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# Patient *and* Prisoner: Mainstreaming NHS primary care and public health in the male prison estate in England and Wales

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This Thesis is submitted for the Degree of Doctor of Philosophy, School of Applied Social Sciences, Durham University, May, 2008



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**Abstract**

*For more than two hundred years responsibility for the provision of primary health care for prisoners in England and Wales has rested in the hands of individual prisons who managed health care budgets in tandem and often in tension with security imperatives. However, following publication of 'The Future Organisation of Prison Health Care' report, responsibility for the commissioning of primary care services for inmates was transferred to the National Health Service (HM Prison Service & NHS Executive, 1999).*

*This policy shift was based on evidence which suggested that health care standards in the prison estate lagged behind those in the wider community and was instigated with the aim of bridging the gap between the two, i.e. 'mainstreaming' services. However, analysis of data collected using semi-structured interviews with key health care and security professionals as well as from secondary documents suggests that while the delivery of services in line with mainstream NHS services may be a step in the right direction, the conditions of their consumption, i.e. the prison environment, renders the mainstreaming goal incomplete.*

*In order to move more fully towards an equalisation of services, the thesis argues that a further paradigm shift is needed; one which acknowledges difference between environments as fundamental to the manner in which services are not alone delivered but consumed. In order to address health inequalities associated with a particularly unhealthy population cohort, changes in medicalised services need to be accompanied by the development of a more robust public health agenda within the prison estate. This change would be underpinned through a reconceptualisation of prisons as neighbourhoods in their own right.*

*Lastly, from a social policy perspective, the thesis argues that successful policy implementation is highly contingent, with outcomes dependent as much on complex local variables as the nature of the policy directive in the first instance.*

Key words: Prisons, Primary Care Trusts, public health, neighbourhoods, policy implementation, social policy, health inequalities

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Turning to other academics I would also like to thank Dr Ian Roberts for support and friendship, Dr Steph Lawlor and John Tierney. Also, to my second primary supervisor Prof Tim Blackman for the work he put in. In addition, thanks are due to Dr Alison Learmonth and Prof David Hunter, members of the Steering Group for the research, who made valuable contributions to the work during the first year. Also to the ESRC and the HDA who funded the research.

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## Glossary

| | |
|---|---|
| AIDS | Acquired Immune Deficiency Syndrome |
| BBV | Blood Borne Virus |
| BMA | British Medical Association |
| CARAT | Counselling, Assessment, Referral, Advice, Through-care |
| CASE | Collaborative Awards in Science and Engineering |
| CEO | Chief Executive Officer |
| CHD | Coronary Heart Disease |
| COREC | Central Office for Research Ethics Committees |
| CPN | Community Psychiatric Nurse |
| CPA | Care Programme Approach |
| CRB | Criminal Records Bureau |
| DAT | Drug Action Team |
| DES | Department of Education and Skills |
| DH | Department of Health |
| DHA | District Health Authorities |
| DNA | Did not attend (NHS term for failure to attend GP appointments) |
| DSPD | Dangerous and Severe Personality Disorder |
| DTI | Department of Trade and Industry |
| ECT | Electroconvulsive Therapy |
| ESRC | Economic and Social Research Council |
| GP | General Practitioner |
| GUM | Genito-Urinary Medicine |
| HAC | Health Advisory Committee |
| HCO | Health Care Officer |
| HDA | Health Development Agency |
| HEP | Hepatitis |
| HHSRS | Housing Health and Safety Rating System |
| HIA | Health Impact Assessment |
| HIMP | Prison Health Improvement Plans |
| HISP | Health Information System for Prisoners |
| HIV | Human Immunodeficiency Virus |
| HMCIP | Her Majesty's Chief Inspector of Prisons |
| HMP | Her Majesty's Prison |
| HMSO | Her Majesty's Stationary Office |
| HMYOI | Her Majesty's Young Offender Institution |
| HNA | Heath Needs Assessments |
| HPA | Health Protection Agency |
| IMB | Independent Monitoring Boards |
| IMR | Inmate Medical Record |
| IST | Insulin Shock Treatment |
| IT | Information Technology |
| LREC | Local Research Ethics Committee |
| LSP | Local Strategic Partnership |
| MDT | Mandatory Drug Testing |
| MOH | Medical Officer of Health |
| NEPHO | North East Public Health Observatory |

| | |
|---|---|
| NHS | National Health Service |
| NOMS | National Offender Management Service |
| NPM | New Public Management |
| NPS | National Probation Service |
| NRF | Neighbourhood Renewal Fund |
| NRT | Nicotine Replacement Therapy |
| NRU | Neighbourhood Renewal Unit |
| NSF | National Service Framework |
| NVQ | National Vocational Qualification |
| ODPM | Office of the Deputy Prime Minister |
| PCG | Primary Care Groups |
| PCT | Primary Care Trust |
| PHDP | Prison Health Development Plan |
| PHLM | Prison Health Liaison Manager |
| PIS | Participant Information Sheet |
| PMS | Prison Medical Service |
| POA | Prison Officers Association |
| PSI | Prison Service Instruction |
| PSO | Prison Service Order |
| REC | Research Ethics Committee |
| RMN | Registered Mental Nurse |
| RSG | Research Steering Group |
| SHA | Strategic Health Authority |
| SLB | Street-Level Bureaucrat |
| SMO | Senior Medical Officer |
| SSA | Site Specific Assessment |
| STD | Sexually Transmitted Disease |
| STI | Sexually Transmitted Infection |
| UN | United Nations |
| UK | United Kingdom |
| WHO | World Health Organisation |

**I hear that train a-commin', it's rolling' around the bend**

**And I ain't seen the sunshine since I don't know when**

**I'm stuck in Folsom prison, and time keeps draggin' on**

**But that train keeps a-rollin' on down to San Antone**

**Johnny Cash**

**Folsom Prison Blues (Cash, 1968)**

The mood and temper of the public in regard to the treatment of crime and criminals is one of the most unfailing tests of the civilisation of any country. A calm and dispassionate recognition of the rights of the accused against the state and even of convicted criminals against the state, a constant heart-searching by all charged with the duty of punishment, a desire and eagerness to rehabilitate in the world of industry of all those who have paid their dues in the hard coinage of punishment, tireless efforts towards the discovery of curative and regenerating processes and an unfaltering faith that there is a treasure, if only you can find it in the heart of every person – these are the symbols which in the treatment of crime and criminals mark and measure the stored up strength of a nation, and are the sign and proof of the living virtue in it.

Winston Churchill

House of Commons speech, given while Home Secretary, July 20, 1910 (Churchill, 1910)

Chapter 1

# Introduction

Reporting on the state of health care in prisons in England and Wales, Her Majesty's Chief Inspector of Prisons (HMCIP), Sir David Ramsbotham's discussion paper *Patient or Prisoner?: A new strategy for health care in prisons* recommended that new partnership arrangements between the Prison Service and local NHS providers be established to ensure that 'prisoners are given access to the same quality and range of health care services as the general public receives from the National Health Service [NHS]' (HMCIP, 1996, p.1).

A Joint Working Group of officials from the Prison Service and the NHS Executive was then established for the purpose of investigating how prison health care could be reorganised and improved. Their report, *The Future Organisation of Prison Health Care*, while acknowledging that some good work was being done, nonetheless pointed to several shortcomings in the service as it stood (HM Prison Service and NHS Executive, 1999). These difficulties were summarised as follows:

> '[ ] looking at prison health care as a whole, this is characterised by considerable variation in organisation and delivery, quality, funding, effectiveness and links with the NHS. No two prisons can be regarded as the same. This situation is largely a product of a historical legacy, ad hoc development, and relative isolation from the NHS. Prison health care is often reactive rather than proactive, over-medicalised with health needs assessments being the exception. Lack of direction, poor lines of communication and confused accountability resulted in many instances in less than optimal health care delivery. Arrangements for the continuing professional development of health care staff were not well established. In general there was no way to monitor effectively the outcomes of care (HM Prison Service and NHS Executive, 1999, p.8).

It was therefore clear that the manner in which prison health care was delivered needed reform. The Labour government took on board the recommendations of the above documents and put in place arrangements to create working partnership agreements between prisons and their local NHS Primary Care Trusts (PCTs). In addition, funding responsibility for prison health services was transferred from the Home Office to the Department of Health (Department of Health, 2005a). This was the first step in a process that has seen PCTs becoming responsible for the commissioning and provision of primary health care services to prisoners and ex-prisoners in their areas.

This represents a major policy shift and raises important research issues. Prison health care, although sometimes staffed by local General Practitioners (GPs), had been planned and commissioned separately from other health services, shaped by and in tension with the security and correctional aspects of prison life. In addition, it was primarily concerned with the treatment of illnesses and reducing health damaging behaviours within the prison walls. Instead, the concept of 'mainstreaming' services, i.e. seeking to achieve broad equivalence between what services are provided in the wider community and within the prison estate, is now to be employed as a central policy driver for prison health care.

In addition, PCT responsibility has brought new challenges to both the Prison Service and the NHS. These two lead organisations and those who work in them may have conflicting approaches and priorities. Decisions on the amount and nature of resources to be allocated to prison health care relative to other areas will be more transparent and are likely to be contentious. Also, connections between health in prisons and public health issues in the community could become more evident from a health care perspective.

Furthermore, a number of reports have expressed concern about prisoner health and prison health care, outlining evidence that the health status of prisoners is relatively poor, notably in relation to mental health problems (Singleton et al, 1998, Marshall et al, 2000a, Prison Health, 2002). There is also a high incidence of smoking, histories of excess alcohol consumption and other drug misuse (Keavney, 2004). Failure to tackle the health problems of prisoners can have far-reaching implications, not only for

prisoners themselves and their families, but also for the (often disadvantaged) communities into which they are released.

Also, crime has considerable and wide-ranging costs for health, in terms of the impact on victims and health services (Robinson & Keithley, 2000, Keithley & Robinson, 2000). Given that prisoners are more likely to be disadvantaged and in poorer health than the general population, prioritising prison health would seem to follow from the current government's emphasis on tackling health inequalities (Department of Health, 2004).

In addition, PCTs now have responsibility for prison health care but they are operating in a context which stresses the need to meet targets and deliver on improving diagnostic and treatment services (Hunter, 2002, Department of Health, 2005b). Noting these operational pressures it is relevant to explore whether service providers will actually be in a position to prioritise prison health or will it be considered to be less important than meeting expectations in respect of other priorities, for example, acute care waiting list targets?

Taken together these policy shifts have implications for the broader public health agenda. For example, will public health, so prominent in current NHS strategies, be adopted by health care teams within prison establishments in line with mainstreaming goals (Department of Health, 2003b)? Also, how do PCTs understand public health issues within prisons in the first place? A substantial part of the research is therefore concerned with what opportunities (and barriers) may arise for introducing a public health model into an environment which may be argued to be detrimental for an individual's health in the first instance (Smith, 2000).

The question of feasibility and the delivery of national policy goals (especially the public health agenda), at local level is therefore central to the thesis. This will be explored by applying the literature on implementation for the purpose of establishing whether or not there are certain conditions which help or hinder producing positive policy outcomes. Here, the notion of an 'implementation gap' will be identified as the central thread of the thesis (Gunn, 1978).

Supporting the findings on implementation gaps will be Lipsky's ideas on the 'street-level bureaucrat', i.e. those responsible for the implementation of policy at local level who, in effect, *are* the mainstreamers. This concept will be used for the purpose of looking at why and in what circumstances policy may or may not be delivered along the lines prescribed by central government (Lipsky, 1980). Here, issues such as resistance to change, facilitating factors and barriers to implementation will be explored through respondents' descriptions of their working lives.

In addition, it is appropriate to highlight the 'social administration' character of the thesis at this point (Mishra, 1986, Slavin, 1985). Here, the practical issues which street-level bureaucrats encounter as they go about implementing national policy, i.e. organising services and delivering them, are explored through an identification of barriers and challenges to provision as well as an outline of the methods employed to address shortcomings whether successful or not.

Now, more than ten years after his initial proposals, the vision outlined by Ramsbotham is being put in place. Although ultimate responsibility for health care remains with Governing Governors, PCTs have now taken over responsibility for commissioning primary care services in prisons in England and Wales. This would therefore appear to be an appropriate stage at which to review to what extent implementation has actually been achieved, what tensions, obstacles, facilitating factors and successful outcomes were/are being encountered and how the management and delivery of change has unfolded.

The thesis has been set out as follows. Firstly, Chapter Two looks at the history of health care in prisons. As the thesis progresses the principles underpinning incarceration are seen as particularly important in producing outcomes. The chapter therefore begins with an outline of historical thinking on the subject of imprisonment. Starting with the 1774 Health of Prisoners Act, I then trace the relevant legislative developments up to the present day. Included in the discussion is the powerful role of Medical Officers (MOs) and the conditions in which prisoners were maintained before the chapter ends with a more detailed description of the move to PCT commissioning.

Next, Chapter Three deals with the emergence of PCTs in the NHS. Here I begin by defining what is meant by 'primary care' before moving on to trace its role in the NHS from the economic crises of the 1970s onwards. The political context within which the NHS has evolved will be seen as particularly important. Issues such as the development of the internal market (of central importance to the emergence of commissioning principles) will be described before the development of the Prison Service/NHS partnership is outlined. The chapter concludes with a brief summary of criticisms which have been made and tensions which have emerged as PCTs take a lead role in health care nationally.

In Chapter Four, I move on to the key conceptual tools which were employed as relevant guiding mechanisms for the research. Here, Gunn's (1978) notion of the 'implementation gap' is highlighted as central to the study and the chapter begins with a more detailed explanation of the concept. I then outline my use of two other concepts, the street-level bureaucrat (Lipsky, 1980) and mainstreaming. Again, the supporting literature and rationale for employing each is described.

Having set the context within which the research was set and described the guiding concepts Chapter Five deals with the methodology employed. Here, I begin by describing the origins of the research and its beginnings as a collaborative piece of work between the university and the Health Development Agency (HDA). The research questions are then outlined. Next, I describe the commitment to an inductive approach based on grounded theory before moving on to a description of practical issues which arose during the fieldwork (Glaser & Strauss, 1967).

The selection process for the qualitative interviewee sample is then outlined together with details of how the *Framework* analysis tool was introduced for the purpose of identifying themes and sub-themes which emerged from the data. While identifying some strengths of the *Framework* model this section also includes a commentary on the inadequacies of the tool for a sample of this size. The documentary analysis source material is then described before an outline of the ethnographic and case study nature of the fieldwork is provided. The chapter ends with a breakdown of the sometimes difficult process of applying for ethical approval (Ritchie & Spencer, 1994) and a look at some methodological and practical critiques of the research.

As described in Chapter Three prisons and PCTs were obliged to produce Health Needs Assessments (HNAs) and Prison Health Development Plans (PHDPs) in preparation for and as part of the transfer of commissioning to the NHS. In Chapter Six the first original findings from the research are presented in the form of a documentary analysis of the HNAs and PHDPs for the various institutions. Here, questions arise as to both the level of engagement the concerned parties made with the prescribed tool for completing these documents, the *Toolkit for Health Care Needs Assessment in Prisons,* and the quality of the source material used in their construction (Marshall et al, 2000b).

The principal findings related to difficulties in implementing policy are outlined in Chapter Eight. This chapter begins with a section on 'receptive contexts' which emerged as a sub-theme during the analysis of data using *Framework*. The following section looks at respondents' attitudes to mainstreaming before I address the importance of the implementation gap concept to the thesis as a whole. I then turn to specific examples of 'explicit failure' to implement policy before outlining areas which are characterised as 'problematic but being addressed'.

The chapter then moves on to identify barriers and challenges for implementation. Here, issues which I have divided into five categories; funding, the security environment, national policy directives, the inmate population, and staffing issues are examined. Next, findings related to an area which was considered by respondents to be of particular importance, care pathways, are outlined. I then move on to how service providers, the street-level bureaucrats, at ground level produce coping strategies for managing change within the context of the difficulties just described.

Direct comparisons are then made between services in the wider NHS and what was found to be happening in the Prison Service as perceived by respondents. What emerges is a more mixed picture than the view of an isolated, out of date Prison Service health care model lagging behind a better quality of service in the wider community. Before concluding, a discussion of what this may mean for mainstreaming in the longer term is offered.

I then turn to a key driving goal of the original research proposal which was to examine the possibilities for introducing a more public health orientated service into the prison estate as a result of the policy shift. Chapter Eight therefore begins with an outline of the origins and debates surrounding public health and its relevance for the research. The actual findings are then presented in the second half of the chapter.

Similarly, Chapter Nine starts with a review of thinking on organisational culture before moving on to the differences between organisational culture in the NHS and the Prison Service as articulated in respondents' experiences. The relevance of these findings for both achieving the mainstreaming goal and implementing the public health agenda within the prison estate is then discussed.

The penultimate chapter stands to the side of the thesis as a whole reflecting as it does my own thoughts on how matters may be improved in practice. Here, I begin by suggesting that there must be a standard against which the outcomes produced as a result of introducing the NHS into commissioning primary care in the prison system may be measured. This is developed through an interrogation of what is meant by 'neighbourhood' in the first instance. I then make direct comparisons between prison environments and wider communities before presenting a broad sweep of policy initiatives which have been aimed at health and neighbourhood renewal more generally. In the conclusion I relate these social policy initiatives more specifically to the prison estate.

In the final chapter I return to the central question running through the thesis, i.e. how service providers seek to address implementation gaps and develop the discussion to explore what lessons the research may have for the implementation of social policy more generally. I then reprise the commitment made in the earlier section on the *Framework* analysis tool and place the work within the category of applied social research. Next, I outline a series of recommendations for health care policy in prisons which were conceived as a result of my engagement with the research. I then move on to outline a number of limitations and criticisms of the thesis before suggesting opportunities for further studies in the area of prison health care. In the conclusion, I provide an evaluation of how far this new direction in prison heath care policy has progressed, highlight opportunities for further research, talk briefly about possible

pitfalls for the future and finally situate the work within the context of the current state of the penal system in England and Wales.

Chapter 2

# The background: a history of health care in prisons

## 2.1 A chronological summary of developments in prison health care

As stated in the introduction *The Future Organisation of Prison Health Care* (HM Prison Service and NHS Executive, 1999) noted significant problems with health care in the prison estate in England and Wales. However, these shortcomings were not a recent development but rather the culmination of a history of professional isolation for health care staff, poor infrastructure and training and institutionalised practices which gained currency and hegemony over a period of more than 200 years. In order to understand the system and critically address it, it is necessary to understand how it evolved in the first place.

This chapter therefore begins with a chronological exploration of the development of medical services in prisons in England and Wales. Beginning with the 1774 Health of Prisoners Act it traces the evolution of health care by outlining the main features of relevant acts of parliament, the changing role of the medical profession in prisons, its often difficult relationship with security aspects of prison life and the guiding principles which influenced policy makers. This essentially medicalised model is then set in contrast to developments in the public health agenda which emphasise more proactive preventative initiatives as well as a more holistic approach to well-being in general. Bringing the story up to date I then turn to recent government policy on public health as outlined in *Choosing Health*: *Making Health Choices Easier* before setting these objectives in the context of health care in prisons (Department of Health, 2004).

Historically health care provision in prisons has been the responsibility of individual prisons. The 1774 Health of Prisoners Act formally empowered Justices of the Peace to monitor health care for the purpose of maintaining standards therein and the Prison Medical Service (PMS) was initiated. Importantly, both for an understanding of prison

conditions and the development of my thesis, interventions were guided by the principle of 'less eligibility'. This utilitarian doctrine decreed that:

> 'convicted prisoners are less morally deserving than the least well-off persons enjoying their freedom in the community, and should therefore not enjoy a life-style and facilities superior or *equal* to those enjoyed outside the prisons and workhouses' (Morgan, 1997, p.1143, italics author's own).

Underpinning this was the view that providing criminals with better facilities inside prison walls than the worst off in society at large could act as an incentive to commit crime in the first place. This fundamental principle was destined to produce dire consequences for health care over the following years as well as tie the medical profession ever closer to disciplinary regimes in prisons.

As Sim (1990) records, Medical Officers and doctors were called to adjudicate on a number of issues which were connected with the security aspects of the prison. For example, reducing the amount and quality of food, which was not to be better than that available on the outside in the first instance, was regularly used as a punishment for bad behaviour. Doctors were called upon to dilute portions, allocate minimal rations and generally ensure that the consumption of food was consistent with subsistence levels but not above. In addition, they made decisions regarding whether or not a prisoner was fit for hard labour.

This led to the practice of 'shamming', i.e. pretending to be sick or incapacitated. If it was suspected that the prisoner was playing out some pretence, the doctor would use a variety of methods, including bathing the prisoner in freezing water to decide if the inmate was genuine. These would often be prolonged sessions and if the subject was not sick beforehand deterioration in health afterwards was not uncommon. In any case, the 'treatment' would continue until either the doctor was satisfied about the prisoner's claims or the prisoner, unable to take any more, would admit the sham. Indeed, prisoners could also be denied medical attention if they were labelled troublemakers.

Importantly, these methods, and the doctrine of less eligibility itself, also met with resistance both from the medical profession and prisoners themselves. Following Foucault on power, Sim records numerous instances of opposition and protest by prisoners as well as articles in influential medical journals such as *The Lancet* decrying such practice. For example, in 1837, it comments:

> 'To turn criminals out upon society, even a shade worse in health and ignorance than distinguished them when they entered the dungeons of a gaol is in itself a crime of the very worst description' (*The Lancet* quoted in Sim, 1990, p.23).

At the beginning of the twentieth century, alongside conditions of overcrowding within the prisons, contagious disease was a major social problem. Within the prison system however, because a large number of crimes attracted either the death penalty or deportation to the colonies, many inmates were incarcerated for relatively short periods and thus health care provision in prisons was only seen as a limited problem by those overseeing incarceration (Morris, 2001) [1].

This changed following penal reforms which resulted in the large scale reduction in the number of capital offences and the end of deportation in 1857[2]. Thereafter the opportunities for contagious diseases to run their course within the prison walls increased for the paradoxical reason that prisoners now lived longer and remained in close proximity to each other. Treating this population cohort, which now faced long periods of incarceration, fell to the prison Medical Officer who acquired a status equal to that of Governor (Morris, 2001). This independent status arose, at least in part, from the particular powers which accompanied the role such as responsibility for certifying if the prisoner was fit for punishment mentioned above. Indeed, Sim makes note of numerous instances where prisoners regarded the Medical Officer as part of the disciplinary regime and as 'biased by the opinions of their masters' (Sim, 1990, p.23).

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[1] These included virtually 'all offences against property as well as assaultive crimes' (Morris, 2001). As Foucault records, by 1819, these numbered some 223 offences (Foucault, 1977).

[2] At its height in the 1830s the number of offenders exiled numbered 5,000 per annum. (Emsley, 2005)

Early problems such as the closure of the new penitentiary at Millbank because of the spread of cholera from the hulks (prison ships) at Woolwich are well documented (Morris, 2001). In addition, although some advances in epidemiology such as the introduction of running water and flush toilets at Pentonville Prison mirrored those on the outside, the prison health care system developed largely in isolation from provision for the wider community. As Morris puts it:

> 'The early history of medical provision for prisoners is part of the history of public medicine in 19th century Britain; the sad thing is that for most of the 20th century, with a very few notable exceptions, it largely remained in that time warp' (Morris, 2001, p.6).

At this time relations between the Victorian state and the medical profession were becoming closer. The 1863 Carnarvon Committee recommended that doctors, instead of speaking as individuals, made representation to government with one voice and operated as a professional group of state servants. In common with prison reformers such as John Howard, the state's concern with discipline, morality and control became more and more reflected in how health care was managed in prisons (Howard, 1929)[3]. While the debate about the medical profession's role in punishment and nutrition continued, Sim (1990) argues that their intervention on behalf of the security regime both served to strengthen their identification with it and also to legitimise the interventions which Medical Officers made.

During the second half of the nineteenth century a number of important acts of parliament were passed which had consequences for the medical profession working in prison and prisoners themselves. For example, the 1865 Prisons Act recommended the provision of an infirmary in each prison, that a surgeon see individual prisoners at least once a week and, crucially, that Medical Officers and doctors proactively look for 'signs of insanity' (Sim, 1990, p.41). Alongside developments in criminology, notably for example, Lombroso and the positivist turn, the state was becoming increasingly concerned with the breakdown of society and how criminal behaviour

[3] It should be noted that Howard, while mostly known as a great reformer was also very interested in discipline and correcting the morals of prisoners themselves. He died, somewhat ironically, of gaol fever which he contracted whilst visiting the prison at Kherson in the Ukraine (Morris, 2001).

could be controlled (Tierney, 1996). The centralisation of prison health care and control over it which began with Carnarvon was enhanced in 1874 with doctors required to provide government with records on prisoners' health and treatment. Furthermore access to prisons for the purpose of monitoring conditions by independent reform groups became more difficult (Sim, 1990).

