emergency situations, one woman described being encouraged by a nurse to insert a syringe into her own groin (which is a dangerous practice when performed by a person without medical training) when a nurse was unable to obtain a blood sample. She assumed that the nurse thought that this was acceptable because she had a history of drug use.

Participant: I went to have a blood test done and because the nurses couldn't get a vein, this one nurse asked me, 'can you get yourself in the groin?' ...and I says 'no I will not'...I was shocked. Just disgusted really, you know what I mean?

Researcher: And what did she do when you refused?

Participant: She just left it because she couldn't do it. She asked me if I wanted to get myself in the groin, she says "yeah, because if you can, then I'll let you." And I said 'well, no I can't.' So she just had to leave it.' (Sentenced Prisoners Group)

4.3.10.3. Recognising the Challenges

The strength of feeling that some women conveyed in relation to their complaints about the healthcare system were undeniable. But there were also occasions where women acknowledged the challenges that prison healthcare services faced and sought to put their criticisms in context.

'Like there's one nurse for however many people they have to see coming through reception here...Most of the people that come in "clucking" or withdrawing they want their drugs and they want whatever is going to make them feel better now.'
(Young Women's Group)

The young woman went on to recognise how stressful prison healthcare could be for practitioners.

'So the doctor's had a really shit customer – patient sorry, and then someone else comes along that's being genuine then that person might have it taken out on them but that's how the doctor feels they've got to understand.' (Young Women's Group)

One woman's assessment indicated that structural issues such as frequent prisoner movement and communication systems that did not support healthcare staff went some way to explaining some of the problems.

'There's so much coming and going, like people coming in, people leaving, people going to different wings, going to court, coming back, your file's gone and it's come back, it's come up late. I think some of it is not their fault. I'm not blaming it a hundred percent on them. I think it's more a breakdown of communication with the doctors, the nurses and the medical team.' (Interviewee 11)

5. DISCUSSION

This report details the findings of one of the largest studies examining the health of women prisoners in the England and Wales and provides a great deal of new and useful information about the health of these women. The study objectives as outlined in Section 1.2. were achieved with the exception of determining whether the health needs of imprisoned female ‘foreign nationals’ differ from other female prisoners. This was because only 6 respondents said they were resident in a country other than the UK prior to imprisonment and would therefore be classified as ‘foreign nationals’. Obviously it is not possible to draw any firm conclusions from a sample of only 6 individuals.

The study does however have some limitations. Whilst the questionnaire survey achieved a good response rate, there were some notable differences between the sample and the wider female prison population, such as marital and employment status, suggesting that the sample is not wholly representative of the female prison population. In addition, it relied on self report data from the women and we were unable to validate their responses using other data sources. The findings from the focus groups and interviews were remarkably consistent across the heterogeneous groups and individuals but it is not possible to generalise these findings across the whole women’s prison estate. In addition, as previously stated, this was work conducted at a particular time in the history of the prison service and NHS (the transition of health care services) and the researchers only elicited the views of the service users; the service providers were not interviewed and therefore the picture is one-sided. Nevertheless the study provides some important data on the health of women in prison.

The results of the questionnaire highlight the very poor mental and physical health of these women, but also show that some important aspects of women’s health improve during imprisonment. The mental well-being of these women, as measured by both the SF-36 and the GHQ-12, improves over the three months of imprisonment. Yet although improved, the mental health of these women remains poorer than that of the general population. It should also be noted that these improvements can be attributed to improvements in the subjective health status of women who used illicit drugs in the community; similar improvements were not seen in those who did not use drugs.

Imprisonment also seems to have beneficial effects on some health related behaviours; women smoke less tobacco, and their alcohol and illicit drug intake is moderated if not stopped completely. However, the evidence from this study suggests that the prison environment does little to promote healthy eating or physical exercise. There are of course examples of good practice within the prison estate but these should be the norm rather than the exception; healthy choices need to be the easy choices throughout the women’s estate and women should not have to choose between exercising and earning money.

The findings regarding women’s health service use in the three months prior to imprisonment suggest a rather atypical pattern of service use. Despite the extraordinarily high prevalence of long-standing illness or disability, only three quarters of women were registered with GPs although there was frequent use of Accident and Emergency services and many women were in contact with drug and alcohol services too. There were differences in the use of health services in the three months before prison and the three months following imprisonment; women were more likely to be registered with a GP and to be in contact with drug treatment services, and less likely to have visited A&E, stayed overnight in hospital or visited outpatients. There were other notable changes in the use of medication; after three months in prison women were more likely to have been prescribed antihypertensives or antidepressants and less likely to be taking benzodiazepines or any opiate substitute. This is likely to reflect more appropriate prescribing patterns.