Although more facilities were being offered for care the connection between Medical Officers and discipline in the prison continued. For example, the treadwheel continued to be used as punishment and beatings, admission to solitary confinement in damp underground cells, withdrawal of food which led some prisoners to eat soil and candle grease and 'hobbling' (tying a female prisoner's legs and arms behind her back) *inter alia* continued as punishments sanctioned by Medical Officers and doctors. Again, some within the medical profession complained and articles continued to appear in both *The Lancet* and the *British Medical Journal* condemning such practice. Penal policy, however, was dominated by a punitive approach with prison seen as a place of punishment and as a deterrent to others rather than a site of rehabilitation. Conditions continued to deteriorate with the result that attacks on medical staff increased.

The response was the 1877 Prison Act which increased the power of Medical Officers. Medical staff continued to rely on prison Governing Governors for their income and although they had been fighting an ongoing battle for increased wages they still commanded less than medical professionals working in the wider community. Allocation of the prison budget was a matter for the Governing Governor whose priority was, and still is, security. Against this background the Act promoted Medical Officers and allowed them to engage in general practice thus making significant savings on doctor's salaries. Attention to how qualified they were to engage in general practice seems to have been negligible (Sim, 1990).

Fears about genetically transferred criminality and the rise of expert professions further empowered health care professionals in prisons. The 1898 Prison Act reinforced the role played by Medical Officers and doctors in determining the sanity of inmates. The medical profession now became a major investigative apparatus in the state's concern with the incarcerated. Those labelled as particularly troublesome were separated from 'better' prisoners. Reform of the individual entered the discourse and

this was to be achieved by experts via the use of new techniques such as psychiatric modelling. These interventions had enormous consequences for prisoners. An inmate could now be adjudged insane by Medical Officers who had little or no training for the job. This could lead to different sentences than would normally be handed down and also influenced court proceedings. In addition, judge's calls for medical assessments of people held on remand increased. Indeed, where the mental state of an accused individual was deemed suspect by the court, the individual could be held in prison on remand indefinitely for medical observation from the mid-1890s onwards (Fitzgerald & Sim, 1982).

Throughout the early twentieth century conferences were held on what to do with the prison population and crime more generally. Again, mental illness was closely related to criminal activity in the language of the day and doctors/Medical Officers were seen as ideally placed to measure, determine and learn from incarcerated individuals. The reports they produced commanded considerable fees from academic institutions; useful money taking into account their lowly status (Stern, 1989). However, the training they had received, if any, in areas such as psychology was diverse as were the treatment methods used in different prisons.

Prisoners support groups campaigned for more regulation and in 1919 the Prison System Enquiry Committee was established by the government with a remit to investigate what was going on in prisons in England. Their report, *English Prisons Today*, was highly critical of doctors' practice and found that the increasing role they played in 'classifying illness and lunacy was based on little training or qualifications' (Sim, 1990, p.67). Importantly, it also found that conditions in the prisons *themselves* could lead to insanity and deterioration in the mental health of prisoners generally.

Autobiographical accounts written by prisoners during the 1920s and 1930s continue this theme of mistreatment while independent reports from the 1940s speak of the 'shamefully inadequate' medical facilities available (Sim, 1990, p.72). The response, however, seems to have been even greater dependency on psychiatry and psychology. In addition, during the post-war years staff who gained some experience of nursing while serving in the armed forces were recruited.

The tools of the psychiatric profession were therefore increasingly brought to bear on the prison population and the dividing line between treatment, experiment and punishment became ever harder to distinguish[4]. For example, from the 1950s onwards the use of electroconvulsive therapy, psychotropic drugs (whose availability increased with the growth of the multinational pharmaceutical industry) and insulin shock treatment on prisoners all increased (Sim, 1990).

Alongside this the prison population was increasing rapidly and overcrowding worsened. Various reports, such as the Prison Reform Trust's *Inside Story*, raised concerns and stated that the PMS was still using diet as a disciplinary tool on behalf of security regimes. Thus, as illustrated by Smith (2000, p.341) more recently, prisoners have long been in a dependency relationship where security takes precedence even though a key objective of the Prison Service is to provide a 'safe, decent and healthy environment' (see also Stern, 1989).

In any case, in 1961 *The Lancet* referring to the PMS as 'this corner of medical practice – one might say a backwater – that receives little attention' called for integration between the PMS and the NHS (*The Lancet* quoted in Sim, 1990, p.97)[5]. However, the 1962 Gywnn Inquiry into prison heath care rejected the recommendation when in spite of evidence in favour of the move both the doctors themselves and the British Medical Association (BMA) objected (Sim, 1990). The Gwynn Inquiry turned out to be the last official investigation of the PMS until the May Inquiry in 1978.

Attention turned instead to a 'new breed' of dangerous criminal. The media's coverage of high profile cases and concern among more conservative elements in British society about greater liberalisation, i.e. 1960s 'counter-culture', provides an interesting background for what went on in the prisons around this time. In the early 1960s special security wings were established to house those designated as particularly dangerous. Alongside this a number of violent disturbances seemed to

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[4] Interestingly, a Howard League Report in 1954 stated that 'to secure some uniformity of procedure and a broadening of experience a closer relation between the PMS and the NHS should be encouraged' (Sim, 1990, p.95).

[5] When the NHS was founded in 1947 Prison Service health care apparently argued that it did not need to join as it was the oldest health care service in the country (Ramsbotham, 2002).

confirm the authorities' worries. In 1972 there were over 100 demonstrations and a confidential government document, the Cox Report, led to the building of control units (for example at Wakefield prison) where control techniques such as sensory deprivation were employed. Following legal challenges by relatives of prisoners they were subsequently closed down, however, they remain an indication of the degree to which the medical profession was linked to the disciplinary regime.

Bringing the story more up to date, incidences of rioting in British prisons increased dramatically from the mid-1980s onwards and helped to focus attention on conditions within prisons themselves. In particular, the disturbances at Strangeways prison in Manchester, which involved a 25 day riot and siege in 1990, brought conditions in British prisons to the forefront of political debate (Player & Jenkins, 1994). While the causes of these disturbances have been variously blamed on overcrowding, a lack of security, a 'crisis of legitimacy' and a 'toxic mix' of prisoners the most important finding in the subsequent report compiled by Lord Chief Justice Woolf for our purposes concerns the notion of 'justice' in prisons. Woolf defined this concept as referring to 'the obligation of the Prison Service to treat prisoners with humanity and fairness, and to prepare them for their return to the community in a way which makes it less likely that they will re-offend' (Cavadino & Dignan, 1997, p.24).

Concern with conditions in prisons increased and became more acute from the mid-1990s onwards. The rioting already mentioned along with overcrowding and a greater recognition of the wider public health implications helped to focus government attention on health care. In addition, the prison population was now at an all time high in England and Wales with these figures projected to rise in the coming years (now over 80,000, NOMS, 2007). Furthermore, with prisoners now spending an average of six months in prison the numbers per annum leaving prison (throughput) has reached 201,000 per annum (NEPHO, 2004).

The interconnectedness of this transient population with their communities was further highlighted by estimates that they have significant contact with 1.5 million people annually on release (Department of Health, 2003c). Given the well documented poor health of the incarcerated community in the first instance, the dangers of failing to treat addictions and mental illnesses and the opportunity offered by the very fact of

having this population available for treatment, were increasingly recognised at government level as having major implications for the public health more generally (HM Prison Service, 1998).

Other considerations added weight to the argument in favour of improving health care and health promotion in prisons. For example, the moral right of prisoners to adequate health care and the proposal that improving the health of prisoners may also reduce offending through reducing drug dependency and crime associated with financing addictions. Furthermore better health may have other 'value added' effects such as improving employment prospects for ex-prisoners in legitimate labour markets. Lastly, positive outcomes from improved health care are also very attractive not only morally but politically as well in terms of reducing criminality and the cost to society of crime (Brand & Price, 2000). However, as the HM Prison Service and NHS Executive (1999) pointed out, prisons continued to be treated as separate entities[6].

This mixture of concern, need and opportunity was then brought into sharp focus by the report *Patient or Prisoner?: A New Strategy for Health Care in Prisons* by the then HMCIP, Sir David Ramsbotham. Specifically, Ramsbotham stated that:

> 'Prisoners should be entitled to the same level of health care as that provided in society at large. Those who are sick, addicted, mentally ill or disabled should be treated, counselled and nursed to the same standards demanded within the National Health Service' (HMCIP, 1996, p.5)

Ramsbotham then goes on to explicitly call for the transfer of responsibility for health care for prisoners from the Prison Service to the NHS. In addition, reporting on mental illness in prisons, the Health Advisory Committee (HAC) to the Prison Service identified the 'uncoordinated' manner in which mental health care for prisoners was delivered as well as the need for 'more effective throughcare arrangements to ensure

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[6] Perhaps this is because 'separateness' is at the core of society's understanding of prisons in the first place and therefore a change in the very way we understand prisons in the public consciousness is required in order to drive through prison reform? See Chapter Ten for a broader discussion on this.

continuity of care following release' (HM Prison Service and NHS Executive, 1999, p.3, Health Advisory Committee, 1997)[7].

Importantly, the HAC also cited 'equivalence of care' as a guiding principle for assessing the health care provided to prisoners. Indeed, the HM Prison Service and NHS Executive also reference the Prison Service Health Care Standards where the stated aim is to 'give prisoners access to the same quality and range of health care services as the general public receives from the National Health Service' (HM Prison Service and NHS Executive, 1999, p.5). Indeed, they go on to further clarify prisoners' rights citing the UN Standard Minimum Rules for the Treatment of Prisoners as follows: '[t]he [prison] medical services should be organised in close relation with the health administration of the community or nation' (HM Prison Service and NHS Executive, 1999, p.5). Taken together then, in terms of the development of the philosophy of the penal justice system, this focus on equivalence of service offers an interesting contrast to the principle of less eligibility outlined earlier.

The government responded to these concerns when the Home Secretary, the Secretary of State for Health and the National Assembly for Wales announced the establishment of a Prison Service and National Health Service Executive Joint Working Group whose remit was to work jointly to:

- 'Develop practical proposals for change that will deliver care for prisoners equivalent to that of the general population.
- Take account of the wider Prison and NHS agendas.
- Take account of the views of the key stakeholders.'

(HM Prison Service and NHS Executive, 1999, pp.3-4).

Importantly, while the Joint Working Group identified some good work taking place in some establishments, substantially difficulties existed. In addition, the contentious

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[7] Other important and influential reports include (Bridgwood & Malbon, 1994, Gunn et al, 1991, and Maden et al, 1994).

relationship between the disciplinary regime and the role of the prison health care system is reflected in their identification of a 'tension' between custody and care across the prison estate. They went on to make a number of important recommendations. Firstly, a 'formal partnership' between the Prison Service and the NHS should be established within 3 – 5 years.

Secondly, Health Authorities and Prison Governors, in accordance with wider NHS reforms concerning Health Improvement Programmes for the wider community, should come together to produce HNAs for the prison populations as well as HIMPs. Thirdly, a Prison Health task force was to be established to oversee the changes. Fourthly, a Prison Health Policy Unit was to be created which would replace the Prison Service Directorate of Health Care. The Policy Unit would be responsible for the development of prison health policy, drawing on and integrating with wider national health policies. Lastly, specific mention was made of care for mentally ill prisoners. Here, the report found that the 'care of mentally ill prisoners should develop in line with NHS mental health policy and national service frameworks including new arrangements for referral and admission to high and medium secure psychiatric services' (HM Prison Service and NHS Executive, 1999, pp. i-ii).

Taken together with *Patient or Prisoner?: A New Strategy for Health Care in Prisons* (HMCIP, 1996) this report is therefore central to the development of prison health care in England and Wales since 1999. However, it stopped short of recommending the immediate transfer of responsibility for prison health care to the NHS. Instead, it concluded that 'the question of whether or not the NHS should assume full responsibility for prisoners' health care should be examined again, when the actions and recommendations set out in this Report have had an opportunity to have an effect, and their impact has been assessed' (HM Prison Service and NHS Executive, 1999, p. iii).

Firstly, the recommended Prison Health Task Force and Prison Health Policy Units came into being in April 2000 for the purpose of providing leadership and facilitating links between the key prison service and NHS partners. In December 2002 they merged under the title Prison Health and were initially accountable to both the Prison

Service and the Department of Health. However, Prison Health now forms its own section within the NHS (Prison Health, 2003).

Importantly, Prison Health included a remit to not only assist those working in prisons to provide reactive medical treatment as part of the whole prisons approach but also to promote health and prevent the deterioration of a prisoner's health 'during or because of custody' in a manner consistent with the concept of 'decency' in prisons (Department of Health, 2002a). Importantly, from a public health perspective, these principles involve *all* aspects of prison life which 'touch on the wider determinants of health, *in addition to* health care, health promotion and health education' (Palmer, 2004, italics added).

Alongside this Regional Prison Health Development Teams were set up to monitor progress at local level and assist with bringing local NHS PCTs and prisons together to fulfil their new responsibilities. On 25th September 2002 the Home Office formally announced that funding responsibility for health care within the Prison Service would become part of the NHS. In addition a Prison Health Development Network was set up for the purpose of ensuring the transition of health care from the Prison Service to PCTs.

In addition, and in accordance with guidelines prescribed in the *Toolkit for Health Care Needs Assessment in Prisons*, as part of these developments prisons were required to produce HNAs and HIMPs for their populations during 2002 (Marshall et al, 2000). The guidance for the production of these plans was that although funding arrangements would remain 'broadly' as before, i.e. costed by where health care delivery took place, they should be produced in line with those being delivered in the NHS (North East Public Health Observatory, (NEHPO), 2004).

In July 2002, further underlining the concept of mainstreaming services, the standards against which the performance of prisons are measured was amended. In particular, Standard 22, the health care services baseline for prisoners now reads 'to provide prisoners with access to the same range and quality of services as the general public receives from the NHS' (HM Prison Service and NHS Chief Executive, 1999, p.1). This was further supported by documents and directives such as *Developing and*

*Modernising Primary Care in Prisons* which was issued jointly by the prison service and the NHS (Department of Health, 2002b). From 2004 these HNAs and HIMPs have been replaced by PHDPs which were produced jointly by the PCTs and prisons, with prison governors and PCT chief executives having statutory responsibility for development and implementation.

Under the terms of the National Health Service Reform and Healthcare Professions Act (2002) these changes have now culminated in the roll out of the first wave of eighteen PCTs who demonstrated a 'clear understanding of the health needs of their local prison populations and have in place robust plans to bring the prison health care in line with the wider NHS' (Prison Health Newsletter, 2004, p.1). The remaining PCTs in England and Wales with prisons in their boundaries were adjudged to have met the required criteria by April 2005. The transfer itself was overseen by Prison Health, which in 2004 became part of the new joint Department of Health/Home Office division of Health Partnerships. Completion of 'full devolution' of commissioning responsibility, i.e. when management of the whole budget for the commissioning of primary care in prisons will be solely within the remit of each PCT was completed in April 2006.

## 2.2 Relating broader government policy on health to prison health care

Having traced the development of medical services in prisons I will move on to look at broader government policy on health care and place it within the context of the prison estate. Firstly, it is well documented that the health status of prisoners in England and Wales is generally worse than similar demographic cohorts in the wider population (Department of Health, 2004, p.129, HM Prison Service and NHS Executive, 1999). An estimated 90% of prisoners have a diagnosable mental health (including personality disorder) problem, substance misuse problem or both, 24% of prisoners self report having injected drugs and of these 20% are infected with Hepatitis B, and 30% with Hepatitis C. In addition, more than 80% of prisoners smoke compared to around 25% of people outside the prison estate (Boyington, 2003, see also Department of Health, 2002e).

While tackling health inequalities in the prison context provides an opportunity to treat patients who often have had little or no contact previously with NHS services a number of problems are evident. Firstly, as outlined above, the prison environment itself is seen as being a fundamentally unhealthy (Smith, 2000, Stern, 1989). Also, the majority of prisoners are in custody for weeks or months rather than years (the average sentence is six months) meaning that treatment and/or immunisation and education programmes may be interrupted. In addition, as stated elsewhere and worth reiterating here, it is estimated that the 150,000 prisoners who make up the annual turnover from the prison system directly affect the lives of 1.5 million immediate family and friends (Boyington, 2003). The health and risk behaviour of these ex-inmates clearly has important consequences for the wider community.

As outlined in the *Choosing Health: Making Healthy Choices Easier* White Paper the public health model is being developed in the wider community (Department of Health, 2004). This strategy is also being advanced within prisons with *Health Promoting Prisons: A Shared Approach* (Department of Health, 2002a) championing a proactive health promoting strategy alongside the reactive medicalised model.

This approach reflects the World Health Organisation's (WHO) Alma-Alta Declaration which states that:

> 'The Conference strongly reaffirms that health, which is a state of complete physical, mental and social wellbeing, and not merely the absence of disease or infirmity, is a fundamental human right and that the attainment of the highest possible level of health is a most important world-wide social goal whose realization requires the action of many other social and economic sectors in addition to the health sector' (WHO, 1978).

However, as detailed in *The Future Organisation of Prison Health Care* the existing health care system in the prison estate posed particular problems (HM Prison Service and NHS Executive, 1999). Addressing this historical legacy in the context of the prison system which has a substantially different operational culture characterised by rigid systems and regularity as well as unequal power relations between actors is therefore a substantial challenge (Sim, 2002). However, as illustrated by the figures on turnover, it would be a mistake to see the issue as isolated from society as a whole. The prison walls in this context are porous and the implications for the health of the general population (as well as of prison inmates and staff) means that while the allocation of resources towards an unpopular section of society may be highly sensitive politically it remains an agenda which has the potential to not only improve health generally but may also result in reduced recidivism, for example, through a reduction in drug related crime.

In sum, the journey from less eligibility to mainstreaming represents a sea change in both the principles underpinning how prisoners are treated and how services are to be delivered. However, while achieving parity of service offers the potential for many positive outcomes, it also represents a formidable challenge. Having looked at the development of health care historically the following chapter will now turn to the partner body, the NHS, for an examination of how PCTs emerged at the front line of medical care in England and Wales.

Chapter 3

# The shift to a primary care-led NHS: the emergence of Primary Care Trusts and the new public health agenda

## Part 1

This chapter will begin by defining what is meant by primary care. Next I will describe the make-up of PCTs and situate them within the overall structure of the NHS. The discussion will also briefly look at PCTs' statutory duties as well as the possibility for some to evolve into Care Trusts working alongside other local agencies such as Social Services. I will then move on to the political contexts within which PCTs developed by identifying structural weaknesses in the NHS which were exacerbated by the economic crises of the 1970s. Following on from this I will describe the policy initiatives which sought to address these problems by tracing the search for more efficient health care services from the 1979 Conservative administration and the introduction of GP fundholding in the early 1990s to the creation of Primary Care Groups (PGCs) and PCTs under the Labour government. Here, the key political philosophies underpinning devolution of budgetary control and decision making to local agencies will be examined. Next, issues surrounding PCT's new responsibilities for prison health will be explored before the chapter ends with a number of criticisms which may be relevant to the prison estate as the PCT/prisons partnership develops.

### 3.1.1 Primary care definition and PCT structure

Beginning then with what is meant by primary care. Here, primary care may be understood as 'health services provided by GPs, nurses, dentists, pharmacists, optometrists and ophthalmic practitioners' (Department of Health, 2002a, p.6). Primary care has also been more broadly defined as 'a philosophy that emphasises the need to move care out of large institutions and into community-based settings' whereby local agencies are understood to be in a better position to respond to local care needs rather than be driven by centrally planned government health care strategies (Baggott, 1998, p.210).

Turning next to PCT structure, this was first outlined in Labour's *NHS Plan: A Plan for Investment, a Plan for Reform* (Department of Health, 2000). A complete restructuring of the NHS followed, including the creation of 48 PCGs. These PCGs were to be governed by a board 'comprising four to seven GPs, one or two community nurses, one social services nominee, one lay member, one health authority non-executive and the group's chief executive' (Ham, 1999, p.58) with their main responsibilities summarised as 'health improvement, development of primary and community care and commissioning [ ] secondary services' (Exworthy 2001, p.270). PCGs then became Primary Care Trusts (PCTs) the main commissioning and service delivery arm of the NHS. By 2003 there were 315 PCTs in England however, following mergers the number of PCTs as at October 2006 stood at 182 with PCTs now holding approximately 80% of the NHS' budget (NHS, 2007)[8].

The crucial difference between the old PCGs and the present PCTs is that while PCGs were established as sub-committees of Health Authorities, PCTs are 'free-standing bodies accountable to the Health Authority for commissioning care' (Ham, 1999, p.59). In addition, in contrast to their position within PCGs, GPs have lost their automatic majority on the Executive Committee. That said their influence remains strong. For example, only one of the first forty PCTs had a non-GP as chair of their Executive Committee (Exworthy, 2001, p.270). In addition, PCTs may also co-opt additional members. With regard to structure, the PCT Executive Committees report to the PCT board which has a lay chair and majority lay membership. Figure x summarises the evolution from PCGs to PCTs.

[8] For arrangements in Scotland, Wales and Northern Ireland, see Ham (1999, pp. 67-69).

Table 3.1

**Primary Care Groups/Trusts status levels**

| | |
|---|---|
| Level 4 – PCT Status | Become established as freestanding bodies accountable to the Health Authority for commissioning care, and with added responsibility for the provision of community services for their population |
| Level 3 – PCT Status | Become established as freestanding bodies accountable to the Health Authority for commissioning care |
| Level 2 – PGC Status | Take devolved responsibility for managing the budget for health care in their area, acting as part of the Health Authority |
| Level 1 – PGC Status | At minimum, act in support of the Health Authority in commissioning care for its population, acting in an advisory capacity |

Adapted from Ham (1999, p.59, Fig. 3.2) (See also Hann et al, 2001, p.286).

While levels three and four both acquired PCT status, at level four qualifying PCTs may take on additional responsibility for social care, reflecting Labour's commitment to partnership working where social services and health care providers work together in Care Trusts to provide a one-stop shop for community based services (Webster, 2002, p.242). For example, '[t]here was a clear understanding that PCGs (and Health Authorities) are increasingly required to work across local government, not just with social services' (Department of Health, 1999a, p.6) with Health Authorities given a major role 'in the development and support of primary care groups' (Ham, 1999, p.57)[9]. Lastly, performance is monitored by government appointed bodies, principally the Healthcare Commission.

[9] More recently, PCTs have been encouraged to contract out their community services and become purely strategic commissioning bodies. Detailed commissioning is also being transferred to GP practices. These changes are beyond the scope of the current study.

### 3.1.2 PCTs: Political context and policy development

Turning next to the political contexts within which PCTs emerged, in common with other spending on public services which had expanded in the post-war era, health care funding was thrown into chaos by the oil crisis of the mid-1970s which acted as a catalyst for a climate characterised by industrial unrest, high taxation and general dissatisfaction with the government's 'corporatist' social and economic agenda (Ham, 1999, p.27).

There were, however, a number of additional problems associated with the NHS of the time. Baggott (1998) divides these into a number of key areas: structural difficulties, difficulties regarding accountability, control and planning, and funding, efficiency and resource allocation. Briefly, the original structure was seen as inefficient due to organisational duplication, a lack of communication and coordination between its constituent parts, excessive managerial tiers and administrative bureaucracy.

In addition, Health Ministers, although they held responsibility for policy had no power over independently contracted doctors who orchestrated 'service developments [ ] at a local level'. Furthermore, Health Authorities could not be 'relied upon to impose policies designed by central government [because] the planning process was persuasive rather than directive' (Baggot, 1998, pp.97-98).

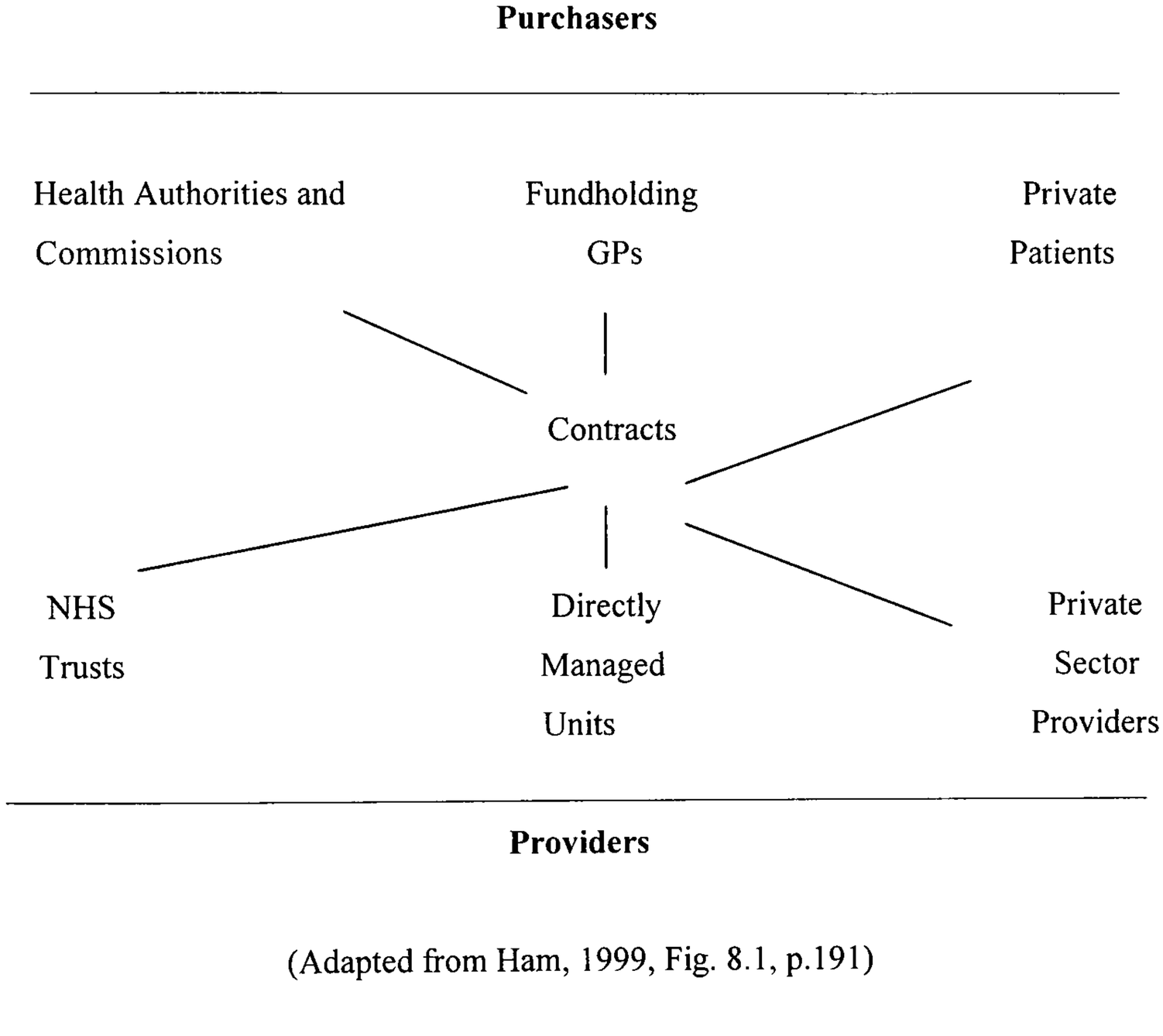
In any case, bringing the story more up to date, in 1979 the Conservative Party was elected to government and previous Keynesian economic policies which championed government spending and borrowing as a central tool of economic growth were abandoned in favour of a neo-liberal, market driven, economic and social model whereby much of the state sector was to be privatised. In addition, business efficiencies generated by competition were to be introduced into the remaining public sector (Kirkpatrick et al, 2005).

However, privatising a business such as British Gas, whose organisational ethos could be adopted to the requirements of the market, was one thing, the 'commodification of health care' and of what had become a popular national institution where many

services were available free was quite another. The New Right solution[10] was to introduce an internal market to the NHS whereby the method by which health services would be delivered at primary care level, i.e. via GPs in particular, would 'create the conditions for competition between hospitals and other service providers, through separation of purchaser and provider responsibilities and the establishment of self-governing NHS trusts and GP fundholders' (Ham, 1999, p.37)[11]. However, reflecting political sensitivities, these changes took some time to be developed and were only formally articulated in the 1989 government White Paper *Working for Patients* (Department of Health, 1989, see pp.48-53 on GP budgets).

Fig. 3.1

**The Internal Market**




(Adapted from Ham, 1999, Fig. 8.1, p.191)

In sum, in an era of reduced fiscal income achieving value for money was now to become critical for government spending decisions. New Public Management (NPM) developed during the Thatcher years and continued under Major saw neo-liberal

[10] For example, introducing new general managers and encouraging individuals to take out private health insurance.

[11] The GP fundholder schemes which identified four kinds of fundholding, depending on practice size, developed from 1990 onwards and by 1996 more than 50% of the population of England and Wales were covered (ibid, pp.118-119).

business principles and the perceived efficiency of the 'invisible hand' of the market introduced to the NHS by placing budgetary responsibility in the hands of those general practitioners who became fundholders and empowering them to exercise market choice as purchasers of medical services. This purchaser/provider mechanism was believed to improve efficiency and generate competition between suppliers as well as having the added benefit of freeing up District Health Authorities (DHAs) to concentrate on the strategic planning of health services (Ham, 1999, Jones, 2003).

In 1997 Labour came to power and set out its plans for the NHS in *The New NHS: Modern, Dependable* White Paper (Department of Health, 1997). Although vocal with regard to what it saw as the fragmentation caused by the introduction of the internal market while in opposition, Labour recognised that there would be no going back to previous systemic difficulties. Instead they sought to 'carve out a niche in the market place of political ideas' via a 'third way' which continued reforms initiated under the previous Conservative government but with a particular Labour twist (Ham, 1999, p.53). This was to be achieved in accordance with the following principles as outlined in *The New NHS :Modern, Dependable:*

- 'to renew the NHS as a genuinely national service.
- to make the delivery of health care against these new national standards a matter of local responsibility.
- to get the NHS to work in partnership.
- to drive efficiency through a more rigorous approach to performance and by cutting bureaucracy.
- to shift the focus onto quality of care so that excellence is guaranteed to all patients.
- to rebuild public confidence in the NHS' (Department of Health, 1997).

Labour's 'what counts is what works' approach entailed a firm commitment to long established NHS principles such as universality of access but within a system 'based on partnership and driven by performance' (Department of Health quoted in Ham, 1999, p.55). Importantly, this 'evidence-based policy-making' (Exworthy, 2001, p.269) retained what was seen as the best of previous government policy by abolishing GP fundholding altogether and expanding the scheme whereby 'the principles of

fundholding [would be extended] to all family doctors and community nurses' in the form of PCGs (Ham, 1999, p.56).

Also noticeable was the emergence of a new health care discourse which reflected Labour's third way policies. The purchasing role of primary care health professionals was to be replaced by commissioning – a significant semantic difference illustrating Labour's plans to replace purely market driven systems with service provision based on partnership and 'competition by comparison'. Thus, in accordance with Labour ideas on stakeholding, ownership of the provision of primary care was to rest with PCGs (based on groups of practices) who were understood to be better placed to respond to the health needs of local communities than the more limited perspective offered by GP fundholders (based on individual practices).

In addition, as mentioned above, Labour's NHS policy included involving the government more in the NHS through advising and monitoring bodies such as NICE and the Commission for Health Improvement. Indeed, such involvement was also believed to improve the possibility for reducing national inequalities – a 'one nation NHS' (Ham, 1999, p.56). Also, Health Authorities, now reshaped as regional Strategic Health Authorities were to be left free to develop the public health agenda and incentives for greater efficiency such as the opportunity for PCTs to use savings for other purposes were introduced.

The changes introduced by the Conservatives were therefore taken a good deal further as Labour expanded on concern with value for money to include assessment models which took into account 'health improvement, fair access, effective delivery, patient experience and health outcome' as well as enhanced devolution to local health care partnerships (Ham, 1999, p.61). This commitment also included addressing health inequalities as outlined in the *Choosing Health: Making Healthy Choices Easier* (Department of Health, 2004) White Paper which also includes a stronger emphasis on competition (including the introduction of private sector providers) and transferring commissioning to GP practices (although with budgets still held by PCTs), (Hawkes, 2007).

The implication for prison health is therefore that there should be explicit commissioning of appropriate care for this particular population group, and an emphasis on prevention (mainly lifestyle focused), health improvement and managing chronic conditions. In keeping with this broader definition of PCT responsibilities attention thus turned to a hitherto isolated section of society. It is to this issue I will now turn.

### 3.1.3 PCTs and prison health care

> 'Prisoners are entitled to the same level of health care as that provided in society at large. Those who are sick, addicted, mentally ill or disabled should be treated, counselled, and nursed to the same standards demanded within the National Health Service. Failure to do so could not only damage the patient but also put society at risk' (HMCIP, 1998, p.25).

Here, I will look at the transfer of funding responsibility for prison health care in England from the Home Office to PCTs who are assuming responsibility for the commissioning of primary health care services for prisoners (Prison Health Newsletter, 2003). The agreed timetable called for all budgetary responsibility to be passed to the Department of Health from April 2003. However, for the first three years of the handover the Prison Service retained a considerable influence and control over spending. Therefore, full devolution to PCTs did not occur until April 2006.

As illustrated above the background to this change is a long running concern with poor standards of health care in prisons. For a population identified as having little prior contact with NHS services and high levels of health care need the opportunities this offers for health improvement are argued to be substantial. Indeed, it may also offer better career opportunities for health care staff within prisons who were previously seen as 'professionally isolated' (Keavney, 2003). However, 'communities most at risk of ill health tend to experience the least satisfactory access to the full range of preventative service, the so called 'inverse prevention law' (Acheson, 1998, p.112) and it will take considerable effort on behalf of policy makers and those working in prison health to see the reforms through.

In support of these initiatives the government is also committed to improving staff training and has promised substantial additional funds which will rise to an extra £46m per year by 2005-2006 (HM Prison Service, 2003a). The emphasis is intended to be proactive as well as reactive with the goal being to promote continuity of health care both within prisons and afterwards in the community via throughcare provided by PCTs.

However, it is acknowledged that this allocation of resources towards an unpopular section of society is highly sensitive politically and, leaving aside the moral and ethical rationale for equality of health care provision, an emphasis on the broader potential benefits for society may be required before the goal of parity of health care standards is extended to within the prison estate[12].

### 3.1.4 PCTs: criticisms and tensions

Before concluding I will briefly outline a number of criticisms/tensions which have been raised in the early days of PCTs. It is not an exhaustive list. However, the issues raised may be seen as important factors as the partnership between the PCTs and the prison develops. Firstly, the Audit Commission Report on assessing performance in the NHS plan described the current position as follows; '[t]he overall picture is one of good progress [ ] but the system is not working universally well' (Audit Commission, 2003, p.2). For example, 80% of the newer PCTs, i.e. those established since April 2002, are adjudged to be at a 'high risk' of not achieving financial balance, while 72% may fail to recruit the required number of extra nurses.

Secondly, tensions between what *The New NHS: Modern, Dependable* termed a 'genuinely national service' (Department of Health, 1997, p.11) and locally commissioned services and choice in an area characterised by pre-existing inequalities may leave NHS users and residents disillusioned when some areas are demonstrably

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[12] For instance, as the UK based human rights organisation *Justice* point out it remains a basic principle of English Law that 'in spite of his imprisonment a convicted prisoner retains all his civil rights which are not taken away expressly or by necessary implication' (Justice, 2007).

shown to be under served. Here, the patient's (and indeed family and supportive others) willingness and/or ability to travel is an obvious problem when exercising consumer choice, which is an obvious difficulty for imprisoned individuals.

Furthermore, health care professionals themselves have been obliged to take on new administrative roles such as the management of budgets as well as their medical duties. As Ham points out, these responsibilities will inevitably impinge on doctors' long standing independence and challenging this 'professional autonomy' in the context of integrating general practice into the NHS is another challenge for government policy on primary care (Ham, 1999, pp.159-160). How this works out in the prisons is another challenge for the transitional process.

Add to this the political problems associated with shifting resources from secondary to primary care such as the rationalisation and closure of hospitals, initial problems with both PCTs and Care Trusts whose development is being hindered by inheriting previous Health Authority deficits and the particular problems inherent in earmarking often scarce resources for remand and convicted prisoners, the challenges for PCTs over the coming years are substantial (Baggott, 1998, p.225).

In conclusion then, '[t]he tendency begun with GP fundholding has now been carried to its logical conclusion with PCGs/PCTs' (Webster, 2002, p.242). This is being done through devolution of power to PCTs who are entrusted to both operate their own budgets as well as commission health care services at the point of consumption. In contrast to the internal market competitive gains are to be obtained through comparisons of quality of service indicators, monitored by bodies such as the Healthcare Commission as well as the production of plans designed to meet future health needs, in the form of HNAs and PHDPs in the case of prisons

In short, the third way is designed to combine local empowerment with the potential for government intervention, a 'managed devolution'. At the same time, responsibility for the commissioning of primary care services in prisons in England and Wales has been moved from the prison estate to the Department of Health with frontline responsibility being transferred to PCTs. While a number of problems have been mentioned this move may offer an opportunity to address the medical needs of an

otherwise neglected section of society with additional benefits for the communities into which they will be released.

Returning to the local then, whatever the problems mentioned above, primary care's new position at the frontline of prisoner health care provision in the UK reflects its move away from its previous position in the 'backwater' of health services more generally (Baggott, 1998, p.225).

Part 2

### 3.2.1 The background: a history of the public health agenda

Having traced the emergence of PCTs to the forefront of health care delivery I will next turn to an issue which is central to my thesis: the evolution of thinking on public health and its place in the prison health care system. This section therefore begins by defining public health and exploring relevant concepts such as the upstream preventative model before moving on to an overview of the history of public health in England and Wales. I will then describe the main policy initiatives aimed at improving the health of the population as whole. Rather than narrowly defining health as an absence of illness, these will emphasise the importance of environment and the more holistic goal of achieving individual well-being. Next, I will focus more specifically on public health programmes in the prison estate. In this section the link between inmate populations and the wider community will be emphasised. Before concluding I will offer a critique of the agenda itself.

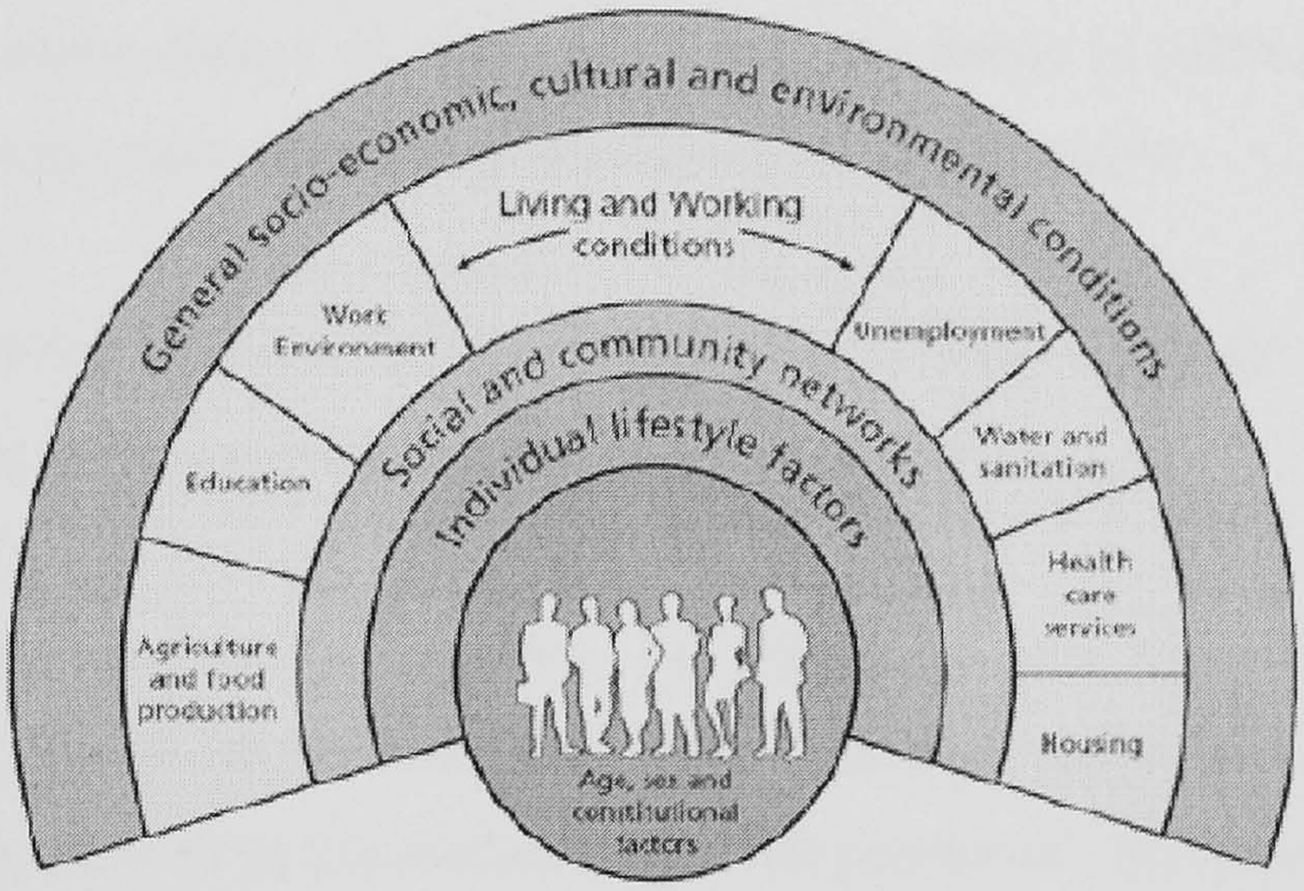
Firstly then how is public health defined? The Acheson Report (1988, p.5) puts it thus: 'the science and art of preventing disease, prolonging life, and promoting health through the organised efforts of society'. This definition is recognised by the Department of Health as 'reflecting the essential focus of modern public health' (Department of Health & Chief Medical Officer, 2003). It is concerned with collectively improving the health of the population rather than the health of individual cases. Importantly it recognises the centrality of the organised efforts of society as a *whole*.

This emphasis on health improvement illustrates that it is not just about addressing ill-health when it is diagnosed. Instead, upstream interventions such as better housing, lowering pollution levels and creating pleasant environments are included in order to decrease risk of disease. Furthermore, while longevity is increasing and modern medicine may prolong life substantially the quality of that life may be poor. The public health agenda recognises this and seeks to address quality of life through promoting health in a proactive manner, not least to help prevent health care costs downstream. Making available information on healthy choices regarding lifestyle is

therefore seen as central to the state's responsibility to citizens (Department of Health, 2004)[13].

This idea that it is not merely the absence of illness which defines good health but a more holistic sense of well-being emphasises wider determinants of health such as the social, environmental and economic factors summarised in Box. 1 below:

Box 1. Consolidated concept of determinants of health




*Source: Dahlgren and Whitehead (1991)*

Fig. 3.2 The main determinants of health (Dahlgren and Whitehead, 1991)

Public health therefore occupies a separate position from medicalised, post-diagnosis clinical interventions.

Turning to a brief overview of public health in Britain the great demographic change precipitated by the Industrial Revolution saw the rapid growth of great cities and urban areas when proximity of large populations led to concern about sanitation, poor quality housing and epidemics. The response, passed into law under the Public Health Act 1875, required each sanitary authority (after 1894 each borough or district council) to appoint a Medical Officer of Health (MOH) who were required to report

[13] The matter of the individual's own responsibility is addressed below.

on matters of public health to their local authority (Cambridgeshire Local Authority, 2006). Thus, public health practitioners were situated within local government accountability and reporting networks at their inception.

After the NHS was established in 1948 public health practitioners remained in situ in local government and maintained this position until 1974 (Rivett, 1997). This resulted from a belief that pursuing the health of the population from a public health perspective was more appropriately done outside an NHS environment which was dominated by 'service and management considerations' where 'public health concerns are nearly always in competition with the needs of clinical services, and these nearly always take precedence' (Hunter, 2003, pp.105-106).

By the mid-1970s however, there was renewed interest in public health. Baggot (2005) sees this revival as prompted by a number of factors:

> 'the rising costs of health care, the arrival of new technologies for screening for health and early diagnosis, challenges to the medical model of illness, interest in the methods of health promotion and concern about the impact of modern lifestyles on health' (Baggot, 2005, p.229).

Also important was a growing disenchantment with therapeutic medicine (Ranade, 1997). In addition, while people were living longer the quality of their lives in later age was at times poor and increasingly costly for governments already facing budgetary cuts and the effects of the 1970s oil crisis (Issawi, 1979). As these governments increasingly turned away from Keynesian spending programmes and looked to neo-liberal market reforms focused on an upstream model which offered the possibility of better health in addition to substantial longer-term cost savings became increasingly attractive.

In 1974, as part of the reorganisation of the NHS, public health was renamed 'community medicine' and integrated into the service, thus relocating the 'leadership role' for public health within the health-care system (Hunter, 2003, p.106). However, this brought with it other problems. For example, the accompanying wider remit which included analysing and evaluating community based services meant that the

newly formed Faculty of Community Medicine now needed to engage with agencies such as environment and housing which were traditionally outside the scope of the NHS. Instead of being seen as more community focused it became identified with the medicalised NHS model and somehow separate from the community.

In addition, Hunter points out that public health became redefined with the focus shifting from environmental concerns towards individual responsibility. This highlighting of individual responsibility is consistent with what was to become the hegemonic political philosophy from the late-1970s to the mid-1990s: the focus on the market as a distributor of goods and services and the neo-liberal attention to individual achievement (Sullivan, 1989). Two important public health related inquiries were initiated by the newly elected Thatcher Government in 1979 during this time. The first, the *Royal Commission on the NHS* (1979) recommended greater emphasis on prevention and screening as well as an expansion of health education. However, public health programmes in the 1980s tended to be reactive and directed at specific food health scares such as BSE/CJD and increasing concerns about HIV/AIDS (Baggot, 2005)

At the same time as social models of health were beginning to challenge the hitherto dominant 'bio-medical' model, policy elsewhere was focussing more and more on what became known as the New Public Health. Here, the Lalonde Report is particularly important because the beginnings of New Public Health as a specific policy goal may be traced to its core argument that improvements in the health of Canadians 'depended far more on environmental and lifestyle change than on improvements in health care and medical science' (Ranade, 1997, p.177)[14]. However, the 1979-1990 Thatcher government was reluctant to embrace evidence which linked public health with socio-economic factors and the recommendations of the second enquiry, the Black Report, commissioned under Labour but reporting to the incoming Conservative administration, which recommended substantial spending programmes to reduce health and inequalities, were rejected (Black et al, 1980).

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[14] This emphasis is consistent with the WHO (1981) statement that 'the main social target of governments and WHO in the coming decades should be the attainment by all citizens of the world by the year 2000 of a level of health that will permit them to lead a socially and economically productive life' (Ranade, 1997).

Instead, what happened during the term of this government was an internal restructuring of the NHS. The aim was to introduce market principles ('the internal market') into the organisation in order to produce efficiencies argued to be an outcome of the free-market but lacking in public service institutions[15]. Underlying these changes was the shift to NPM driven by a combination of a desire by government to reduce spending, increase efficiencies and adopt neo-liberal economic principles (Kirkpatrick et al, 2005).

This included introducing 'hands-on' professional management to the public sector which was argued to be lacking the dynamic style of leadership available in the private sector. In addition, performance measurement, target setting, an 'emphasis on output controls linked to resource allocation' and 'discipline and parsimony in resource use' were also prioritised as part of this model (Hood, 1991, pp.4-5).

Managerial and administrative responsibilities increased and, critically, the NHS' role in delivering services was spilt in two. The new system introduced a commissioning responsibility alongside the provider aspect whereby it was envisaged that cost savings could be made through competition among providers. Competition to provide services was therefore introduced into what was almost a monopoly provider of health care services. The role of the public health manager was also expanded to include this commissioning aspect.

The Thatcher administration's focus on the individual and individual responsibility fitted well with some aspects of the new public health agenda such as people making conscious decisions to change their lifestyles which may lead to reductions in welfare spending in the longer-term (Baggot, 2005, p.229). Aside from some cancer screening programmes, introducing health promotion in GP surgeries and some high-profile health education campaigns such as on HIV/Aids, upstream care was left to the individual.

Moving on to the Major government (1990-1997) a relative increase in engagement with wider determinants of health is evident. *The Health of the Nation* White Paper

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[15] See also Chapter Four on the evolution of PCTs, GP fundholding and NHS Trusts.

(1992) set targets for reductions in a variety of diseases such as coronary heart disease (CHD), HIV/AIDS and sexual health. In addition, 'risk factor' targets such as changing diet and nutrition, reducing smoking and alcohol consumption were introduced (Cm 1986, 1992)[16]. However, the criticism remained that it continued to focus on the bio-medical rather than lifestyle model with the result that upstream interventions were again neglected[17]. In addition, the government, while acknowledging 'health variations' (in contrast to health inequalities) between communities continued to 'ignore the impact on health of socio-economic factors such as poor housing, poverty and income inequalities' (Baggot, 2005, p.230). In short, the main focus remained on the medicalised model and the NHS continued to exist as primarily a 'sickness service' (Wanless, 2004, p.6).