The results also suggest that these women were less likely than women in the general population to make use of the preventative services provided by opticians, dentists or the national cervical screening programme before coming to prison. However, the results also suggest that some of these women who had not accessed these services in the community did so once in prison. Women who had been in prison before were more likely to have been tested for a blood borne virus such as Hepatitis B. Unfortunately despite a national drive to vaccinate all prisoners against Hepatitis B and the use of an accelerated schedule, only 50% of those still in at three months had received at least one vaccination.

The qualitative findings provided some very useful insights into the women's health beliefs and attitudes. When discussing health, women had a broad, positive view of health and clearly described the effect of the *whole* prison environment – not just health care- on their well-being. Women who had had healthy lifestyles before imprisonment were critical of many aspects of the prison regime – the quality of food, the lack of exercise opportunities, the attitude of the custodial staff, etc. In contrast women who had previously misused drugs or alcohol and had led a precarious existence prior to imprisonment could see that prison had positive consequences for their health: regular meals, protection from violent relationships, access to health services, etc. This corresponds with the findings from the quantitative data, the SF 36 mental and physical component summary scores, which showed little change in women who did not use drugs but significant improvement in women who had used drugs.

However, there were some issues which women from whatever background felt had a negative impact on their wellbeing - the attitude of both custodial and health care staff being a particularly important one. In addition there were some important concerns raised about the quality of health care – access issues, a lack of confidentiality, questioning of professional competence and issues of the inability to self-medicate. As already stated, the qualitative findings present a very one sided view, however, these issues are of such importance and so central to these women's well being that they merit further action.

These findings are not an indictment of the health care services provided within prisons. Clearly many women's health improves and they are able to engage with services that they would not access in the community. That is not to say the services provided are ideal; the results from the qualitative research in particular highlight important weaknesses in the services which need to be addressed. However, it is important to consider the pressures upon these health services – the situation is simply not comparable to general practice in the community despite the move to 'equivalence of care'; in the prison setting there is a huge turnover of extremely vulnerable women with very complex needs. In many ways the primary care services in prison are being required to provide '*compensatory care*' – that is, in a very short space of time they attempt to address the many health needs of these women prisoners, health needs which have hitherto been neglected in the community. The improvement in women's health whilst in prison is an indictment of the chaotic and socially marginalised lives that many lead when in the community and the failure of services to engage these women when in the community.

Despite its limitations, the study provides a great deal of interesting and useful information about the health of women in prisons in England. It might be argued that some of the findings are self-evident and indeed many health professionals who work in prisons will not be surprised at many of the findings: the prevalence of psychological disturbance, the high rates of self harm, the weight gain whilst imprisoned. However, this study is the first to document health issues and provide written evidence of what many health professionals in this setting already know. We hope as such it will be of use to those providing services for these women. Despite the fact that some important aspects of women's health improve during imprisonment, their health remains much poorer than that of the general population and so these findings should not be used to endorse the imprisonment of women but instead they should be used by both those providing prison health services and those in the community to work together to meet the complex needs of this vulnerable group. For when they are released, they will remain vulnerable – if not more so- and they need to be assured of access to services.

6. RECOMMENDATIONS

The Prison Service

The prison environment has a considerable impact on women's health. Government ministers acknowledged that promoting the health of prisoners is a core activity for the Prison Service in the strategy 'Health Promoting Prisons: a shared approach'(39). However, it is clear that further work needs to be done in this area, and that more health indicators should be Key Performance Indicators.

Linked to this, at all levels of the Prison Service, staff should be aware of the huge importance of the health of women prisoners; these women's health is often central to their offending behaviour (40) and so key their rehabilitation. An understanding of the health issues faced by them may help officers better understand these behaviour and concerns.

Continue to ensure adequate training and numbers of staff who are therefore able to deliver high quality care to this vulnerable group. Respect for prisoners should be a key feature of this care.

Ensure that all women are able to exercise each day and that the operation of the prison regime encourages this rather than deters this.

Ensure that the food provided is healthy, varied and well prepared, and that at the very least, women are able to obtain their 'five-a-day'. There have been successful pilots conducted in several prisons from which to learn.

Acknowledge that the women prisoners themselves, as well as the prison staff, who witness suicides or self harm are also deeply affected by these incidents and need support.