Turning to the change of administration following the 1997 general election, in opposition Labour had severely criticised the outgoing Conservative government for failing to engage with the wider determinants of health and health inequalities. While the 'third way' adopted some market orientated reforms such as NPM the new government nonetheless retained a commitment to social reform which sought to address wider inequalities through central government intervention (Kirkpatrick et al, 2005).

Focussing specifically on the public health agenda, the first step was to appoint a Minister for Public Health. The Black Report which was rejected by the Conservatives was followed up by Labour with the commissioning of the Acheson Report to update it (Acheson, 1998). It made a number of recommendations with regard to the importance of improving nutrition, reducing income inequalities, transport and housing (Baggot, 2005). As outlined in more detail in Chapter Ten the government went on to introduce neighbourhood regeneration programmes and policies such as Sure Start which was aimed at improving the health and well-being of deprived neighbourhoods and children from all backgrounds (Sure Start, 2006).

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[16] Here, prisons are mentioned in the context of plans to establish a Health Advisory Committee, develop health standards in prison and, in any early reference to what was to evolve as commissioning, introduce an effective purchasing role through contracts with the NHS and other providers (pp.28-29, Cm 1986, 1992).

[17] For example, the government failed to meet targets for obesity in adults, alcohol consumption and smoking among children (National Audit Office, 1996).

Alongside this other initiatives such as NSFs and performance management and planning incorporating the public health agenda were developed. Key stakeholders such as the NHS bodies, local authorities, the police and education agencies were expected to work in partnership and incorporate public health in their strategies. This commitment to public health was continued in the White Paper *Saving Lives: Our Healthier Nation*[18] which extended the public health workforce and set up nine regional public health observatories with responsibility for monitoring health trends and promoting upstream interventions (Department of Health, 1999b)[19].

However, concerns remained. The ministerial post did not have Cabinet status and was therefore perceived as not wielding as much influence as it might. Also, health inequality targets were not initially adopted at a national level even though poverty and inequality persisted. Furthermore, health improvement and inequalities remained the poor relation in NHS priorities while efficiency and service delivery were prioritised (Baggot, 2005). The *NHS Plan: A Plan for Investment, a Plan for Reform* sought to address these issues by introducing new national heath inequalities targets, using Local Strategic Partnerships (LSPs) to coordinate initiatives across stakeholder agencies and further promoting education on sexual health and nutrition (Department of Health, 2000).

These initiatives were made all the more important following publication of the Wanless Reports (2002, 2004) and *Tackling Health Inequalities: A Programme for Action/Status Report of the Programme for Action* (Department of Health, 2003d, 2003e). Taking Wanless (2002) first, this report was commissioned by the Labour government to identify health trends and the resources which would be needed to address them over the following two decades. The idea was to bridge the gap between standards in other developed countries via the ambitions nature of *The NHS Plan* and return to the principles upon which the NHS was founded, i.e. as a 'comprehensive health service designed to secure improvement in the physical and mental health of

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[18] Prisons are referred to on three occasions here. Firstly as housing populations with greater risk of having a psychotic illness, secondly as an arena which should play a part in improving mental health as well as health more generally and, finally, as one of a number of institutions which should develop strategies for combating bullying (Department of Health, 1999a).

[19] Public Health Observatories were also established. Responsibilities included; monitoring health and disease trends and highlighting areas for action; identifying gaps in health information; advising on methods for health equity audits and health impact assessments (NEPHO, 2006).

the people…and the prevention, diagnosis and treatment of illness' (National Health Service Act, 1946, quoted in Wanless, 2002, p.1).

Of particular relevance to the discussion here Wanless found that better public health could affect the demand for health care. Importantly, this would not alone improve the nation's health but also 'postpone the average age at which health need would become expensive' (Wanless, 2002, p.6). Health promotion was therefore seen as especially important. Particular population cohorts, especially those living in deprived areas were therefore prioritised as needing intervention and support before they could become 'fully engaged' with their own health (Wanless, 2002, p.35).

In order to update Acheson, establish baselines for inequality and set targets for action Labour then produced *Tackling Health Inequalities: A Programme for Action* (Department of Health, 2003d). Noting longer-term trends and increasing inequalities between social groups it set out twelve key areas which would be addressed by programmes designed to ameliorate the worst affects of the wider determinants of health and thus reduce health inequality. Importantly, the goal was not just to improve the overall level of health of the nation but to reduce gaps between social groups.

While not an exhaustive list, these included reducing inequalities in areas such as child poverty, mortality from major killers, access to primary care, smoking prevalence, housing and education (see Department of Health, 2003, p.51). Improvements in these areas were to be achieved through such schemes as Sure Start, the National Healthy Schools Programme, Lifelong Learning, and the Neighbourhood Renewal Fund (NRF), with the NHS playing a key role in coordinating and delivering services[20].

Turning to the final Wanless Report (2004) its remit was to report on 'prevention and the wider determinants of health in England and on the cost-effectiveness of action that can be taken to improve the health of the whole population and to reduce health inequalities' (Wanless, 2004, p.3). It proposed a broader definition of public health which expanded on Acheson to include the 'organised efforts and informed choices of

[20] These are dealt with in more detail in Chapter Ten on reconceptualising prisons as neighbourhoods.

society, organisations, public and private, communities and individuals' (Wanless, 2004, p.3). Here, marking out informed choice and the specific identification of the private and the individual point to a more inclusive 'responsible body' which seems to engage with the market as well as the private sphere.

In any case, from the public health perspective Wanless focused on the need to support individuals to make informed choices before they can become 'fully engaged', as envisaged in the original report, with their own health. Individuals are seen to be unaware of the consequences of their lifestyles both with regard to themselves and the costs of their behaviour. However, this is not to be done in a coercive manner, it is after all, a choice. Rather individuals are to be made more conscious of detrimental effects and supported in changing.

A number of difficulties with regard to initiatives implemented since the first report were also identified. Concentrating on public health, Wanless found that there was a general lack of 'evidence-based principles' for justifying public health expenditure and made recommendations for how they may be implemented. In addition, this led to the introduction of a wide range of initiatives 'often with unclear objectives and little quantification of outcomes and it has meant it is difficult to sustain support for initiatives, even those which are successful' (Wanless, 2004, p.5). Problems therefore continued but the ethos of promoting health as a means to reducing costs and health inequalities remained.

*The NHS Plan* also included a restructuring of the NHS as a whole with more power to be devolved to local service providers (Evans, 2004). This meant that regional authorities were disbanded to be replaced by SHAs who would have responsibility for overseeing locally based PCTs[21]. As the old regional authorities had public health functions a new home was needed for public health and it was on its way again, this time to be monitored by SHAs but situated within the new PCT structure. Each PCT was to have a Director of Public Health reporting to the Chief Executive.

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[21] See Chapter Four for more detail on the background to the introduction of PCTs.

In addition, the Health Protection Agency (HPA) was established to support PCTs in specialist areas such as radiation and infection control and new national networks were introduced to link locally based public health professionals and share best practice (HPA, 2006). Lastly, a regional public health role was allocated to the Government Offices for the Regions, maintaining contact with the locales of decision making for issues such as transport, the environment and regeneration. The response to these programmes had a familiar ring however; there was still an imbalance between the priority attached to the reactive bio-medical and the upstream model (Baggot, 2005)[22].

By now the reader will have identified a pattern. The strategy was again seen as failing to make real inroads into public health needs. For example, evidence pointed to increasing problems of obesity which rose from less than 10% in the mid-1980s to over 20% by 2000. STIs also increased by 37% in just 5 years between 1996 and 2001 while 'binge-drinking' entered the lexicon to describe intensive alcohol abuse which was also on the rise. It seemed that the more focus that was placed on public health issues the more problems escalated (Baggot, 2005).

However, the picture may be more mixed. As *Tackling Health Inequalities: Status Report on the Programme for Action* illustrates during this period some progress was being made. For example, 'the proportion of children in England living in poor households, defined as 60% of Great Britain median income in the year in question (before housing costs), has fallen from 24% to 20% between 1998/99 and 2003/04'. Also, different diseases have different 'lead times – the gap between change in exposure and change in disease rates' (Department of Health, 2003, p.3). Thus some diseases are more receptive to lifestyle changes such as giving up smoking than others. For example, comparing 2001-03 to 1995-97 the reduction in circulatory (heart) disease mortality was more rapid than the reduction in deaths from cancer.

On the other hand, the problem of improving overall health while maintaining or increasing inequalities remains. Comparing figures between social classes the *Status*

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[22] The NHS Plan mentions prisons just once, in section 14.36, where it refers to planned improvements in mental health services. No mention of prisons and public health is made (Department of Health, 2000).

*Report* found that inequalities continued to widen in infant mortality rates and life expectancy at birth with 'the relative gap in life expectancy between England as a whole and the fifth of local authorities with the lowest life expectancy increasing for both males and females (continuing a long-standing trend), with a larger increase for females' (Department of Health, 2005d, p.7). Without going into too much detail here, the report also noted the lack of improvement in fruit and vegetable consumption in disadvantaged groups as well as the failure to make any significant improvement in smoking prevalence between manual groups and other groups.

A new White Paper *Choosing Health: Making Healthy Choices Easier* was published in 2004 (Department of Health, 2004). Here the public health agenda was to some degree refocused with the aim of making it easier for people to make healthy lifestyle choices such as giving up smoking, reducing alcohol intake and eating better. In addition, services were to be reshaped to improve access, prevention, early diagnosis and treatment (Baggot, 2005)[23]. Community based health trainers were introduced to provide individual advice on healthy living, GPs were to develop the health promotion message in their surgeries, smoking cessation programmes were to be expanded and PCTs were allocated specific responsibility for promoting health (Department of Health, 2004). Finally, a further £1 billion over three years was allocated to fund public health initiatives.

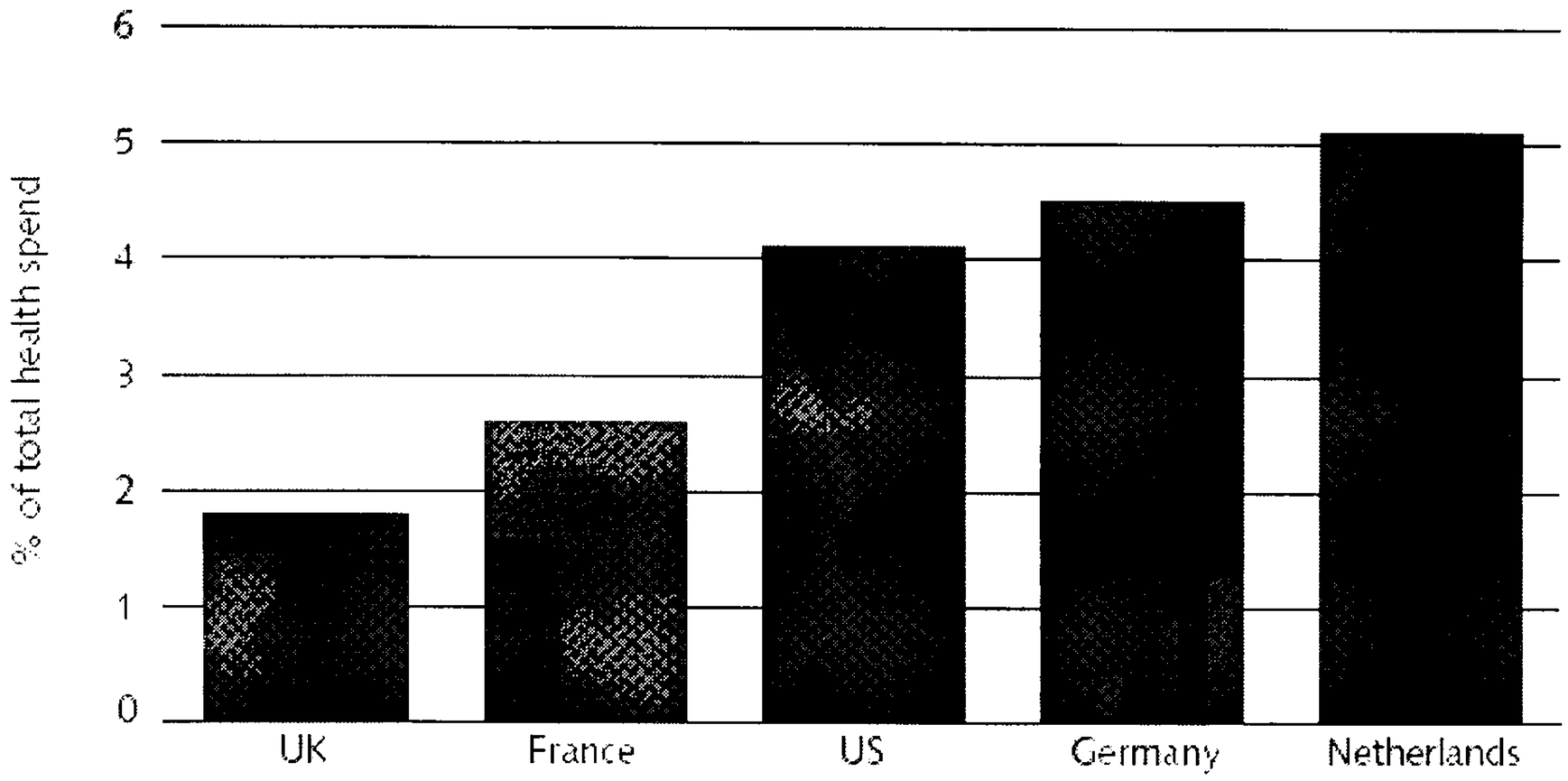
Back, however, to our pattern. Again criticism held that not enough attention was being placed on the environments within which people experienced 'being', well or otherwise. Also, the funding, though on the face of it substantial, only represented a small proportion of overall spending on health care (see Fig. 4.3 for comparison with other European Union nations).

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[23] Prison health is referred to on a number of occasions in *Choosing Health*; *Making Healthy Choices Easier* regarding government leading by example and procuring good food for the service and recognising the poor health of the population as well as promoting the health of inmates (see pp.129-131, Department of Health, 2004).

Fig. 3.3

Spending on prevention and public health as a percentage of total health spending




Source ODEC (1999 figures). Figure adapted from *Our Health, Our Care, Our Say* (Department of Health, 2006a)

In addition, doubts have been cast over the NHS' ability to transform itself into a Nation *Health* Service and the priority given to acute care persists. Also, monies allocated to PCTs for public health were not ring-fenced and could therefore be utilised for other purposes. Lastly, although the commitment to supporting individuals to make better choices was seen generally as a positive step, the wider determinants of health such as the environment, transport and housing received little consideration in the White Paper. In short, much appears to have been done and the NHS remains a sickness service primarily focused on health care rather than improvement (Hunter & Marks, 2005).

This is not to say, however, that important progress is not being made on the public health model and the NHS' role in supporting upstream measures. A case in point here is the move to a total ban on smoking in pubs, clubs and restaurants and 'virtually every enclosed public place and workspace' in England from the summer of 2007 (White, 2006). Indeed, this legislation went further than recommendations in the *Choosing Health: Making Healthy Choices Easier* White Paper by including membership bars such as private clubs (Department of Health, 2004). The NHS is to

support this by providing counselling and advice as well as Nicotine Replacement Therapy (NRT). While how this relates to prisons is outlined in more detail below it is worth mentioning their peculiar position in that they are both places of work for prison staff and places of residence (and indeed work) for inmates. The decision which has been reached is that prisoners' cells will be viewed as their private residencies but other enclosed spaces will be subject to the smoking ban.

Bringing the account up to date, the most recent White Paper *Our Health, Our Care, Our Say* reinforces the commitment to giving local service users and providers more say on how programmes are delivered and consumed with the aim of 'ensuring that they are more personalised and that they fit into people's busy lives' (Department of Health, 2006a, p.7)[24]. Again, the public health agenda is strongly featured with the emphasis on developing strategies to promote prevention and address inequalities 'that promote the health of all, not just a privileged few' (Health Secretary Patricia Hewitt in foreword, Department of Health, 2006a, p.3). In addition, producing regular health needs assessments of the population and developing strategies to tackle findings are envisaged as part of a wider, better resourced role for Directors of Public Health[25].

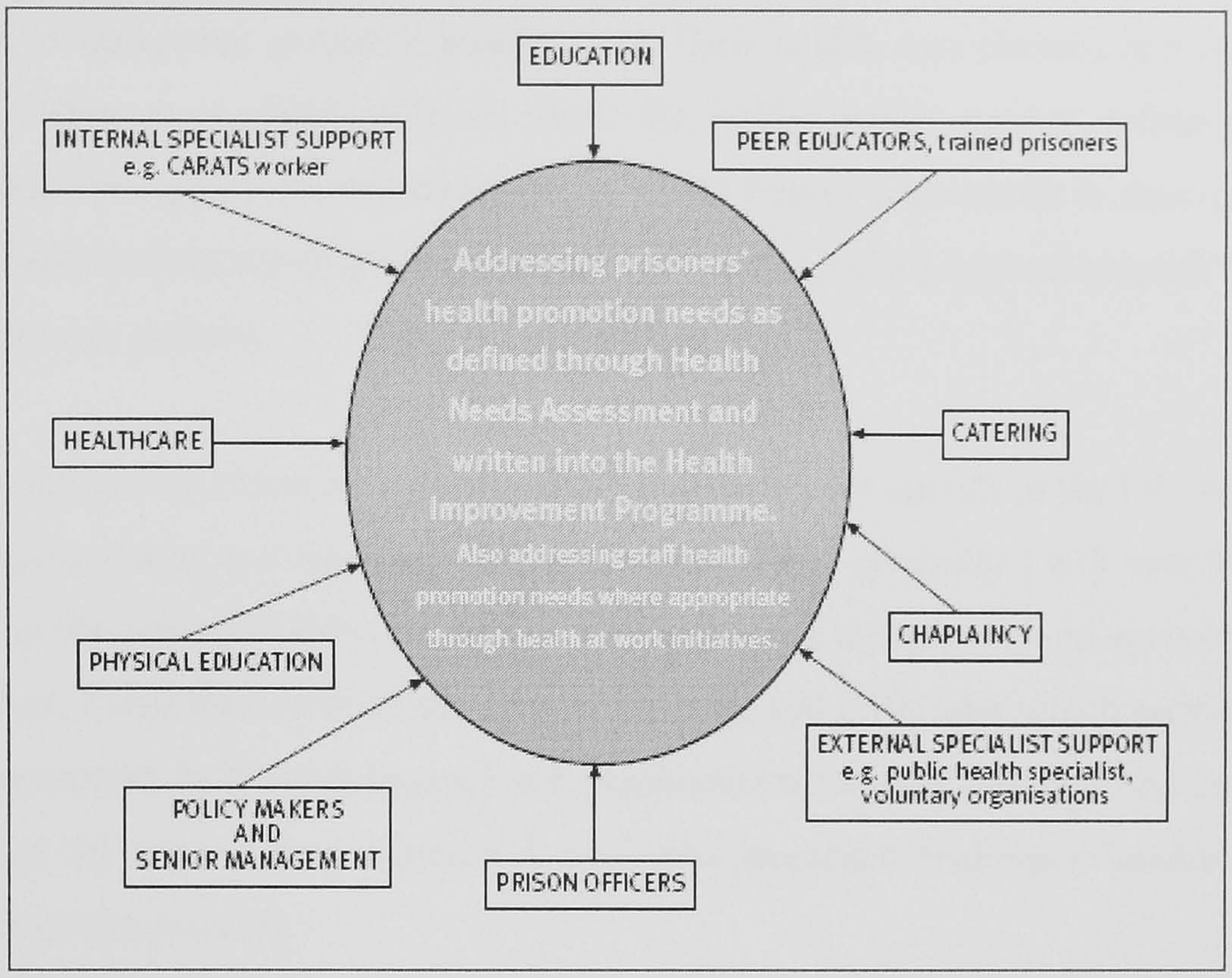
Where, though, does this leave public health in prisons? As documented above, the public health agenda is an inclusive one. However, prisons, let alone public health in prisons have received only minimal attention in the White Papers and reports under review. The first major guideline document which focused specifically on upstream health care in prisons did not appear until 2002. Here, *Health Promoting Prisons: A Shared Approach* (Home Office et al, 2002) outlined an approach similar to that adopted in the 'Healthy Schools' strategy where the aim is to involve all sections of the prisons, including the inmates themselves, in an holistic attempt to promote health within each institution (Department of Health, 1998a).

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[24] As an aside, it appears to be part of the problem that some people's lives are not busy enough. While the sentiment in this approach is understandable it appears to marginalise the unemployed and those with debilitating physical and mental illness.

[25] Recognition of mental health problems, prison as a barrier to employment, the need and opportunity for PCTs and prisons to work together tackle inmate health care issues are all commented upon in this White Paper. Interestingly, there is also a claim, though one made without supporting evidence, that addressing inmate's health care may also reduce crime *itself* (Department of Health, 2006a, p.106).

Fig. 3.4




A '*Whole Prison Approach*' to health promotion (Home Office et al, 2002, NEPHO, 2005)

This approach, which interestingly and perhaps tellingly excludes the environment, is recorded as being intrinsic to other functions of the prison estate such as security, punishment, and deterrence[26]. As the summary to the report puts it 'improving the health and well-being of prisoners is recognised as a vital element in their [prisoners] rehabilitation and resettlement' (Home Office et al, 2002, p.21). In addition, the document clearly sees health promotion in prisons as needing to be mainstreamed or broadly equivalent with services in the wider NHS. The basic issues this relates to are 'health promotion, disease prevention, self care, rehabilitation and aftercare' (Home Office et al, 2002, p.21).

Backing up the programme is PSO 3200 which seeks to build on earlier in-house initiatives and commits prisons to working with PCTs and other partners to deliver the decency in prisons programme (HM Prison Service, 2003b). Following the WHO's

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[26] This was followed up with a new Prison Service Order (PSO) 3200 which dealt with health promotion and the prisons' responsibilities in the new partnership arrangement with the NHS (HM Prison Service, 2003b).

health promotion definition, i.e. 'the process of enabling people to increase control over and to improve their health' PCTs and prisons are to come together to support inmates in exercising greater autonomy over their health care choices and outcomes (Home Office et al, 2002, p.5). In short, the public health agenda within prisons, which had been given cursory treatment in White Papers and reports to date, now had official acknowledgement and commitment as well as a fundamental concept to guide it - decency in prisons.

Having outlined an albeit brief history of the public health agenda in the UK as well as its changing status and location within health care more generally I will now move on to look at the key policy drivers which are guiding the agenda with an accompanying discussion. I will then outline the main difficulties and criticisms which public health has encountered. In the conclusion I will summarise the above before providing a brief outline of the next chapter which will deal with empirical findings related to public health from the research.

Beginning with the principal policy drivers, the contemporary debate on public health rests on two main pillars;

a. Personalisation of health care; choice, support, lifestyle and individual responsibility
b. Structural approach; addressing social and economic inequalities

On the one hand people are being offered choice and the information to make those choices: the personalised focus. On the other there is the structural approach which seeks to address social inequality, poor environments and deprivation through programmes designed to ameliorate structural disadvantage and create conditions where social mobility may be more feasible and quality of life is improved (see also Chapter Ten on prisons as neighbourhoods, Orme et al, 2003).

In addition, the NHS plays a role in secondary prevention, defined by the American Heart Association as:

> 'identifying and treating people with established disease and those at very high risk of developing cardiovascular disease [as well as] treating and rehabilitating patients who've had a heart attack or stroke to prevent another cardiovascular or cerebrovascular event' (American Heart Association, 2006).

For example, under 'Improving Health and Reducing Inequality', *The NHS Plan: A Plan for Investment, A Plan for Reform* specifically targeted improvements in secondary prevention as part of a strategy to address the 'inverse care law' whereby 'communities in greatest need are least likely to receive the health services that they require' (Department of Health, 2000, p.107).

An important element of this strategy is the Supporting People initiative launched in 2003 which targets people with long-term conditions with the aim of helping them help themselves through self care. It is hoped that this will not only improve people's health but also return a degree of independence to individuals (well-being) and also reduce the need for hospital appointments and more expensive professional care (Office of the Deputy Prime Minister (ODPM), 2003).

In keeping with the shift of health care services to the community, these strategies have focused more and more on the local level with local authorities and key stakeholders involved in partnership working. As *Choosing Health: Making Healthy Choices Easier* states, promoting the public health agenda now involves 'supporting individuals to make healthy choices in the communities where they live' (Department of Health, 2004, p.13). This is to be done in ways that 'take into account the realities of people's lives, particularly those people who are relatively disadvantaged' and 'to foster environments in which healthy choices are easier' (Department of Health, 2004, p.15).