Ensure that all women have access to in cell sanitation.

Consider piloting access to cleaning products to enable women to self care.

Ensure that there is compliance with the Disability Discrimination Act and that reasonable adjustments are made for disabled prisoners.

Prison Health

Consider developing an overarching health improvement plan for women in prison. This should pull together the existing strategies and identify important areas for health gain which have not yet been identified as a priority. There should be specific and measurable objectives which can be used to monitor progress.

Consider revisiting 'Health Promoting Prisons'(39). The important ideas contained within this document need further dissemination (to remind key players) and possibly development of more goals.

Primary Care Trusts & prison health care units

Work with all partners to produce Prison Health Development Plans (PHDPs) that use this latest information and evidence. Whilst mental health and drug misuse are very important issues, women also suffer from poor physical health. There are very high levels of need and delivering primary care in prison is not comparable to delivering it in the community.

Ensure that the monitoring systems in place for the PHDPs capture health outcome and process data (such as proportion of eligible women screened for cervical cancer) as well as structural measures (such as number of nursing staff).

Ensure that all women are being offered Hepatitis B vaccination and that other measures to reduce the spread of blood borne infections in prisons are utilised (such as making available sterilising tablets).

Consider working with the Prison Service to bring in more non-governmental/ voluntary organisations to deliver health promotion in the areas of sexual health, diet, nutrition.

Work to improve communication between health care staff and prisoners. This might include the development of regular consultations with prisoners on services, an improved transparent complaints procedure, or simpler measures such as photographs of staff in the health care facility with their name and qualifications for the prisoners to see. More explanations needs to be given to women so that they see why a nurse always sits in with a doctor, why medication is not given for sleep disturbance, etc.

The application system to see a health care professional needs review. Women need to know what has happened to their 'app' – when they will be seen and by whom. This is simple information, easily provided.

New staff should be recruited on the basis of their aptitude and ability to work with vulnerable individuals.

There should be adequate staffing levels with time for professional development etc. so that new and existing staff do not 'burn out'. Consideration should also be given to adopting the same working model for both doctors and nursing staff; nursing staff, like GPs, should continue to work at least part of the week in the NHS in the community.

Work to ensure adequate throughcare for those vulnerable women leaving prison.

Develop health services locally to engage marginalised groups so that those who enter prison are then not in need of 'compensatory care'.

Research

More research is needed on the following areas in particular:

- ⇒ Barriers to women prisoners accessing health care when they return to the community
- ⇒ Innovative ways of engaging these women with health services on release, and the effect that this engagement has on future offending behaviour
- ⇒ The health needs of foreign national women
- ⇒ Effective non-pharmacological interventions for sleep problems in the prison setting
- ⇒ The role of the social environment (including other prisoners and prison staff) in the prevention of self-harm
- ⇒ The feasibility and effectiveness of self-help strategies for self-harm in the prison context
- ⇒ The appropriate use of the segregation unit, examining in particular its use to hold mentally ill prisoners

7. REFERENCES

Reference List

- (1) National Offender Management Service Estate Planning & Development Unit. Prison Population & Accommodation briefing for 21st April 2006. http://www.hmprisonservice.gov.uk/assets/documents/10001B7F21042006_web_report.doc; 2006 Apr 21.
- (2) Home Office. Statistics on Women in the Criminal Justice System. Home Office, London; 2003.
- (3) Her Majesty's Inspectorate of Prisons for England and Wales. Patient or Prisoner? A new strategy for health care in prisons. London: Home Office; 1996.
- (4) Joint Prison Service and National Health Service Executive Working Group. The Future Organisation of Prison Health Care. London; 1999.
- (5) Marshall T, Simpson S, Stevens A. Toolkit for health care needs assessment in prisons. 2000. Birmingham, University of Birmingham.
- (6) Department of Health and HM Prison Service. Transfer of Prison Health to the NHS - Update. Prison Health Newsletter 11, 1-2. 2003.
- (7) Fazel S, Danesh J. Serious mental disorder in 23 000 prisoners: a systematic review of 62 surveys. *The Lancet* 2002;359:545-50.
- (8) Butler T, Spencer J, Cui J, Vickery K, Zou J, Kaldor J. Seroprevalence of markers for hepatitis B, C and G in male and female prisoners--NSW, 1996. *Aust N Z J Public Health* 1999 Aug;23(4):377-84.
- (9) Jenkinson C, McGee H. Patient assessed outcomes: measuring health status and quality of life. In: Jenkinson C, editor. *Assessment and evaluation of health and medical care: a methods text*. Buckingham: Open University Press; 1997. p. 64-84.
- (10) Jenkinson C, Layte R, Wright L, Coulter A. *The UK SF-36: an analysis and interpretation manual*. Oxford: Health Services Research Unit; 1996.
- (11) Lewis K, Hayes S. Health of women ex-prisoners. *Psychiatry Psychology and Law* 1997;4:1-64.
- (12) Kravitz H, Cavanaugh J, Rigsbee S. A cross-sectional study of psychosocial and criminal factors associated with arrest in mentally ill female detainees. *J Am Academy Psychiatry and the Law* 2002;30:380-90.
- (13) Plugge E, Fitzpatrick R. Assessing the health of women in prison: a study from the United Kingdom. *Health Care Women Int* 2005;26(1):62-8.
- (14) Goldberg D, Williams P. *A user's guide to the General Health Questionnaire*. Windsor: NFER-Nelson; 1998.
- (15) Hurley W, Dunne MP. Psychological distress and psychiatric morbidity in women prisoners. *Aust N Z J Psychiatry* 1991 Dec;25(4):461-70.