All this seems to come at a curious time however. Various governments have been criticised for not taking on 'big business', for example, the length of time it took to

ban tobacco advertising and introduce the smoking ban itself. In addition, twenty four hour licensing and a failure to ban alcohol advertising when set alongside the public health agenda appears to give confusing signals as to how government thinking is now operating with regard to public health.

That said, in addition to the public health agenda making sense from a health perspective there are also substantial cost benefits to government and tax payers from healthier living. As the Wanless Report puts it:

> '...cutting out smoking, improving diet and encouraging more exercise could significantly improve the population's health status. This would potentially reduce demand and postpone the average age at which health need would become expensive' (Wanless, 2004, p.6).

This issue though is not straightforward. For example, the Institute for Applied Health and Social Policy sees public health as:

> 'the one major area of government activity that can, but mainly over the long term, reduce demand for health care and other related services is public health promotion and sickness prevention' (quoted in Wanless, 2004, p.6)

However, there is also the issue of how long it may be before investment in upstream initiatives yield cost savings downstream (Department of Health, 2003b). In the context of political cycles this may be problematic as government investment may not yield results until further down the line when opposition parties may reap the benefits.

While this may be a somewhat cynical view on government intentions, given the pressures on the NHS regarding, for example, acute care, in the realpolitik world of winning votes spending on immediate need would appear to make instrumental sense, whatever happens down the line. On the other hand, it is argued that applying an adequately funded health promotion service to what is a high maintenance section of society may produce more immediate gains in the context of reducing crime and the

costs of crime both to the NHS, the Home Office and victims themselves (Department of Health, 2006a, Brand & Rice, 2000, Robinson & Keithley, 2000)[27].

Furthermore, initiatives are actually planned as long-term commitments. For example, the National Strategy for Neighbourhood Renewal which is designed to devolve decision making to local actors as part of renewing deprived areas is a ten year programme (Department of Health & NRU, 2002). Also, funding for Sure Start which is aimed at giving each child gets the best start in life has been increased and expanded geographically since its initiation in 1999 (Department of Health, 2002c, 2002d). Again, the fact that benefits may not accrue for some time has not stopped work going ahead. Lastly, it is important to note that some positive outcomes may be apparent in the shorter term. For example, WHO research indicates that giving up smoking reduces the excess risk of CHD to half that of a continuing smoker after just one year (Mackay & Eriksen, 2002).

While cynicism about the necessarily long-term commitment needed and delay before real benefits are seen may be misplaced it is nonetheless the case that an appropriate setting and status has yet to be found for public health. Should it be a free standing specialisation of the NHS, be integrated within the NHS or be located in the wider community with the most appropriate setting being in local government? (Hunter, 2003). Each has its drawbacks. Situated outside the NHS it may be marginalised, seen as not 'real medicine', low status and therefore unattractive to health care professionals (Holland & Stewart cited in Hunter, 2003).

Within the NHS it may suffer from the priority attached to 'the service and management considerations' mentioned above. Lastly, as part of local government, it may again be seen as distant from the NHS and would require substantial executive clout to make its influence felt. More positively, however, this debate may create an opportunity to raise the profile of public health in the prison estate, with health promotion specialists reprising the role of the MOHs as NHS employees in 'prison

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[27] Of course, this depends on the strength of the link between crime and mental illness/addiction which needs investigation through further research.

neighbourhoods' and Directors of Public Health influencing prison environments through partnership working[28].

Returning to the negatives though there is also the classic criticism that the public health agenda simply represents more government interference in peoples' lives: the 'nanny state' argument. Here, the agenda is seen as the patronising big brother that 'knows best'. In this view central government is not just content to take part of our earnings in taxes, it also wants to dictate what we spend the rest of our money on: not content to make sure we go to work and school it is also telling us what to do with our leisure time. Is there *no* end to it?

Finally, there is the charge that it leads to a 'blame culture' whereby deprived communities are stigmatised as obese, alcoholic, and lazy: the unemployed and unemployable, pushing prams and drugs, Harry Enfield's '*Wayne and Waynetta Slob*' existing, just about, behind a smog of tobacco fumes on the no-go council estates of marginalised Britain (Tiger Aspect Productions, 1994). In this sense the public health agenda is seen to alienate the exact social cohorts it seeks to engage.

Where, then, does this leave us? Firstly, as the overview of public health indicates the NHS continues to be primarily a 'sickness' service. From the introduction of MOHs in the mid-nineteenth century to present day Directors of Public Health and health promotion specialists it has occupied a position on the margins of the bio-medical health care model. In addition, public health has faced an ongoing dilemma linked to where it is best located to establish and maintain influence while at the same time avoiding marginalisation and inadequate funding.

The reasons for this marginalisation have been outlined above: the priority attached to the medicalised model, relatively low-status as a health care profession, the need to engage with other agencies outside the NHS and difficulties in identifying short-term returns compatible with political cycles. While its status is evident from the low percentage of overall health care spending, the change of focus precipitated by increasingly costly reactive health care and broader thinking championing the

[28] See Chapter 12 suggestions which have emerged from the research.

upstream well-being model, public health has begun to occupy a more central position on the policy agenda. Also, though lagging behind, as *Health Promoting Prisons: A Shared Approach* indicates this move has also been evident with regard to introducing a more holistic approach in prisons (Department of Health, 2002a).

As it has moved, albeit slowly, to occupy a more important position in health care the public health policy strategy has also changed. Policy on public health now includes the wider determinants of health, for example, addressing socio-economic inequalities, to a greater extent than before. In addition, it retains the weight attached to individual responsibility but emphasises the need to support often deprived communities and individuals in making those choices. Furthermore, in keeping with government policy on local government more generally, power for implementing public health initiatives is being devolved to local actors.

Also, in response to charges of under spending Baggot (2005) acknowledges the government argument that not all spending on public health may be traced back to health care budgets. New parks, redeveloping inner cities, research on reducing carbon emissions, funding for the 2012 Olympic Games and Sport England all contain elements of the public health agenda which are funded by non-Department of Health government departments (Sport England, 2006).

In addition, as respondents pointed out health promotion may be very cost effective (R2). Medication, for example, may only be consumed once while a leaflet may be used repeatedly. Furthermore, the accusation of nannying seems to owe at least as much to political agendas as it does to a real concern with improving the health of the general population. Indeed, extending licensing hours while at the same time promoting the drink-less message may be argued to offer choice over coercive nannying.

In sum, although it has been marginalised, restructured and relocated the public health agenda has not gone away. The potential gains of a successful public health strategy which produces increasingly worthwhile outcomes in terms of cost savings, lower

taxes and a healthier population outweigh the attendant criticisms[29]. Prisons, however, offer a real challenge to this agenda. The denial of liberty is in direct contradiction to the idea of holistic well-being and leading productive lives.

Or is it? Again, the link which is elaborated in Chapter Ten on reconceptualising prisons as neighbourhoods is relevant here. Taking the public health agenda into the prison setting is not seen either in government policy or in programmes on the ground as an insurmountable proposition. Indeed, the very fact that the denial of liberty is a central part of prison life makes it all the more important that this approach is taken (McAllum, 1995). Furthermore, it is also an important part of the mainstreaming goal. To what extent though is it possible? What barriers and opportunities exist and how may they be addressed and exploited? Before responding to these questions, however, Chapters Four and Five will first outline the key exploratory concepts employed and the research design and methods respectively.

[29] While it is not the purpose of this paper to examine the pharma-medical industrial complex, it would seem naïve to dismiss the commercial interests which may be affected by healthier populations and their influence on the debate.

Chapter 4

# A conceptual framework

In this chapter I will expand further on the three explanatory concepts which will be used to explore how health care professionals, prison health centre medical staff and prison security personnel manage the implementation of national policy. Firstly, and most importantly for how the thesis developed, the idea of 'implementation gaps' will be utilised to understand how changes in national policy are played out at the local level (Hill, 1997, p.130, Gunn, 1978). As described by Hill this is essentially a 'top-down' approach which places substantial emphasis on external factors, such as resources, which inhibit implementation.

An alternative approach which focuses more on local circumstances and cultures will then be employed. Here, I will begin with an outline of what Lipsky (1980) termed the 'street-level bureaucrat' before moving on to how it will be used as a conceptual tool for understanding how local officials engage with national directives. In contrast, this method places an emphasis on 'an action-orientated bottom-up perspective' and looks at how policy *in effect* may actually be made at the local level through a series of negotiations and interactions between agents, cultures and policy directives played out in the context of unique local settings (Hill, 1997, p.8).

Lastly, I will provide an outline of mainstreaming, the key policy concept by which prison medical services are to be managed in order to improve standards and work towards broad equivalence of service provision with the wider NHS (HM Prison Service and NHS Executive, 1999).

## 4.1 Implementation gaps

Looking firstly at the central thread of the thesis, addressing implementation gaps, I will employ what is recognised as essentially a hierarchical model for establishing and describing both the facilitating and inhibiting factors which affect policy implementation. Hill (1997) describes a number of studies where the gap between policy aspiration, for example, Johnson's 'Great Society' programme in the United

States, and reality is wide. Also, Pressman and Wildavsky (1973) argue that even small implementation deficits can result in large shortfalls. Importantly for the research where two major government departments are coming together along with various professional organisations to manage fundamental changes in the way in which health care in prisons is delivered, the extent of linkages along the implementation chain is critical to successful policy outcomes. In addition, external factors such as the provision of sufficient resources, complete understanding of all issues and objectives and the wider political context are also seen to be important variables when minimising implementation deficits.

Taking this concept and applying it to the research allows examination of a number of factors which are particularly relevant. Beginning with resources, the mechanics of transferring commissioning responsibility to PCTs involved reallocating the Home Office's health care budget to the NHS. However, since April 2006 this sum is no longer ring-fenced to be allocated specifically to prison health care by the NHS. Instead, potentially difficult funding decisions will have to be made by PCTs with regard to where exactly they will spend their limited resources, i.e. in the wider community or on inmates? As illustrated by Webb and Wistow (1952) in their study of local authority spending and the manner in which central guidelines which demanded cutbacks on social service spending were ignored, it is by no means certain that local actors will comply with national directives.

Furthermore, another externality the political context may have is a significant impact on how money is spent. It has already been mentioned that spending on a less than popular section of society may be both highly controversial and sensitive politically. Also, there is the issue of targets. This raises a number of questions. For example, how will the delivery of health care to prisoners by PCTs with prisons in their boundaries be affected by their operational imperative to meet government targets? Also, noting that Governing Governors no longer have responsibility for commissioning primary care, how will variables such as limited resources, the political context and targets have on delivery of care to prisoner/patients in future?

In addition, Hogwood and Gunn (1984) argue that successful minimisation of policy deficits requires that all elements in the policy formation and implementation process

are consulted and that communication between the various elements is perfect. Using a model similar to the one employed by economists when describing perfect competition, analysis here is driven by an exploration of how far the ideal model differs from actual outcomes. Noting the importance of robust linkages in the implementation chain described above the research has been designed to include as many professional health care workers and security staff as is feasible within the timeframe of the work.

## 4.2 Street-level bureaucrats

Turning to the street-level bureaucrat, this approach acts as a counter weight to hierarchical top-down decision making policy analysis and directs attention to interaction at ground level. Lipsky focuses on local culture and the idea of 'bureaucratic behaviour and bureaucratic personality' (Lipsky, 1980, p.197). Following Weber on instrumental rationality at issue here is that while an effective bureaucracy demands adherence to superimposed rules and regulations, the application of general, inflexible order which is implemented by similarly inflexible bureaucrats (who have either been recruited because of such personality traits or acquired them in the working environment) may produce inefficiencies in specific or unique environments (Morrison, 1997)[30].

Alongside this is the possibility for subordinates to resist doctrine. As Foucault argues power is omnipresent and adherence to strict rules and guidelines is not guaranteed by audit trails and box ticking (Dodd, 2003). In this instance it is argued that agents may employ various techniques to circumvent procedure such as the creative maintenance of records. The rational for this may be manifold. For example, in a public service organisation where an employee is motivated by a 'public service ethos' and who fundamentally disagrees with superimposed policy directives at the level of his/her conscience, alternative methods of service delivery which are more in keeping with the individual's personal beliefs may be sought out. Also, the individual's personal experience of various situations may be brought to bear on a particular problem

[30] See also Morrison on Weber's ideas on unintended consequences and rationalisation (Morrison, 1997, pp.217-223).

whereby the service provider knows from past interaction that new policies are inappropriate. As Hill puts it:

> '...public officials are placed in a particularly difficult position *vis-à-vis* their clients. They may be putting into practice political decisions with which they disagree; they are facing a public who cannot normally go elsewhere if their demands are unsatisfied, as they often can with private enterprise; and the justice of their acts is open to public scrutiny, by politicians and sometimes by courts of law.' (Hill, 1997, pp.198-199).

Also, it may be simply for the purposes of 'having a quiet life' where the customer is likely to cause difficulties if the designated policy or procedure is adhered to. The summary effect of these negotiations, compromises and interactions at local level form the basis of Lipsky's thesis, i.e.:

> '...that the decisions of street-level bureaucrats, the routines they establish, and the devices they invent to cope with uncertainties and work pressures, effectively become the public policies they carry out' (Lipsky, 1980, p.xii).

In addition, while some public service sector workers see themselves as 'cogs in a system, oppressed by the bureaucracy within which they work' and/or working in a demoralising environment which erodes idealistic aspirations they may have had when entering public service, they also appear to have attained substantial discretionary freedom (Hill, 1997, p.210). Furthermore, Hasenfeld and Steinmetz argue that it is valid to see bureaucrat-client relationships as exchanges, but that in social services agencies serving low-status clients those clients have little to offer except deference in an environment where choice in limited[31]. They go on to propose that service providers therefore have substantial control over consumer's lives and that an environment exists where clients have to wait for help, experience 'status degradation', have difficulty getting information and possess a limited range of

[31] Noting unequal power relationships between customers and services providers in the prison environment this issue has particular relevance within the context of the current NHS policy which calls for a 'customer led service' based on client consultation (Sim, 1980).

responses (Hasenfeld and Steinmetz, 1981). Indeed, given the dependency relationship described by Smith (2000) above this may have particular resonance for customers in the prison estate.

However, it is evident that the centrality of consumer choice to the government's strategy for the public services poses particular problems for patients/prisoners as consumers (Department of Health, 2000, 2005e). Alongside receiving universal access to NHS services as a right, citizens are also encouraged to make a conscious choice to take responsibility for their own health (Department of Health, 2004). However, it is difficult to see how prisoners may exercise consumer choice as well as make healthy lifestyle choices in the context of the prison system. While this is obviously a practical matter of security, cost and policy it nonetheless implies that a fundamental part of the public health contract the between the state and the individual may be compromised in the prison environment.

Returning to the concept of the street-level bureaucrat, in addition to the possibility for actors to exercise discretion, Lipsky argues that the issue of control of subordinates may be problematic for supervisors. Resistance to change is therefore seen as an important part of the organisation's structure and the possibility of exercising agency is argued to be a feature of street-level bureaucracies (see Layder on Giddens, 1996). Importantly, Lipsky argues:

> 'The essence of street-level bureaucracies is that they require people to make decisions about other people. Street-level bureaucrats have discretion because the nature of service provision calls for human judgement that cannot be programmed and for which machines cannot substitute' (Lipsky 1980, p.161).

He therefore sees the street-level bureaucrat as determining 'the allocation of particular goods and services in the society' at the point of delivery (Lipsky 1980, p.161). As demonstrated by Walker and Gilson (2004) who employed the street-level bureaucrat as an exploratory tool in their study of nursing in South Africa, the milieu in which policy is enacted, the local, may be in practical terms where policy is constructed.

This point may be further complicated within the prison environment. For example, the minimisation of disturbance in prisons requires adherence to routine. Prisons are subject to direct and specific Prison Service Orders (PSOs) and Prison Service Indicators (PSIs) issued by the Home Office which determine how they and the populations for which they are responsible are managed (HM Prison Service, 2005)[32]. However, health care officials who have been transferred to the NHS will now also be subject to these rules and regulations *as well as* being required to adhere to NHS guidelines covering matters such as clinical governance and medical ethics. Looking at how local actors negotiate delivering services in the context of not just one, but two bureaucratic structures/masters therefore forms an important part of the research.

While Lipsky (1980) obviously acknowledges agency he also argues that the street-level bureaucrat may experience alienation as a result of a sense of helplessness or frustration at having only limited control over outcomes. Indeed, the documentary analysis of the initial HNAs which was carried out before the fieldwork began found clear evidence of this[33]. This may be exacerbated by a lack of resources, working on only a segment of the product and/or frustration at the pace at which work may be completed. Looking at this from the point of view of delivering health care in the prison environment, the potential for health care professionals to experience alienation is clear. For example, prisoners who are undergoing particular courses of treatment are still subject to transfer to other prisons or release. This will disrupt whatever course of treatment or educational programme they were on and the issue of whether or not it is continued either in the new host institution or in the wider community is outside the control of the original health care regime and therefore may be a source of demoralisation.

Moving on, there are a number of other aspects of the concept which have relevance in the prison setting which are highlighted by Hill (1997). For example, he comments on Lipsky's identification of the manner in which street-level bureaucrats categorise

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[32] PSIs are mandatory instructions which have a definite expiry date. They are also used to introduce amendments to PSOs. PSOs are long-term mandatory instructions which are intended to last for an indefinite period (HM Prison Service, 2005).

[33] Please see Chapter Six where the frustration of Prison Service officials at broader societal problems over which they had no control but yet adversely impacted on their ability to do their work.

clients and respond 'in stereotyped ways' to their needs. Using the example of studies of policing behaviour in America which argue that 'it is misleading to attribute police racism simply either to the predisposition of recruits or to pressures from peers', rather, dealing with rules and regulations is made more manageable through stereotyping which 'offers short cuts to decision making on how to approach people, how to determine whether to act on suspicion and so on' (Hill, 1997, p.205). This may be of particular importance in the prison setting and staff attitudes to prisoners and will be taken up at the fieldwork stage of the research.

Finally, Hill briefly outlines Lipsky's discussion of the role of professionalism in bureaucracy. Although not elaborated upon here, (unfortunately no examples are given) he concludes that while professionals will play some 'corrective to forms of bureaucratic behaviour' in the manner in which policy is implemented, it is not always clear that their influence will be definitive thus implying that street-level bureaucrats continue to influence policy implementation in environments where professionals are important actors (Hill, 1997, p.206). The importance of this finding is that health care professionals such as nurses and GPs whose training and experience was gained in many cases outside the prison environment will now be working within the context of PSOs and PSIs which are highly bureaucratic in nature.

Delivering health care in this unique setting may therefore pose a unique set of challenges for professionals who may find that they do not have the same degree of autonomy they would expect in wider health care communities. Indeed, the uniqueness of the setting has effectively been tacitly acknowledged by the Department of Health as evidenced in the publication of the *Report of the Working Group on Doctors Working in Prisons* (Department of Health, 2001b). Again, exploring this issue has been built into the research questionnaires and will be dealt with at both the fieldwork and analysis stages of the study.

## 4.3 Mainstreaming

The final concept which will be employed is that of mainstreaming health care services within the prison environment. The background to the guiding principle can be traced back over fifty years to a resolution adopted by the United Nations in 1955 and drawn upon by The Committee of Ministers of the Council of Europe in 1987 which stated that 'The [prison] medical services should be organised in close relation with the health administration of the community or nation' (HM Prison Service and NHS Executive, 1999, p. 5).

In England and Wales the definition used is providing prisoners with access to the same 'quality and range of health care services as the general public receives from the NHS' (Department of Health, 2005f). The principle therefore has both local and supranational recognition and points to the progressive goal of equalising services for a community whose punishment is the denial of liberty not the deprivation of health care.

However, there are a number of issues such as prisons being regarded as often unhealthy environments in the first instance, which are worth highlighting at this stage. Firstly, the main priority of the prison estate is security. In the past, tensions within the prison budget between allocating resources for health care and meaningful activities on the one hand and maintaining adequate security levels on the other resulted, at least in part, in the problems identified in the executive summary of *The Future Organisation of Prison Health Care* (HM Prison Service and NHS Executive, 1999). However, while these issues focus on problems within the prison and raising standards to those experienced in the outside community, mainstreaming *itself* poses potentially controversial problems for the future of health care provision in prisons.

To elaborate, it is by no means clear that this is a one-way street where patients in the wider community receive better services. For example, no nationwide Hepatitis C programme exists for non-offenders. However, providing immunisation programmes for Hepatitis C is a key objective for prison health care centres. In addition, detoxification facilities within a number of prisons are markedly better than those

provided in the community. While the issue of prisoners receiving better services has not as yet become a matter of national debate it is very possible that the resource allocation decisions which ensue from the merging of PCT prison budgets with resources for community services may provoke substantial resistance to provision for what some may see as self-inflicted lifestyle illnesses. Finally, there is the simple but difficult question of how exactly we will know if services have been actually equalised?

To sum up then, three central ideas or models will provide a conceptual framework for the research. Firstly, the implementation deficit model serves to highlight impediments to the successful delivery of policy which is formulated at a national level but delivered locally, i.e., the top-down model. While the street-level bureaucrat focuses on the local, theory on implementation gaps directs attention on to the overall process of policy formulation, consultation and linkages between various participating bodies as well as externalities such as the political context and resources.

Secondly, the street-level bureaucrat will serve to draw attention to how local actors interact with national policy in their daily working lives. What national policy outcomes are produced will be seen as a result of an ongoing negotiation between the policy itself and local contexts, cultures, and professional lives. Finally, the central idea driving policy at government level, that 'prisoners should be entitled to the same level of health care that is provided in society at large' (HMCIP, 1996, p.5), will be explored for the purpose of determining to what extent this goal is being achieved in the prison setting at present as well as what the possibilities are for it to be achieved in the future. Having set the research in context and outlined the key conceptual tools employed I will now turn to the research design and methods.

Chapter 5

# Research design and methods

The first part of this chapter deals with the origins of the research and the creation of what was to become an Economic and Social Research Council (ESRC) CASE studentship[34]. Noting that the research did not take place in isolation, free from outside influences, I then move on to relate how various factors affected the direction the work subsequently took before turning to my own experiences in the field. Here I highlight a number of practical issues which arose while conducting the research and which may be useful for other researchers working in the prisons/NHS environment. In the conclusion I summarise my feelings about how the study evolved before turning to the main part of the chapter which deals with the actual methodologies employed and associated technical issues.

In Part Two, I begin by outlining the research questions before providing an account of the relationship between each question and the concepts employed. I then describe the documentary analysis of PCT and prison health plans which shaped the construction of the interview schedules. The chapter then turns to the actual fieldwork. Here I have summarised how particular local actors were identified as relevant respondents, the difficulties encountered in the field and how access was obtained for interviews[35]. Having outlined the interview process, *Framework*, the analytical tool which I used for analysing the resulting data, is described (Ritchie & Spencer, 1994). The next section deals with the process of applying for ethical approval and is followed by a short critique of the methodologies employed. An outline of the more ethnographic elements of the study follows before the chapter concludes by describing the 'case study' approach which was taken to the research.

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[34] CASE: Collaborative Award in Science and Engineering.

[35] Noting the need to maintain the anonymity of participant actors and institutions it is worth pointing out here that the word 'local' is used throughout the text. It is therefore important to point out that this is not to make any inference as to the location of host bodies but, rather, is used to differentiate between central government and actors 'on the ground'.

Part 1

## 5.1.1 Background to the research

Firstly, for an understanding of how the research was conceived and developed, it is important to return to the original research proposal which was submitted to the ESRC in 2003 and the environment in which the research evolved. Further to the writing of the initial HNAs by the prisons in 2002 a NHS public health official, a representative of the Prison Service and my original supervisor, Dr. Jane Keithley from the Sociology Department at Durham University, began analysing the HNAs from a public health perspective. In all 16 HNAs were examined, however, it became clear that limiting the analysis to those primary documents would leave a number of questions, not least how these assessments of need were being addressed in the prisons, unanswered.

Given professional commitments and constraints it was decided to create the opportunity for a Ph.D studentship and the Health Development Agency (HDA) who at the time had a remit for developing research in the area of vulnerable people and health inequalities, were approached as suitable partners in what became a CASE studentship jointly funded by the ESRC and the HDA. Reflecting the original focus on public health the research was titled 'Prison Health and the Public Health'.

After an advertising and interview process I was awarded the studentship. However, this was the time when the 1 + 3 Ph.D format was being introduced. While I held an MSc from Cardiff University in Criminology and Criminal Justice Studies this did not qualify for an 'R' rating with regard to ESRC criteria on Research Methods competence. A compromise was reached whereby I would complete all Research Methods modules on the Research Methods MA at Durham University but was not required to submit a dissertation. The required modules were completed by April 2004 and I began work on the Ph.D in earnest in May 2004.

During the Research Methods modules it was possible to do some background reading, writing and make a number of contacts who proved extremely useful when

the time came for the fieldwork. I also arranged meetings with a number of people who had a particular interest in prison health care but who would not subsequently be involved as respondents. These included the head of a local organisation dealing with drug strategies and a GP working in the wider community in one of the PCTs[36]. Given my lack of knowledge of the subject, most particularly with regard to the NHS/medical side of things, these became really important in filling the many gaps in my awareness of what was going on in prison health care. In research methods terms these became 'piloting' exercises whereby I tried out various questions and asked for feedback as to how they may be improved (Bryman, 2001). For example, asking 'is there anything else that you think I should look at?' became a standard concluding question at these meetings.

In addition, for the purposes of including a comparative chapter on how prison health was organised in another country, I made contact with a senior official from the New South Wales Justice Health Department who came to Durham and attended a meeting I organised between local health care professionals and a PCT non-executive director[37]. Although the comparative analysis was eventually set to one side because of other priorities these meetings nonetheless proved valuable in advancing my understanding of the field, writing research questionnaires and producing more material for the Research Steering Group (RSG, see below) to consider.

I was also kindly allowed access to the monthly prison health meetings at one of the PCTs. These were attended by officials from the prisons, specialists on drug awareness, NHS public health staff and the Prison Health Liaison Manager (PHLM). I was there purely in an observatory capacity and I did not have any active participation. However, I was allowed to take notes and these were also used to provide feedback to the RSG and formulate my thoughts on how I may go about taking forward the research.

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[36] Their anonymity has been guaranteed in line with the overall NHS ethical approval for the research.

[37] I should add that the initial e-mail contact did not precipitate urgent flights from Sydney to Durham for the purposes of meeting yours truly. Rather, the official was already in the UK on business.

In addition, I attended a number of conferences. Firstly, and most conveniently, the research was introduced at the Durham Prison Health Forum in 2003[38]. I also went to the Acquitted Conference on Smoking Cessation at Redworth in 2003 and the Howard League conference on prison health in London in 2004 (Department of Health, 2003a). Other conferences attended include the annual prison health conference in York and the North East conference on Crime and Disorder at Stockton. Again, these provided information and direction as well as some useful contacts which were developed further as the research progressed.

### 5.1.2 Research focus and the issue of 'ownership'

As mentioned above, in addition to my academic supervisors, the research was being directed by a RSG consisting of stakeholders from the HDA, the NHS and the Prison Service. However, after a series of regular meetings during the first year due to other professional and personal commitments the membership of the RSG changed significantly and after a year or so the RSG disbanded and supervision and direction was left in the hands of the academic body[39].

Prior to the dissolution of the RSG, the changing nature and leadership of the HDA meant that other factors influenced the direction the research eventually took. Firstly, the Chief Executive Officer (CEO) who initially agreed the funding on behalf of the HDA left the post to take up a position elsewhere. This left a vacancy which was not occupied for several months. When the post was filled an additional research topic which concerned Local Strategic Partnerships (LSPs) and their understanding of sex workers' health issues was introduced by the new CEO.

I understand that this is known in the jargon as 'specification creep' and I would advise any researcher to be aware of the very real possibility of it occurring. During the time span of a PhD. it is very possible that both personnel and the collaborative organisation's remit may change or in my case disappear altogether. This may be

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[38] I also co-write an article for the Prison Health Newsletter with my supervisor and a member of the RSG to raise awareness regarding the research (Keithley et al, 2004). My input was limited to an editing of the final draft to ensure it complied with the publication's word count limits.

[39] I took minutes at each meeting which were distributed to each RSG member for comments. The subsequent feedback was then incorporated in second drafts which were again circulated for members' records.

because of organisational restructuring, a different personal interest of a new CEO within the collaborative organisation or other circumstances over which the researcher has little control.

In this instance I spent considerable time making contact with LSPs before the RSG vetoed what they saw as an issue which was tangential to the main focus of the research. However, I felt that the perceived need to serve at least two masters and maintain ownership of the research was a difficult area and one which future researchers may also wish to give some thought to. In any case, in April 2005, as part of the government's spending review of 'arm's length bodies', the functions of the HDA were transferred to the National Institute for Health and Clinical Excellence (NICE) and the HDA ceased to exist as an independent body resulting in the end of the HDA's involvement in the research (NICE, 2007)[40].

Another issue relevant to the question of ownership was the elimination of some items of personal interest by the RSG which were part of the initial proposal to the ESRC. For example, returning to my background in criminology, I was very interested in exploring a link between poor health, crime and as the proposal put it, 'the impact on both individuals and the community of failure to tackle health-related issues with prisoners before their release and/or when they re-enter the community' (Keithley & Learmonth, 2003).

This was to be done using a database which was being developed by local Crime and Disorder Partnerships. However, questions arose about the quality of the data and this element of the research was dropped. Also, a personal interest in including prisoners as respondents was shelved as the RSG felt that, with the quantity of other work which needed to be addressed, this was not possible. Given how the research panned out in retrospect I can only agree with them though it was a disappointment at the time.

Another issue which other researchers who need to go through the process of seeking access to the NHS and the prison estate may wish to take note of was the length of

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[40] Indeed, it is also worth noting that a report which was to be delivered to the HDA on the documentary analysis of the HNAs and PHDPs, which came to over 35,000 words was written but never submitted due to the organisations' demise. That report was subsequently edited to form the basis of Chapter Five.

time it took to apply for and obtain ethical approval. While I expand significantly on this later in the chapter it is worth noting here that no time was set aside in the original proposal for this process. I would therefore counsel anyone developing a research proposal to investigate fully what will be required and integrate a realistic time frame within the proposal for going through the process, particularly if it is to involve multiple sites and more than one organisation.

Finally, under how the direction of the research may change, the issue of supervision, a supervisor's own interests and the relationship with one's supervisor are of major importance. I have already dealt with this issue in the acknowledgements section, however, it is worth commenting here that while the initial emphasis on public health was retained, broader social policy issues were introduced because of the interest in my second principal supervisor in that area. Again, this raises the issue of ownership and while I take full responsibility for the final document the overall process gave me a greater understanding of what other candidates who had completed their Ph.D theses meant when they spoke of the influence of supervision on what direction the final thesis takes.

### 5.1.3 Limitations and boundaries to the research

Just as the direction of the research changed from the original proposal so it became evident that it would be necessary to place limits on what could be achieved within the time allowed. For example, while the initial intention was to approach six PCTs and five prisons with requests to obtain a representative, cross professional role sample of a maximum of thirty five respondents, the final participant cohort was reduced to three PCTs, four prisons and twenty seven interviews[41]. These reductions arose as a direct result of difficulties surrounding access and the need to complete the fieldwork within certain deadlines.

Not all boundaries were determined by me and the RSG, however. For example, it is a source of substantial regret that it was not possible to include a female prison establishment or members of the Mental Health In-Reach teams in the research. After

[41] It was also intended initially to include PCTs who did not have a prison in their area on the basis that they were still responsible for ex-prisoners on release. This proposal was subsequently dropped.

initially being refused access I diarised forward to try again in the hope that they may be more willing to participate as work loads shifted over time. Unfortunately, it was not to be and although both targets groups were always very helpful they stuck to their original position that they could not facilitate the research due to pressures on staff numbers and work priorities.

Other omissions include Local Authorities, the National Probation Service (NPS), the National Offender Management Service (NOMS) and Drug Action Teams (DAT). Even though a good case may be made for the inclusion of all or any of these organisations as well as members of the wider community a line had to be drawn somewhere[42]. For practical purposes it was therefore agreed with the RSG that only those directly involved with prison health in the PCTs and medical care professionals within the prisons themselves would be approached.

In order to achieve a balanced sample it was further decided that as broad a range of professions as possible would be included. In addition, noting the importance of the Prison Officers Association (POA) and the fact that some also provide medical services, a PO shop steward was also recruited[43]. Lastly, members of the Independent Monitoring Boards (IMBs) were approached for their views as it was considered that their independent status would provide a useful additional source of data. In the end, after several requests, two respondents who visited Prisons A and B agreed to participate.

With regard to the choice of type of prison, again, as broad a range as possible was identified. I have already mentioned the fact that I was unable to obtain access to an institution from the female estate, however, one high security establishment, one local training prison, one Young Offender Institution (YOI) and a resettlement facility took part. Approaches to each PCT were then determined by their geographical location in relation to each prison[44].

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[42] The Crime and Disorder Act (1998) places an obligation on Local Authorities to develop and implement jointly a strategy for tackling crime and disorder (Card & Ward, 1998).

[43] A full list of participant occupations is provided in Appendix 1.

[44] A breakdown of security categories for men is provided in Appendix 2 (Home Office, 2007a).

### 5.1.4 Fieldwork issues for researchers in the prisons/NHS environment

Having outlined both self-imposed and external limits which were placed on the research I will now turn to practical issues which arose during the fieldwork. Firstly, it is important to note the distinct possibility that one may go through all the right channels, obtain Criminal Records Bureau (CRB) authorisation, bring along all the identification under the sun, check every battery and tape in your recording equipment, have definite arrangements with specific respondents who you have rang that morning to check they are still available, make the journey to the prison and be told, 'sorry, we have had an incident, access denied'[45]. This is just part of the territory when researching in this area and there is nothing one can do but try to rearrange.

It is also worth noting that even if a researcher has prior authorisation to bring in equipment, ordinary day-to-day items such as recorders attain the status of highly suspicious alien weaponry at reception into the custodial environment[46]. I experienced several unscheduled waits while authorisation for the equipment to be brought into the prison was checked and the equipment itself doubly checked as my interview time grew nearer and nearer.

I also found that turning up fifteen minutes early was completely insufficient as it opened up the possibility of respondents not being able to do the interview or have to cut it short because of time constraints. After the first time this happened I began arriving for appointments forty five minutes before the scheduled meeting time. While this was not always needed the process of going through security and being taken to where the interview was to take place was very time consuming. Though prison officers were always happy to inform respondents that I had arrived, the need to unlock and lock each door and sometimes wait for the escorting officer to be identified by video link to a central security unit before an area could be accessed meant further delays at each facility.

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[45] With regard to CRB clearance this is not indefinite and any researcher in this environment would be well advised to keep a diary as to when their clearance expired and have the relevant authorities re-apply well in advance of the expiry date. Records of CRB clearance are kept and checked at reception.
[46] Mobile phones are not allowed.

Another issue was the keen awareness that each time I went into a prison I had entered a qualitatively different environment. Unsurprisingly, this was most apparent in the high security estate. At its most extreme I had no control over my movements whatsoever. It was also very clear from the outset who was in charge and that I would do as I was told. On one occasion I was commanded, no other word does the interaction justice, to remove my belt as part of the security check. That said, staff were always helpful and friendly and I did not feel intimidated at any stage.

To sum up then I felt that there were a number of issues which influenced the way in which the research developed, not least the question of ownership. I feel that, particularly with CASE studentships in social policy and sociology there is the distinct likelihood that the circumstances in which the research was developed will change resulting in a feeling that when one is asked what is your Ph.D about the answer becomes 'well, yesterday I thought it was x but today I'm told it is y'. No doubt other students have had similar experiences in non-CASE funded studies but while I am very grateful for the opportunity offered and the assistance I was given by members of the RSG and the collaborative partner I would certainly say that it is something for others applying for a CASE studentship to consider.

It should therefore be obvious to the reader that I found establishing and maintaining ownership of the work, given the number of contributing voices (helpful though they were) and unavoidable changes due to the tragic death of my initial main supervisor, Dr. Jane Keithley, to be a difficult issue. However, as I say, I take full responsibility for the finished work. The other important influences which shaped the final draft were therefore practical self-imposed boundaries on the research and those determined by access and ethical issues. Again, I am sure that other Ph.D students will be able to relate similar experiences. Lastly, I should say that I found the actual fieldwork to be the most rewarding part of the experience. Respondents were incredibly generous with their time as were the host institutions.

Having looked at how the research focus evolved I will now turn my attention to the more technical side of the process beginning with the methodologies employed. I will then move on to develop the guiding conceptual tools more fully, identify the research

questions and illustrate how the *Framework* analytical tool was used before concluding with the process of applying for ethical approval.

Part 2

### 5.2.1 Key conceptual issues

Firstly, three key concepts, the 'street-level bureaucrat' (Lipsky, 1980)[47], implementation gaps and mainstreaming were used to frame the research questions about the implementation of national policy at local level. For the purpose of clarifying my methodology I will briefly elaborate on each one here. Beginning with the street-level bureaucrat this concept was used as an explanatory tool for exploring how individuals working in unique local settings implement national policy directives. In this regard Lipsky is concerned with 'an action-orientated bottom-up perspective' which seeks an understanding of policy making and implementation at the local level, where this perspective argues that policy is *actually* made (Hill, 1997, p.8).

This approach acts as a counter weight to 'decisional top-down' policy making analysis which forms the basis of the second conceptual framework which was employed. Here, the idea of the 'implementation deficit' or 'implementation gap' redirects attention to external factors such as resource issues which distort or frame how national policy directives are delivered locally (Hill, 1997)[48]. The final conceptual tool, mainstreaming, was taken from government policy documents themselves. In this instance, the goal of mainstreaming health care services has been defined as the task of providing prisoners with the same 'quality and range of health care services as the general public receives from the NHS' (Department of Health, 2005c, p.1) and was used as a measurement against which barriers to and facilitating factors for mainstreaming could be identified[49].

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[47] Concept 1, see Table 5.3.
[48] Concept 2, see Table 5.3.
[49] Concept 3, see Table 5.3.

### 5.2.2 Research questions

Having looked briefly at the key conceptual tools I will now turn to the six research questions. These are:

1. To what extent has the public health agenda as outlined in *Health Promoting Prisons: A Shared Approach* been incorporated into prison health services (Department of Health, 2002a)? The central conceptual framework for exploring this question is that of the street-level bureaucrat outlined above.

In addition, it has been argued that a public health approach to criminal justice expands the focus of the criminal justice system from a less expansive concern with medicalised interventions, security issues and illegality *per se* towards a more holistic model which seeks to address broader community issues. The following table sets out how this approach may operate and is considered central to the thesis as a whole because of the manner in which it highlights the potential benefits of a fuller engagement with a public health model.

Table 5.1

| **Criminal Justice Approach** | **Public Health Approach** |
|---|---|
| Threat to community order | Threat to community health |
| Concern with illegal behaviour | Concern with unhealthy behaviour |
| Emphasis on custody, security, punishment | Emphasis on prevention, health promotion |
| Health as a concern of clinicians | Health promotion as central to prison function |
| Focus on prison and health of prisoners | Focus on health of wider community |
| Tension between health-related and correctional aspects of prison | Health promotion as contributing to correctional aspects of prison |

Criminal justice vs. public health approaches to crime: alternative conceptual outcomes (Keithley & Robinson, 2003).

2. What is the nature of the PCTs' and Prison Service's understandings of health issues among the prison population and how are the public health consequences of these health issues perceived by actors responsible for local implementation?

Here, my interview schedules were developed following completion of the documentary analysis of the HNAs and PHDPs as summarised in Chapter Five. Both the street-level bureaucrat and the implementation gap concepts were employed as guiding frameworks in examining whether or not local understandings coincided with national guidelines as to what were the health care areas which needed to be prioritised in the first instance and then how these local actors managed policy delivery in the local setting.

3. What information, collaboration, support and resources do PCTs need in order to carry out their commissioning/providing responsibilities towards the prison population?

This question relates directly to the issue of impediments to policy implementation due to a shortage of external resources (Hill, 1997). The interview questionnaires for each category of professional respondent contained a specific question on resources.

4. What are the locally perceived barriers and facilitating factors which have become apparent as PCTs seek to make NHS services in prisons broadly equivalent with those in the wider community?

This question was explored using the other key exploratory framework, mainstreaming.

5. How have two identifiably different organisations, the NHS and the Prison Service, managed this change?

Here, the emphasis is on understanding organisational cultures and how processes and management structures evolved locally. In other words, how do local agents seek to make national policy work at a local level, how compliant are local actors and to what extent does local adoption achieve or distort policy intentions? Again, the three key concepts were used to investigate this question and specific reference was made to the issue of culture in the interview schedules.

6. What evidence is there that the transfer of the commissioning of primary care to PCTs is working and producing positive outcomes?

The interview schedules were designed to allow the opportunity for respondents to highlight improvements in treatment regimes whether evidenced by increases in staff training and skills, recruitment, better facilities and modernised equipment or advances in clinical interventions. Such positive outcomes and data were also monitored through the documentary analysis of prison health plans.

### 5.2.3 Documentary analysis

*The Future Organisation of Prison Health Care* report recommended that each prison begins the process of transferring commissioning by completing a HNA (HM Prison Service and NHS Executive, 1999). These documents then provided the basis for the subsequent Prison Health Improvement Plans (HIMPs) and the later PHDPs which were jointly produced by the prisons and PCTs. The documents were designed to establish what problems existed within the prison population in the first instance, how these issues may be best addressed and what areas needed to be prioritised. They were therefore seen to be of critical importance in guiding local policy and strategy.

The analysis itself utilised the 2002 HNAs for each participating prison and the 2004-2005 PHDPs which were then developed jointly by the prisons and their local PCT. Thus each health care issue which was identified as relevant in the original HNAs and *The Future Organisation of Prison Health Care* as a priority was tracked against local action plans and national guidelines. This was particularly useful in identifying gaps in implementation and the methods by which local actors adapted national policy to fit their perceptions of local need. Also, I believe that using documentary analysis as an additional research tool against which findings from the semi-structured interviews could be compared added another degree of robustness to the overall findings through triangulation (May, 1997, Bryman, 2001).

### 5.2.4 Respondents, host organisations and method

In order to investigate the research questions semi-structured interviews were conducted with key stakeholders in the host PCTs and prisons. While the individuals and institutions have been anonymised each profession has been coded for the purpose of enabling the identification of both common ground and differing perspectives between the various roles[50]. A purposeful sample was constructed to encompass a broad range of professional perspectives. For example, the key postholders sampled in the three PCTs included the Chief Executive, Director of Public Health, Non-Executive Director and the PHLM, while the Governing Governors, Prison GPs and professionals working in the prison health care centre were interviewed in the prisons.

It was also decided to include the shop steward of the POA as they were the person in the best position to represent the views of security staff. In addition, an ex-Governing Governor of one of the prisons who was in charge at the prison from time of the initial HNAs through to the transfer to the NHS was also interviewed because of the individual's experience of both health care regimes.

Approaches were initially made through the Chief Executives of the PCTs and Prison Governing Governors. Often these introductions came about as a result of contacts provided by the RSG or made by myself during the first eight months which were primarily spent on the Research Methods masters modules. In four cases the initial contact was made by means of a 'cold' call to a personal assistant and a subsequent letter outlining details of the research as well as a request to participate subject to ethical approval. In all four of the requests to six prisons were successful while each of the three PCTs who were approached agreed to take part.

The host institution sample was therefore also a convenience sample, a result which emerged because of practical limitations of time and location. That said the sites which eventually hosted the fieldwork were not chosen at random. Each prison provided both a unique setting as well as a varied prisoner population. As mentioned

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[50] See Appendix 1 for a full breakdown of respondent's professions and codes.

above, confidentiality was guaranteed in order to preserve both the anonymity of respondents and the institutions themselves.

Once ethical approval was obtained most respondents were recruited through 'snowballing', i.e. personal introductions, while others were approached using a formal letter or by telephone (Bryman, 2001, p.508). Indeed, snowballing was particularly useful in the custodial setting given the practical difficulties of meeting people in a secure environment. At each interview, the respondent was provided with a letter outlining the confidential nature of the research and a participant information sheet. In addition, they were asked to sign an 'informed consent' letter after they had read and asked any questions they may have had regarding the participant information sheet. These documents are available in Appendix 3.

For this part of the research a qualitative methodology, using my interpretation of respondents' understanding of 'what is', i.e. their ontological reality as the basis of my epistemological position, was employed (Crotty on ontology, 1998, pp10-12). This method has been chosen to provide an in-depth look at the manner in which health care professionals and security staff experience, interpret, manage and apply national policy in unique local settings. In addition, it is worth stating that the semi-structured questionnaires were designed using mainly open questions for the purpose of providing respondents with the necessary flexibility to express their personal and professional perspectives (Bryman, 2001).

The process was therefore an inductive one where 'theory is built squarely on observation of the data themselves' - 'grounded theory' (Crotty, 2003, p.78, Glaser & Strauss, 1967, Searle, 2004). These results were then considered in relation to the key concepts used to frame the study. Once the interviews were transcribed the data gathered was analysed using the *Framework* analysis tool as developed by the National Centre for Social Research (2005) for use in applied policy research settings as described below.

### 5.2.5 The *Framework* analysis tool

Firstly, it is noteworthy that critiques of qualitative research often rest on its supposedly unstructured and subjective nature. In contrast, advocates of quantitative research methods point to its 'objectivist ontological orientation', the 'scientific' basis on which results are obtained and the production of 'facts' on which social policy decisions may be made (Bryman, 2001, p.20). While I would argue that quantitative methods always rely on qualitative decision making as to on what, with whom and where research takes place, *Framework* aims to bridge this gap through a systematic approach which, while allowing for flexibility, still represents a disciplined, logical method. *Framework* allows the researcher to identify emerging major themes and concepts and further divide these main themes into sub-themes. Furthermore, it facilitates the identification of patterns across dimensions of variability such as professional categories and organisations and localities.

The original plan was to transcribe each interview immediately after it had taken place. This seemed to be a reasonable approach given that they would be fresh in my mind; however, at times it was necessary to complete more than one interview in a day which led to a small backlog of three or four at its worst. The process as no doubt any researcher would testify was tedious but obviously represents a fixed cost of such work. In any case, once transcribed, the *Framework* tool as outlined in the following table was then applied to the completed documents.

Table 5.2 *Framework* analysis tool (adapted from Ritchie & Spencer, 1994, p.176)

| | |
|---|---|
| Grounded or generative | Based in and driven by the original accounts and observations of respondents |
| Dynamic | Open to change, addition and amendment throughout the analytic process |
| Systematic | It allows methodical treatment of all similar units of analysis |
| Comprehensive | It allows a full and not a partial or selective review of the material collected |
| Enables easy retrieval | It allows access to and retrieval of the original textual material |
| Allows between-and within-case analysis | It enables comparisons between and associations within cases to be made |
| Accessible to others | Analytic process/interpretations available to people other than the primary analyst |

The focus here is very much on the production of applied policy research, i.e. research which has specific information needs and which identifies 'actionable outcomes' (Ritchie & Spencer, 1994, p.173). The following table then sets out the typology of questions which were designed to meet the research objectives as well as which research questions and conceptual frameworks to which each type relates.

Table 5.3

| Question Category | Objective | Examples | Research question/s | Key Concept/s |
|---|---|---|---|---|
| Contextual | Identifying the form and nature of what exists | What elements operate within a system?<br>What is the nature of people's experiences? | 2, 4, 5 | 1, 2, 3 |
| Diagnostic | Examining the reasons for, or causes of, what exists | What factors underlie particular attitudes or perceptions? | 2, 3, 4, 5 | 1, 2, 3 |
| Evaluative | Appraising the effectiveness of what exists | How are objectives achieved?<br>What barriers exist to systems operating? | 1, 3, 4, 6 | 1, 2, 3 |
| Strategic | Identifying new theories, policies, plans or actions | What types of services are required to meet needs?<br>How can systems be improved? | 1, 4, 5 | 1, 2, 3 |

Following *Framework*: typology of questions. Adapted from Ritchie & Spencer, (1994, p.174)

The *Framework* analysis tool as described above was then used to analyse all interview transcripts and the data which emerged is outlined in tabular form in Appendix 4. Having outlined how *Framework* was used I will now turn my attention to the sometimes difficult procedure for obtaining ethical approval from the NHS for the research.

### 5.2.6 Applying for ethical approval

The process of applying for ethical approval proved to be a drawn out one. Because the respondents included NHS staff and much of the fieldwork was to take place in prisons the ethics application had to be approved by a number of bodies (Central Office of Research Ethics Committees (COREC), 2005). Here I will outline the procedure, including the timescales imposed by the regulatory bodies for making decisions as well as other factors which contributed to the protracted nature of the process.