- (16) Home Office. Statistics on Women in the Criminal Justice System. Home Office, London; 2001.
- (17) Petersen S, Stewart-Brown S, Peto V. Health and lifestyle in four counties: results from the third Oxford Healthy Lifestyle Survey. Oxford: Health Services Research Unit; 1998.
- (18) Weild A, Gill ON, Bennett D, Livingstone S, Parry J, Curran L. The prevalence of anti-HIV, anti-hepatitis B core, anti-hepatitis C antibodies and associated risk factors in prisoners: England and Wales, 1997-1998. London: PHLS; 1998.
- (19) Singleton N, Meltzer H, Gatward R, Coid J, Deasy D. Psychiatric morbidity among prisoners in England and Wales. London: The Stationery Office; 1998.
- (20) Pope C, Mays N. Qualitative Research: Reaching the parts other methods cannot reach: an introduction to qualitative methods in health and health services research. *BMJ* 1995 Jul 1;311(6996):42-5.
- (21) Ziebland S, Wright L. Qualitative Research Methods. In: Jenkinson C ed, editor. *Assessment and Evaluation of Health and Medical Care*. Buckingham: Open University Press; 1997. p. 102-28.
- (22) Kitzinger J. Qualitative Research: Introducing focus groups. *BMJ* 1995 Jul 29;311(7000):299-302.
- (23) Fitzpatrick R, Boulton M. Qualitative methods for assessing health care. *Quality in Health Care* 1994;3:107-13.
- (24) Social Exclusion Unit. Reducing re-offending by ex-prisoners. London: Cabinet Office; 2002.
- (25) Devlin A. *Invisible Women*. Waterside Press; 1998.
- (26) Robson C. *Real World Research*. Oxford: Blackwells; 1993.
- (27) Strauss AL, Corbin J. *Basics of Qualitative Research, Grounded Theory Procedures and Techniques*. London: Sage; 1990.
- (28) National Centre for Social Research. *Health Survey for England 2003*. The Stationery Office; 2004.
- (29) National Statistics. *General Household Survey 2004/05*. 2006.
- (30) Home Office. *2002/2003 British Crime Survey*. 2003.
- (31) National Statistics. *Contraception and sexual health 2000*. London; 2002.
- (32) Department of Health. *Health Survey for England 2004*. London; 2005.
- (33) Hawton K, Rodham K, Evans E. *By their own young hand*. London: Jessica Kingsley Publishers; 2006.
- (34) NHS Cancer Screening Programmes. *Shaping Futures: NHS Cervical Screening Programme Annual Review 2005*. Sheffield; 2006.
- (35) National Institute for Clinical Excellence. *Dental Recall: recall interval between two routine dental examinations*. 2004. Report No.: Clinical Guideline 19.

- (36) The College of Optometrists. The College of Optometrists Members' Handbook. 2005.
- (37) Coulter A. Trends in patients' experience of the NHS. Oxford: Picker Institute Europe; 2006.
- (38) Coulter A. Can patients assess the quality of health care? BMJ 2006;333:1-2.
- (39) Department of Health and HM Prison Service. Health Promoting Prisons: a shared approach. London: Department of Health; 2002.
- (40) Home Office. Women's Offending Reduction Programme. London: Home Office Communications Directorate; 2004.