Firstly, as previously mentioned, the research was overseen and guided by a RSG which came together as part of the original proposal to the ESRC for a CASE studentship. The RSG consisted of three members of the academic supervisory team together with a Director of Public Health, the Chief Executive of a non-participating PCT and a representative from the Prison Service. As a first step the application to the COREC, research questions and interview questionnaire schedules were circulated to the RSG for comments and suggestions[51]. Due to the practical difficulties of getting each member in the same place at the same time this was done by e-mail. Once all members had responded, a second set of e-mails was circulated for comment on the amendments and the final documents were adjusted accordingly.

The next step involved obtaining agreement from prisons and PCTs to host the research. However, the question of exactly which institutions to approach had not been addressed until this point. While the original research proposal included PCTs which did not have prisons within their boundaries it was now felt by the RSG that because ex-prisoners are not treated as an identifiable population cohort in their own right by PCTs then they would not be included in the study. While this may have produced interesting research findings in itself there was also the issue of matching what could be achieved within the time allowed for the work. The study therefore does not include any PCTs without prisons in their areas.

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[51] The interview questionnaires together with Parts A, B and C of the COREC application, and supporting documentation are available in Appendices 3 and 5.

Attention then focused on three PCTs who had responsibility for six prisons. The Governing Governor of each prison and the Chief Executive of each PCT were sent copies of the COREC application together with a covering letter explaining the purpose of the research and a request for responses within a certain time period. While each PCT was happy for the work to go ahead subject to COREC approval, two prisons refused. The reasons given were, ironically enough, that too much change was taking place in their health care centres as a result of the switch to the NHS and staff did not have time to participate. A number of organisations did not respond within the time period, however, and follow-up letters and phone calls were required before definitive answers were received. In total it took over two months for this part of the process to be completed. Indeed, one institution, because of staff shortages in the department responsible for approving research proposals, took more than five months to make a decision which turned out to be positive.

The third stage of the process involved applying to the Research Management and Governance Unit of the local SHA for NHS Research and Development approval. Here, an on-line form, also produced by COREC was completed and forwarded to the SHA together with supporting documentation including the participant information sheets, consent forms, statements on confidentiality and interview questionnaires. The Research Management and Governance Unit meet on a monthly basis and allow themselves a sixty day turnover period to make a decision or respond to applicants with any queries.

In all four mandatory changes were required by the Unit together with seven suggested amendments. These required the expansion of the participant information sheets to clarify the purpose of the study, amending the front-sheet of the research questionnaires to include details of how long respondents had held their current posts and rephrasing the letter of consent. Once adjusted, the application was then resubmitted and approval was obtained. From the date of original submission to receiving full clearance this part of the application took a further two months.

The application was then ready to be submitted to COREC itself. This part of the process required that I 'book' a place at a meeting of a Local Research Ethics Committee (LREC) appointed by COREC at which the application would to be

considered. The procedure required me to telephone COREC and state formally that the application was ready for submission. COREC then went through a number of questions to satisfy themselves that this was indeed the case and issued an application reference number which needed to be quoted on future correspondence. Once this was done I was allowed five days to have the application in the hands of whichever LREC was designated by COREC to consider the proposal. Forwarding the application on-line was not enough, the hard copies, six in all, had to be safely received.

In addition, no extension would be permitted on this. If I had failed to have the application delivered within the given deadline it would have been rejected and the booking process would have had to be repeated for the following month's committee meeting. This would have set the application back at least another month so making sure everything was in order for COREC was critical. Once COREC allocated the research reference number they directed me to South Essex REC who have special responsibility for prisons. Here again, the REC had a sixty day response period from the date of their *next* meeting, i.e. not from the date of receipt of the application. It is also worth noting that during this period the on-line applications were locked and no amendments could be made without applying separately to COREC. Other researchers may be interested to note that no fee was charged by COREC or by any of the other organisations involved.

Turning to the ethics committee meeting itself South Essex requested that I be available by telephone to respond to any questions they may have had. As it turned out they did not contact me but wrote one month after receiving the application confirming that they would be content to give a favourable ethical opinion of the research but, like the SHA, raised a number of queries. While these were mostly relatively straightforward, one issue concerned a letter from one of the prisons which was approved by the SHA was considered unsatisfactory by the committee. This caused a further delay in the application process as the prison were unwilling to adjust their own letter without confirmation from the SHA that it was in order to do so.

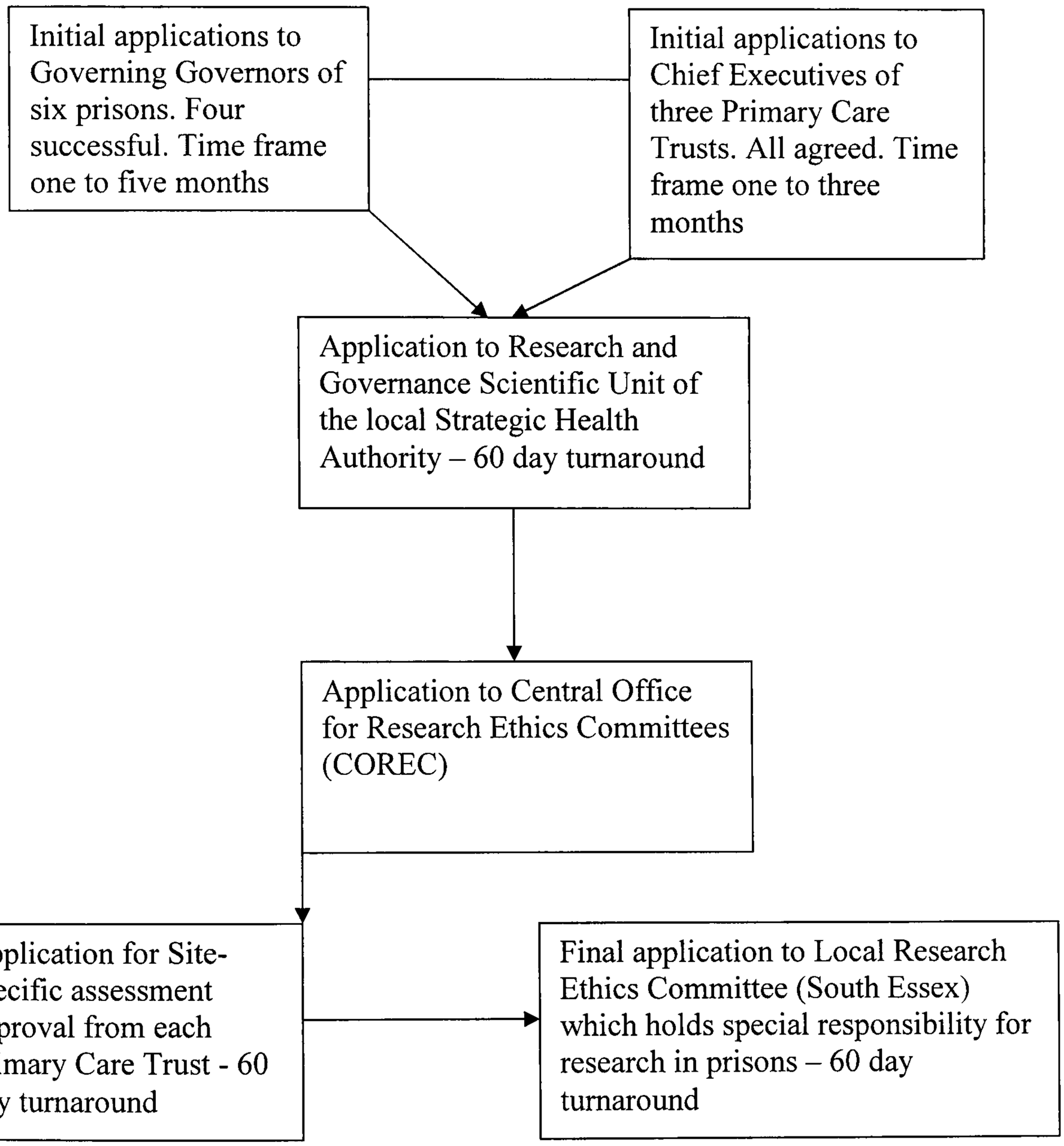
While co-ordinating these changes was going on it was also necessary to make simultaneous applications for 'Site-specific assessment' (SSA) to the appropriate LREC for each of the three participating PCTs. The purpose of this was to satisfy

COREC and South Essex REC that each PCT had the available staff and premises to host the work. While it would appear logical to have made this application at the same time as the initial request to the PCTs, COREC insisted that this could not be done until they had approved an appropriate LREC to consider the application and an application reference number had been issued. This part of the process required that a further SSA application had to be completed for each LREC. These were then considered by the various LRECs at the same time as South Essex were adjudicating on the main ethics application. The final ethical approval was received more than eight months after the initial approaches to the prisons and PCTs. However, this was not the end of the researcher's involvement with COREC as an annual progress report was required by South Essex REC together with and an end-of-study declaration form when the research was finally completed.

In conclusion the process of obtaining ethical approval was a drawn out one. The length it would take was not considered at the time of developing the original proposal and no time was therefore allocated in the research action plan for its inclusion. Indeed, it was further complicated by the fact that the system itself was undergoing a major overhaul with all applications being transferred to an on-line service. Also, the procedure was unfamiliar to either the RSG or my academic supervisors. That said these factors made it all the more of a challenge and a relief when ethical approval it was finally granted.

Fig. 5.1

**Ethics Approval Flowchart**



### 5.2.7 Methodological and practical critiques of the research

Thinking more reflexively on how the research developed it became apparent that there were a number of methodological issues and omissions which needed addressing in the interests of making the findings as robust as possible. In this section I will identify each and describe how I sought to minimise the problems created.

Firstly, there is the issue of generalisability. Each prison is unique. This is hardly a surprising or original finding but taking what emerged from interviews always needed to be qualified by a number of variables such as category of prison, nature of the built environment, PCT level of engagement, age and gender of inmates. I could add others but the picture is clear in its complexity. This, however, did not negate the possibility for making broader statements about policy implementation more generally as I have done in Chapter Eleven. In short while it may be apparent that the delivery of health care may be necessarily different in a resettlement prison to a high security facility I do not feel that lessons cannot be drawn out in a more general way for the implementation of social policy from the data.

Secondly, there is the issue of important respondents which are missing from the research. Here, I have already mentioned the female estate. In addition, it would have been interesting and highly relevant to include the prisoners themselves. Also, it was not possible to engage with the Mental Health In-Reach teams or with those who were concerned with extreme behaviour such as self-harm. Where possible I have attempted to fill these gaps by using data provided by other health care professionals who would have had some contact with patients in these areas. For example, with GPs who had very clear views on mental health issues. However, the fact remains that the data obtained is secondary and incomplete.

Furthermore, some departments which would have been highly pertinent were also not included in the original research proposal. For example, prison psychology departments remain under the remit of the Home Office; however, they may also have been important contributors. Also, bringing us back to the difficulties of where to draw a reasonable line on boundaries to the research, care pathways were described as

being how those who needed to engage with them on a professional basis saw them rather than through their own professional voices. That said, I feel that offering their admittedly secondary views also has value as a research finding.

Lastly, although I am sure that my examiners will identify others, are issues I had personally with the *Framework* analysis tool. Here I found that I was applying my own subjective values as quantified Likert scale responses to respondents' own subjective qualitative discourses (Bryman, 2001). My faith in this process was therefore somewhat limited. In addition, this layering of quantitative values on what is very much qualitative data is further compromised by the limited sample size. Extrapolating findings from, for example, an interview with one PO, albeit a shop steward, to the general PO workforce is not sufficiently robust.

While findings from this particular interview are backed up through reference to relevant literature on working in prisons (Crawley, 2004a, 2004b) and ethnographic 'backstage' (Goffman, 1969) observations, the use of *Framework* itself adds little that would not have emerged from a thorough iterative engagement with the data itself. Of course, this raises the question of what does its inclusion add to the thesis in the first instance? In response, I feel it worthwhile as a research finding *in itself* that *Framework* is recognised as having greater potential as an analytic tool for significantly bigger sample sizes. Also, it may be of use as a cautionary tale, especially given the length of time which went into producing the data, to other researchers who may be considering its use on similar size respondent cohorts.

Alongside this, as I worked more with the tool, especially where scores were more obviously negative or positive I became slightly more comfortable with it. Regarding more marginal decisions I found myself applying mid-range values which reflected the non-committed nature of the respondent. Where I felt a respondent did not engage significantly with an issue no score was awarded. This is why in *Framework* there are some empty boxes on some issues. By then averaging out values I feel that the findings became stronger and that sub-themes which emerged had real 'value' across respondents thus addressing somewhat my concerns about subjectivity. To re-iterate then, my use of *Framework* did not add anything which would not have emerged from a more conventional analytical approach.

5.2.8 The ethnographic and case study nature of the research

Alongside the qualitative interviews being shown around the prisons also offered the opportunity for a number of informal 'backstage' observations (Goffman, 1969) on how staff approached their work and how they viewed relationships with inmates and each other. Instances from these observations are provided in the text where they offered some insight into policy implementation and the relationships just mentioned. Given the environment in which I was working I made the judgement that actively taking fieldnotes while walking around with POs or PCT staff was inappropriate.

Quite aside from the impracticalities of writing while being taken through the prisons there was the very real possibility of raising suspicions and compromising the trust which I had been afforded. The only way around this I felt was to scribble down bullet point summaries of what I had seen or heard on return to my car and then write them up properly afterwards. Indeed, I felt that is was very often these observations which prompted me to look more reflexively at the work I was doing.

For example, an incident where a PO and I were walking past a frail, elderly, bed bound inmate given medication intravenously prompted me to question, albeit briefly, the provision of healthcare itself. On approaching the inmate the PO said, in a jokey fashion, 'Well, X, will you be doing any exercises today?' To which X replied 'Maybe later, Y!' They had a laugh about it and as we walked on I wondered to myself, well, what harm could that man do if released? Once out of sight the PO informed me that he had been part of a paedophile ring.

This made me very uncomfortable about the interaction and also my part in looking to do research which had the potential to identify best practice for care for people who have been either convicted of committing serious crimes or are being held on remand. Indeed, the incident also served to situate me closer to the fundamental question: 'Patient or Prisoner?' In the end I reconciled myself to the fact that medical ethics would not (correctly in my view) allow the denial of medication to any patient and also that the sentence only prescribes the denial of liberty not the absence of care. As I say, other such incidents are related at various points in the thesis.

Lastly, it is worth lastly mentioning the 'case study' nature of the research. The number of sites which were originally approached was eventually reduced to seven. These included a PCT with responsibility for a local training facility and a high security prison, a PCT with a resettlement prison in its boundaries and one which now had a male Youth Offender Institution within its duty of care. Findings have been presented in accordance with this case study approach with the type prison seen as an important variable in seeking to implement mainstreaming.

Having outlined the origins of the research and its limitations, my own experiences, gone through the guiding conceptual frameworks, research questions and various methods employed I will now turn to the first of my original findings; the documentary analysis of the HNAs and PHDPs.



DURHAM UNIVERSITY

Chapter 6

# Documentary Analysis

As detailed in the introduction, *The Future Organisation of Prison Health Care* called for all prisons to complete an audit of present health care need as a basis for planning future services (HM Prison Service and NHS Executive, 1999). These were known as HNAs and were to be produced in accordance with the *Toolkit for Health Care Needs Assessments in Prisons* during 2002 (Marshall et al, 2000). PHDPs were then jointly produced by the prisons and their local PCTs for the purpose of planning services as part of the new partnership arrangements.

The purpose of this documentary analysis is to question to what extent the prisons initially engaged with government guidelines, what they identified as their main priorities, how accurate their information gathering procedures were, whether they picked up on important government reports during their work, how they planned partnership working and staff training and how well the HNAs/PHDPs dovetailed in driving forward the mainstream agenda.

In total the HNAs/PHDPs from four prisons and three PCTs were examined. The prisons included a high security facility, a local training prison, a resettlement facility and a YOI. In the interests of preserving anonymity specific quotes from the documents have been omitted as has other information such as exact data which may have compromised ethical guidelines for the research. The chapter is presented in three parts. Firstly, I summarise the findings from the original HNAs. I then turn to the PHDPs which were completed at various times between 2004-2005. In the final section I comment on general trends and deficiencies which became apparent from the analysis.

## 6.1 Health Needs Assessments 2002

### Prison A HNA 2002

In common with other prisons the HNA begins by referencing *Health Promoting Prisons: A Shared Approach* (Department of Health, 2002a). It identifies the problems associated with prison as a poor environment for health promotion and also recognises that the deprivation of liberty may be an opportunity to address health care need. The wider detriments of health are then listed and how they fit in with the whole prison approach is discussed (Hunter, 2003).

As a baseline for performance the HNA notes that the health care centre had been awarded 'amber' grading[52]. This was as a result of several failings, the most important of which was a lack of permanent GP cover, poor retention of nursing staff and a poor environment for health care. The HNA's aim is to raise health care standards to 'green' by firstly building a picture of current services in Prison A, identifying gaps in services and then producing action plans which will ensure that prisoners have access to the same quality and range of health services as the general public.

The collection of data for the HNA, however, proved problematic. Here, while the views of a range of stakeholders such as prisoners[53], Governors, health care staff and Board of Visitors[54] members were taken into account, the difficulties encountered in collecting accurate information regarding prisoners' health care needs and/or status is made clear. These are summarised as follows:

- Inmate records (IMRs) are difficult to access and the actual recording of the data and its accuracy is questionable.
- The process of collecting data at reception is fundamentally flawed. The inmate population typically come from backgrounds with multiple health

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[52] 'Amber' is defined as 'the problems faced need to be resolved quickly'. It sits between 'green' (the problems faced are manageable and on the whole has acceptable services) and 'red' (failed). The latest ratings system ranks prisons on a scale from 1-4 with 4 as representing 'excellent' status and 1 as 'failing' (see HM Prison Service, 2006).
[53] Via a survey conducted in 2001.
[54] Boards of Visitors are now known as Independent Monitoring Boards.

problems, however, the prisoners themselves display very poor knowledge of their own health status.

- The Health Information System for Prisoners (HISP) allows for the collection of only limited data. It needs to be reviewed by the NHS.
- Lastly, when remand prisoners are discharged or transferred their IMRs go with them. It is therefore difficult to identify the needs of remand prisoners retrospectively in order to plan future services.

Prison A also comments on the ongoing difficulties associated with introducing a workable IT system into its buildings. The background to this is that the local health authority purchased a clinical software system for primary care from Egton Medical Information Systems (EMIS) in 1999 which was to be installed into the prison. However, due to contractual issues and difficulties associated with adapting Victorian buildings to accommodate computer technology, the system was still not in place at the time of writing the HNA.

In addition, actually deciding whether or not to use this system was further delayed because the prison was awaiting the outcome of a national pilot scheme for IT systems within prisons. In order to improve procedures for collecting and storing data in the interim the HNA recommends better cooperation between clinicians, health care workers and administrative personnel to communicate and register correct information on IMRs with the resulting data computerised when the new IT system is in place.

The document then goes on to list what Prison A saw as the most pressing health care issues. For the purposes of making a direct comparison with objectives at a national level I have presented these in tabular form. In the case of Prison A then these matched the main priorities as identified by central government. However, a number of others which took into account specific local need were included.

Table 6.1

| **National Priorities** | **Local Priorities** |
|---|---|
| Primary Care | Primary Care Services |
| Mental Health | Mental Health |
| Substance Abuse | Substance Misuse |
| Health Promotion | Health Promotion |
| Dentistry | Workforce development/staff training |
| | Management of suicide and self-harm |
| | Computerising and Developing IT system |

National vs. local priorities for Prison A

In accordance with guidelines contained in the *Toolkit* Prison A also compiled a table of indicators of current prisoner health status. In the interests of maintaining anonymity only generalised information is provided here. The main issues raised by the prison concerned the numbers of self-harm victims and those diagnosed with Hep B, Hep C and HIV. The HNA commented that although a limited vaccination programme for Hep B was in place, figures for Hep B, Hep C and HIV infection in the prison may well underestimate the extent of these problems. Indeed, the figures recorded here are remarkable as much for what is not recorded as what is. For example, no data are available for the number of prisoners with drug abuse issues at Prison A.

Furthermore, it is worth commenting on the low levels of Hep B and Hep C compared to national statistics. Does this reflect a genuinely low level of infection among prisoners at Prison A, an effective immunisation programme or a lack of detection? Also, figures for alcohol abuse when compared to national statistics show substantially lower levels at Prison A and again the reasons for the disparity (quite possibly linked, at least to some extent, to the problems identified in data collection in the first instance) would be worth establishing. A further problem with the figures is that some inmates with mental illness issues are seen by Community Psychiatric Nurses (CPNs) who are not allowed to give a diagnosis which may account for under recording of problems. In short, compiling comprehensive and accurate base-line health status data was a major problem.

Before turning specifically to mental illness it is also worth noting here that while figures were available on the percentage of inmates who smoked the issue of initiating a smoking cessation programme was not addressed. Indeed, noting the link between smoking and chronic disease it is a concern that the HNA acknowledges the fact that Prison A did not have an organised chronic disease management system in place at Prison A.

The HNA then begins the section on mental health by referencing the *Changing the Outlook: A Strategy for Developing and Modernising Mental Health Services in Prison* document which called for a joint approach to the development and modernisation of mental health services in prisons over the next 3-5 years (Department of Health, 2001a). This strategy is said to be consistent with both the National Service Framework (NSF) and *The NHS Plan: A Plan for Investment, a Plan for Reform* (Department of Health, 2000). The HNA then recommends that a Referral Management Group made up of the CPN co-ordinator, probation psychologist, discipline officer and primary care lead is established.

The seriousness of mental health issues at Prison A may be gauged by a comment which claimed that if placements were based on clinical needs of the patients more than one third should be in secure NHS psychiatric care. Indeed, many of these patients had been previously in NHS psychiatric care. However, the HNA notes that there are extreme difficulties with regard to delays in transferring patients to a high security hospital.

Other concerns:

- It is also noted that listeners themselves suffer from anxiety and depression as a consequence of the problems they encounter[55].
- Recording of mental illness has been poor in the past and the data are most likely inaccurate.

[55] Prison A operates a voluntary 'listeners' scheme whereby peer volunteers are trained to listen to other prisoners' problems and concerns.

- The reception area is inadequate and the in-patients facility in the centre comprises a clinically inappropriate mixture of seriously mentally ill patients, some with more minor psychiatric problems and a few with physical illness.
- In addition, when the prison becomes overcrowded bed vacancies within the in-patient clinic are occupied by healthy inmates. There is also a ward used as a day care facility but it is inadequate for mental health care needs and the HNA recommends the provision of a separate day care facility to cater for mentally ill prisoners/patients and the introduction of counselling sessions, group work and therapy.

Indeed, it is also clear that the figures given for prisoners with mental illness problems were significantly less than the national average, with the HNA identifying awareness of just a third of prisoners with such issues. In contrast, it cites national statistics which refer to rates of psychiatric morbidity among inmates of more than three-quarters for remand prisoners and two-thirds for male sentenced prisoners (Marshall et al, 2000). At the time of the HNA Prison A was undertaking a detailed mental health needs assessment in conjunction with PCT 1 and Prison B which was due to be completed by September 2002. This document is summarised after the mental health section for Prison B below.

Turning next to public health a number of recommendations are included in the HNA and it also displays an awareness of pursuing the whole prison approach and engaging with health promotion. Figures indicate that more than half of male prisoners are employed at the prison and a quarter attended gym exercises. Initiatives which have been put in place are setting up a steering group to develop protocols for health promotion, training in behavioural change and smoking cessation for prison staff. Prisoners themselves requested more activities on the wings, having a greater variety in education courses and a change in the attitude of prison staff as being important items they would like to see addressed. In this context it is interesting that most prisoners who participated in an earlier prisoner survey felt that they did not have any educational need.

Reception into custody was also identified as an opportunity for advancing the health promotion agenda. This is noted to be a particularly vulnerable period for new inmates with the risk of suicide or self-harm high. Each new reception is therefore risk assessed and the induction programme covers items such as anti-bullying, drug awareness, educational testing (though what this may entail is not stated) and being seen by a member of the health care team. The HNA identifies a weakness here in that the information pack which is handed out to all new inmates needs to be reviewed and should include more information on health promotion.

However, where input from prisoners has been sought there is little evidence that their concerns are subsequently addressed in subsequent HNA recommendations. For example, they identified the amount of distress self-harm causes other inmates and the desirability of a separate unit for injured inmates but these issues are not then addressed at least in the documents themselves.

Lastly on health promotion, a major barrier to improving services and the whole prison approach health promotion is the physical structure of the prison itself. As mentioned earlier it is comprised of a series of buildings dating from the Victorian era and as such is an inappropriate environment for delivering modern health services. The HNA therefore ends this section with a call for a new health care centre to be built as a matter of urgency.

Moving on to drugs and alcohol awareness, prisoners with drugs issues are to be identified through observation, monitoring and mandatory drug testing (MDT). It is planned to offer a 'more effective' detoxification programme which will include counselling and treatment. The new service is to be overseen by a local Health Care Trust. It is also noteworthy that an earlier prisoner survey indicated that almost half of the male prisoner population who participated needed help with drug and/or alcohol related problems on arrival at Prison A. Three-quarters had used drugs at some stage and drugs were still a problem for around half. It was acknowledged, however, that only just over a quarter of these were given support at Prison A (Counselling, Assessment, Referral, Advice and Throughcare (CARATs), detoxification, medication or counselling).

Attention is then turned to staff issues and training. The HNA begins this section with acknowledgement of the need to develop the whole of the health care workforce in the prison. In addition, primary care is seen as of particular importance because of the high incidence of consultation rates seen in prisons[56]. Nursing skills are identified as being inappropriately used and need to be separated from custodial duties. What custodial duties are being referred to is not made clear. The HNA also calls for better links with the NHS to facilitate training, reduce health care workers isolation and for new medical staff to be trained in 'jail craft'. Again, what exactly this means is not detailed nor indeed is who would provide such training or what it would involve.

Staying with staffing, the HNA draws attention to the need for the appointment of a clinical nurse manager who will assume responsibility for identifying training needs as well as overseeing the introduction of clinical governance standards which, allowing for the constraints of the custodial environment, comply with those observed in the NHS.

Finally, the HNA draws attention to a number of issues which do not fall easily into the above categories. Here, in the context of the mainstreaming goal, it is interesting to note that a GP focus group felt that many health issues are dealt with better in prison than in the wider NHS. They therefore felt that judging the service in comparison with NHS standards may not be a good idea in the first place. Also, they were concerned about continuity of care on release as well as the issue of prisons absorbing mentally ill patients who should not be there in the first place.

Prison B HNA (2002)

This HNA begins by reiterating the areas for progress as outlined in *The Future Organisation of Prison Health Care*, i.e. improved reception screening, mental health problems, focusing on primary care, incorporating NHS approaches to quality and clinical governance and addressing professional isolation (HM Prison Service & NHS Executive, 1999). The aims of the HNA are to increase understanding of the existing

[56] This is argued to be so as a consequence of restrictions on self medication and informal care in the prison setting.

health care services in Prison B, increase the involvement and ownership of stakeholders in the process, establish what services are required to address unmet need, work towards equity of resources between different groups and use the HNA as a basis for producing an action plan.

Although similar problems with data collection are noted Prison B produced a table based on IMRs of various health care issues. For example, items identified were Hep B, Hep C, HIV, smoking rates (less than national smoking in prison rates but not significantly so) and figures on mental health. The HNA then turns to health promotion issues. Prison B appointed a health promotion specialist in the late 1990s to lead a three-year initiative known as the Prison Health Promotion Development Project. A survey, conducted among prisoners at the time found that many prisoners were interested in engaging with health promotion. Of most concern were diet and nutrition, sleeping problems, handling stress and smoking. Issues such as BBVs, drugs problems and mental illness were less of a priority from the prisoner's perspective. Indeed it is interesting that more people were concerned about relationships than either substance misuse or mental illness.

Health promotion clinics in Prison B address the following areas: mental health, smoking cessation, Well Man, Hep B vaccination, BBV testing and counselling, Hep C and healthy eating. While issues such as literacy and chaplaincy are mentioned in the HNA they are left to the departments concerned. Within this wider agenda the HNA also notes that it is worth considering the effect that the large amount of self-harm has on the well-being of fellow prisoners.

The stated aim here is to improve the health of the prisoners within Prison B and encourage them to adopt healthier lifestyles. The proposals for action are as follows: organise courses on stress management, assertiveness and self-esteem, introduce regular health check-ups at the Well Man clinics, offer regular physical and mental check-ups for elderly inmates and encourage prisoners to obtain National Vocational Qualifications (NVQs). Other initiatives include encouraging more inmates to become Listeners, providing information on HIV, STDs, and testicular self-examination packages, continuing the smoking cessation programme, enforcing smoke free zones and organising a programme for Hepatitis B vaccination. In addition, the plan aims to

reduce boredom, encourage healthy eating and improve access to over the counter medication with low misuse risk.

Condom use is also included under harm minimisation and is to be encouraged. Needle exchange programmes are not addressed. A comprehensive Health Improvement Action Plan was then developed as part of the HNA. In sum, the HNA displays substantial engagement with public health issues, from physical health, making positive use of prisoners' time and developing immunisation services.

Staying with public health agenda related issues, any prisoner identified whether by questionnaire or during general health care procedures as having drugs related issues will be referred to the CARAT team. Any inmate who requests a detoxification regime from CARATs is referred to the Senior Medical Officer (SMO) for assessment. CARATs also liaise with the health care centre regarding testing for Hepatitis B and HIV. The HNA also refers to an earlier survey which found that just less than half of prisoners used illicit drugs in prison.

That said, because of the high secure status of the prison and the fact that it receives no remand prisoners, Prison B has a relatively low rate of admissions per week. At reception all prisoners complete a questionnaire with a member of the health care staff who assesses their need for immediate care, treatment or observation. The HNA also notes that reception may offer further opportunities for promoting the public health agenda as part of the induction process.

Prison B therefore aims to achieve three goals: maximise the number of misusing prisoners who receive treatment, reduce harm incurred by those who cannot remain drug free and maximising the number of prisoners who remain drug free, both in prison and after release into the wider community. Here, then is specific recognition of the prison's and PCT's responsibility to patients which transcends the prison walls. In order to achieve these goals more staff training and increasing liaison with the local Drug Action Team (DAT) is envisaged. Lastly, the plan calls for greater opportunity for prisoners to access dependency reduction facilities.

As with the previous HNA, Prison B then compiled a list of areas which needed urgent attention. Again, these mostly matched national objectives but also allowed for particular local issues.

Table 6.2

| **National Priorities** | **Local Priorities** |
|---|---|
| Primary Care | Primary Care |
| Mental Health | Mental Health |
| Substance Abuse | Substance Misuse |
| Dentistry | Staff Management and Workforce Issues |
| Health Promotion | Training, Education & Continued Professional Development |
| | Reception and Discharge Screening |

National vs. local priorities for Prison B

Moving on to mental health issues the HNA begins by referring to the high rates of mental health illness among the prison population and notes that over half of male prisoners display anti-social behaviour. It then points out that physical exercise is seen as part of improving the mental health condition of inmates. Interestingly, it goes on to list how prisoners' time is occupied during the day, educational activity and the degree of social action as important factors in dealing with less serious problems such as neurotic symptoms. How this time is used is a matter for the security regime in the prison and no recommendation is made in the HNA regarding seeking to influence how this time is utilised. It is also noted that, under the terms of the Mental Health Act (1983), prisoners cannot be treated in prison without their consent. Only following reports from two doctors and permission from the Home Secretary may a sentenced prisoner suffering from a severe mental disorder be transferred to hospital.

The section concludes with a number of recommendations about how Prison B needs to approach the future planning of mental health services. The action plan includes proposals to implement anti-bullying strategies, have regular physical exercise, and improve contact with family, friends and the wider community. However, details of how these goals are to be achieved are not given. Lastly, the plan includes developing

a more effective screening tool for mental illness at reception as well as improving discharge planning arrangements to make better connections with outside agencies.

This plan was then developed in conjunction with Prison A and PCT 1 in a further assessment of mental health need. This free standing assessment begins with staffing issues. Various posts are to be filled. For example a Mental Health Service Co-ordinator is to be recruited and a Mental Health In-Reach Project Group put in place. The plan also aims to incorporate the whole prison approach, to develop an integrated care pathway which will address common mental health problems, severe mental health problems, learning difficulties and personality disorder. The focus is to be on wing based care and also to link mental health treatment with other prison strategies such as bullying, Listeners schemes and suicide prevention as well as to develop staff awareness, work towards early intervention and develop the use of therapeutic interventions.

For prisoners who cannot be managed on the wings a day care centre is planned. The plan also addresses the need for secondary and tertiary mental health services as well as a new mental health promotion forum within each prison which will link to the overall prison health promotion strategy. The ambitious nature of the assessment continues with the aim of developing a comprehensive mental health training plan for all staff working within the prison.

With regard to prisoners with special needs specialist services are to be introduced for those with learning disabilities as well as mental health problems. Those inmates on the Dangerous and Severe Personality Disorder (DSPD) unit are also to have access to the full range of mental health services. In addition, the plan seeks to introduce dual diagnosis for the purpose of developing integrated mental health, drug and alcohol substance abuse services. In short the plan is wide ranging, ambitious and, at this stage, highly aspirational. Indeed, its very comprehensiveness seems to suggest something regarding services (or the lack thereof) which were available in the prisons to date.

Turning to staff issues the aim here is to have strong clinically led services in place in order to have the same quality of care comparable to the community NHS. Regarding

training, education and continuing professional development this section covers the usual items contained in other HNAs, for example, reducing professional isolation, more training for existing staff (though recruitment of more staff is not specifically mentioned) and more contact with their NHS colleagues.

The most interesting item, however, is the development of courses which will help all health care staff acquire the competencies they need in three areas: general nursing, mental health and 'jail craft'. Unfortunately, again, no details of what is meant by jail craft are given. Lastly on staff issues, the need to synchronise clinical governance procedures with NHS standards is acknowledged and plans to introduce a clinical governance lead and also work closely with the PCT in this area are in place.

Overall, however, while this HNA engages with the public health agenda and makes a specific commitment to having the same access and approach as the general practice in the NHS it is the medicalised model of primary care which is dominant. That said, the ideas underpinning mainstreaming are supported and the aspiration to achieve broad equivalence is clear.

Prison C HNA (2002)

Firstly, it is important to note that this is a resettlement facility whose aim is to provide prisoners with the opportunity to undertake the necessary training and education that will equip them for returning to their communities post-release. Given that the prison does not accept inmates with difficult medical issues it is not entirely surprising that the HNA identifies health care priorities as developing clinical governance to NHS standards and improving IT facilities. That said it does appear that not placing the upstream public health model on the list of priorities represents a missed opportunity.

The HNA begins by referring to *Health Promoting Prisons: a Shared Approach* which argues for better custodial environments and health promotion in its broadest sense (Department of Health, 2002a). The potential benefits in terms of rehabilitation and resettlement such an environment may produce are also outlined as are the detrimental affects of the denial of liberty. While primary care standards are praised

they quote *The Future Organisation of Prison Health Care* stating that 'while prisoners had good access to primary care this did not always meet their needs in terms of health promotion and disease prevention' thus suggesting difficulties with regard to the more upstream model (HM Prison Service and NHS Executive, 1999).

That said the HNA goes on to outline a number of health promotion activities. The topics covered are HIV prevention, anti-smoking policy, testicular examination, and substance misuse. These issues are communicated to inmates through the use of leaflets. However, there does not appear to be any formal education or clinics in operation and no mention is made of the potential difficulties associated with promoting health via leaflets to a population with poor literacy levels.

In addition, the HNA notes that the smoking cessation programme (which consisted of the provision of patches subject to a medical examination) has been suspended due to a budget overspend. However, a 'Listeners' scheme operated by volunteer peers is in place and a Physical Education Instructor is available as are yoga classes which are attended by both staff and inmates. A condom service was also available but a survey of prisoners indicated that most were unaware of its existence.

Staying with the public health agenda more generally the prison also actively engages with the local community. For example, there are twice weekly indoor bowls with pensioners where the prisoners participate in joint teams. Other initiatives include visits by severely disabled clients from the local Adult Training Centres to the prison gym where they are assisted by prisoners. In addition, young people from the local Sixth Form College work and study alongside prisoners for Sports Leader Awards and referee qualifications. Also, each year orphans are brought in by the Methodist Church. Finally, the prison works closely with an overseas aid programme preparing furniture, medical equipment and clothing for hospitals and orphanages abroad.

The HNA then acknowledges gaps in their data collection on the current health status of prisoners. Health information was collected by nursing staff, however, no IT clinical information system existed at the time of producing the document. The HNA recognises that this remains a gap in the process for undertaking thorough, evidence-based, health needs assessments. The prison is awaiting instructions from the Prison

Service when the results of their clinical systems pilot are available. In the meantime the prisoners' IMRs are the main source of data. In common with other prisons then no complete record of prisoners' health status is available.

Turning to what problems could be identified, the prison stated that the main medical conditions diagnosed in 2001 in order of frequency were asthma (most), heart disease, diabetes, epilepsy and arthritis (least). Hep C and Hep B were virtually non-existent. The HNA makes the point that, as a resettlement facility, Prison C is not a typical prison and that screening procedures sift out all conditions considered to be unmanageable. In addition, should a condition develop at the prison after arrival which is not manageable by the part-time health care centre staff then the patient is transferred out. Lastly, the assessment claims that there is no known or very minimal drugs misuse in the prison.

With regard to mental health, again it is necessary to take into account the atypical nature of Prison C. The issue is, however, addressed and the HNA begins by commenting on the importance of socio-economic background to health outcomes. It also details the familial ties of prisoners before incarceration and states that 125,000 children are affected by the imprisonment of a parent each year. Because of the low risk status of the prison's population Prison C can offer better access to family, educational and employment opportunities for inmates. It also states that this helps remove some of the major factors contributing to mental health problems in prisoners' lives.

In similar fashion to Prison B the HNA then engages with the *Changing the Outlook: A Strategy for Changing and Modernising Mental Health Services in Prisons* paper which sets out the approach to developing and modernising mental health services in prisons (Department of Health, 2001a). The HNA goes on to quote the range of desired improvements contained in that paper as important for the prison. These are: health promotion, primary care services, wing based services, day care, inpatient services, transfer to NHS facilities and throughcare.

However, again because of the screening process at Prison C, it is unusual for prisoners to arrive with mental health problems. As with other serious issues any

prisoners who subsequently suffer an acute problem are transferred out to local services. Those with more minor psychiatric problems are closely monitored before transfer to a prison with 24 hour medical care. Also, the Action Plan notes that no key mental health issues were identified from the previous health needs assessment.

The assessment then moves on to procedures at reception into custody from a health care perspective. Firstly, all prisoners are seen by a nurse when they arrive and their medical history is discussed and recorded. The doctor then checks each inmate, a fitness to work assessment is made and a management plan drawn up. However, the HNA does not mention IMR transfer from other prisons. Finally, and in contrast to other prisons, prisoners are encouraged to self-medicate where deemed appropriate.

Turning to infrastructure and staffing issues, it is noted that the health care centre is a temporary portacabin situated away from the main buildings with limited access for prisoners in a wheelchair. It operates an 'open door' policy and inmates can call at any time in the morning to see a nurse. Each nurse is part of the drug strategy and suicide awareness teams but there appears to be a lack of engagement with the *Toolkit's* instructions for the provision of effective health services in that there is a lack of detail with regard to nursing training and skills development. However, it is envisaged that as soon as legislation is passed which allows nurses to prescribe for minor illnesses then the nursing staff will take on this role.

To conclude then, perhaps because of its status and the generally stable medical conditions of its inmates this HNA is significantly shorter than those complied by Prisons A and B. That said, even under those circumstances data collection was problematic. In addition, the opportunity for placing health promotion and the upstream public health model in a proactive manner as one of the prisons' priorities seems to represent a shortcoming which could have been addressed.

Prison D HNA (2002)

As observed in other introductions the HNA begins with a commitment to deliver comprehensive health care in line with the wider NHS. Here, Prison D have also produced an additional Prison Development Plan in conjunction with PCT 3 as a

guide for working towards standards of care seen in the NHS. The assessment then goes on to elaborate on the peculiarities of prison as a setting for providing health care stating that the facts of custody and the regulated nature of prisoners' lives mean that prisons are atypical settings in health care terms and give rise to differing models of health care provision.

The HNA then makes a point of recognising the importance of being aware of political and religious sensitivities when providing health care. A brief summary of socio-economic backgrounds then follows which is consistent with overviews of the prison population in general. For example, it recognises that inmates come from poorer communities, have low levels of educational achievement and high instances of alcohol consumption/drug misuse.

In particular the HNA identifies nutritional deficiencies, tooth decay, mental distress, STDs, and physical illness associated with drug and alcohol misuse as common. In addition, the HNA mentions the geographical isolation of Prison D which makes maintaining familial and social contacts difficult. For a group already characterised as having difficult interpersonal relationships this can lead to increased feelings of isolation and, if not addressed, self-harm and suicidal intent.

Turning to mental health issues the HNA begins by stating that no figures were available for prisoners with serious mental illness or for numbers receiving medication for mental illness. In addition, data on those suffering from neurosis, self-harm, alcohol misuse or drug misuse was unavailable. It was also noted that not all referrals were seen and the GP was not well linked to the outside provider of psychiatric services to the prison. The HNA concluded this section by saying that a mental health needs assessment is to be carried out which will also report on this particular matter.

Moving on to the public health agenda, Prison D undertakes a risk assessment of all receptions for location with another prisoner in the event that it becomes necessary to share cells. A comprehensive list of screens which take place at reception into custody is also provided. All are linked in some way to the public health agenda and are seen as important issues. For example, immunisation for BBVs and the ability to cope with prison life are prioritised. In addition, nurses are involved in programmes such as

suicide prevention, equal opportunities, care and support, anti-bullying and race relations. Furthermore, the HNA identifies substance misuse as being strongly linked to illegal behaviour and unsafe sex and states that the period of incarceration provides an opportunity for rehabilitation and preventative measures to be addressed.

The HNA then reiterates its uniqueness as a YOI and states that because preparing inmates for return to the wider community is the prisons' key function there is a strong emphasis on engaging with the public health agenda. It goes on to list a number of important areas, all of which has resonance with the upstream public health model: establishing good health and well-being, stabilising finances, developing and maintaining familial relationships, housing factors and employment.

However, specific details as to how in practical terms these goals are to be achieved are in general lacking. Drugs and substance misuse are not expanded upon and, apart from a brief list of outside agencies it is not clear what relationships have been established. That said a number of the health promotion policies such as educational need are due for review according to the development plan.

The particular nature of the prison as a YOI is also evident in the range of issues and disease addressed by the HNA. For example, the HNA records that requests for admission to the GUM clinic have recently risen by a third (though from what base level this has happened is not available). Unsafe/unprotected sex, engaging in sexual practices whilst under the influence of alcohol and/or drugs and poor sex education are blamed for the demand. However, it is noted that resources at the clinic fall short of meeting the demand for services and condoms are not available within Prison D though the HNA recommends that this policy is changed.

Turning to BBVs (Hep B & Hep C, Meningitis C, HIV/AIDS) prisoners are screened at reception for uptake of hepatitis immunisation, however, it is often difficult to obtain documentation from other establishments and prisoners are uncertain as to where they have reached on a treatment programme. Demand for Hep B immunisation is high with most new entrants requesting vaccination or having been on a course at another institution. Prisoners' IMRs contain details of vaccinations and a discharge letter is given for their own 'home' GP. With regard to HIV/AIDS much of the time in

these clinics is taken up by pre- and post-test discussion. However, the facilities and resources are noted to be poor which impacts on the numbers which can be seen. In addition, it can take up to 4 weeks for results to be returned.

Staying with issues relevant to the age cohort of inmates, the prison had completed a survey questionnaire with inmates which found evidence to suggest that virtually all prisoners received into custody had been involved with a substance misuse related activity prior to sentencing. The survey also found that the main drugs used were crack or cocaine along with widespread use of cannabis and ecstasy. Most prisoners reported consuming more than the amount of units of alcohol deemed safe per week. The prison has two drug free wings and inmates are assessed for residency on these wings by the CARATs team during their two week induction period.

Finally, the HNA records that CARATs and detoxification services are available, however, there is no close link exists between the GP who initiates a rapid detoxification programme to those who admit to drugs misuse at reception into custody and the CARATs team. Although no spot checks are carried out CARATs estimate that less than half of Prison D's prisoners have a substance misuse problem.

Turning to workforce issues a 24 hour health care service is available as a result of Prison D's designation as a type three health care unit. The health care manager is supported by full-time nurses of various grades and a number of auxiliaries. A community psychiatric nurse is also available. There is an ongoing training programme for nursing staff who are also encouraged to attend sessions run by the Prison Service and the PCT. The health care service is seen as very much nurse led and nurses run clinics for Meningitis C, Hepatitis & BBVs, communicable diseases, asthma, smoking cessation programmes, diabetes and a well man clinic. In addition, the peculiarities of each individual prison is evident in the manner in which Prison D have introduced a meningitis immunisation programme which again reflects the age range of its inmates.

The health care clinic itself has a capacity for a dozen prisoners. At the time the HNA was compiled no prisoners were accommodated there. This is as a result of amended protocol arrangements for admission to the centre which previously accepted prisoners

for 'poor coping'. The intention is, as far as possible, to have prisoners carry out their sentences on the wings and have their health care provided in their cells. However, at one point the health care centre was used as a resource to accommodate prisoners due to overcrowding. Nursing staff felt this was inappropriate due to problems regarding discipline and administering interventions. That said up to five prisoners may still be accommodated there in the event of the prison reaching capacity.

GP services are provided by a local surgery with daily sessions at the prison each morning. The security regime necessitates that all prisoners regardless of health care needs are locked in their cells from 10 pm to 7.30 am. Nurses needing access to cells during this time must have a prison officer present.

In conclusion then the HNA very much reflects what would be expected to be the main health care issues of a younger population. In addition, it displays a clear understanding of the wider determinants of health as being relevant to how it provides health care. However, the difficulties in producing accurate data on current health need as prescribed by the *Toolkit* are again evident. That said, this HNA is quite comprehensive in its identification of specific programmes aimed at both the public health agenda and clinical interventions. Lastly, it is noteworthy that no attempt was made to identify national or local priorities as in the other HNAs.

## 6.2 Prison Health Development Plans (2004-2005)

### PCT 1 in partnership with Prison A and Prison B

This PHDP begins with a brief history of the collaborative Prison Health Care Development project between the PCT and the prisons. It goes on to state that the second stage of the project faces a number of major challenges: managing the transfer of prison staff to the NHS, implementing a strategy for co-ordinating GP services in the prisons and the development of the prison health workforce in order to deliver mainstreaming. Chronic disease management and reception screening are identified as the two major priorities for prison health care with BBVs, Hep B, Hep C and HIV and mental health also important.

Drawing on Section 30 of the Health Services Standard for prisons which states that establishments must have effective arrangements for the prevention, control and management of communicable diseases, the PHDP concentrates on the Hep B immunisation programme and ensuring that robust systems are in place across the cluster for identifying and caring for those prisoners deemed to be at risk. The reception screening process is also seen as critical in identifying Hep C. In addition, it recommends that condoms are to be available as well as counselling, testing and referral mechanisms for HIV and Hep C.

A public health team is in place to advise on the promotion of healthier physical, mental and social environments for prisoners. The project plan will focus initially on the development of a strategy for the prevention and detection of blood borne viruses and STDs. The PDHP also plans to develop a programme for health promotion in both prisons which will target and prioritise STDs and BBVs. The main focus of the PHDP is therefore principally clinical interventions such as immunisation programmes and medication. It does, however, also acknowledge that the prison environment poses particular challenges for public health.

The PHDP then refers to Prison Service Standards for direction in producing plans for mental health programmes. Establishments must produce services for the observation, treatment and care of prisoners with mental health care needs. In addition, prisoners are to be treated in line with good practice as laid out in the Code of Practice on the operation of the Mental Health Act and standards set out in the National Service Framework (NSF) for mental health. Regarding ongoing work in the prisons this is being led by the newly created posts of Consultant Psychiatrist and Mental Health Co-ordinator. As with other PHDPs, however, no quantitative data on prisoner health status is available.

PCT 2 in partnership with Prison C

Here, the PHDP begins by re-affirming the PCT's responsibility to reduce inequalities in access to health care in the prisons within its boundaries. It also outlines the PCT's commitment to strengthening and building on existing partnerships and other policy statements such as driving the process of change through. The PCT has also employed a prison health care project manager to support the delivery of modernising prison health care services and the PCT Director of Service Development has lead responsibility for commissioning prison health care. Delivery of the PHDP is to be monitored by a Prison Health Steering group under the Chair of the Chief Executive of PCT 2.

Some evidence of joint working is also available. For example the Health Promotion Lead from the PCT has summarised all health promotion activity and the Health Promotion Group (when in situ) are to take this agenda forward in tandem with officials from prison health care who will sit in on the PCT's clinical governance meetings.

Moving on to priorities the PHDP does not differentiate between national and local issues and instead groups them together as follows: Mental Health, Substance Misuse, Primary Care and Pharmacy Services, Workforce Development, Health Promotion, Dentistry, and Communicable Diseases.

While clinical governance is not mentioned it was identified as a key priority in the HNA. Issues concerning enhancing IT and the 'information infrastructure' are also included in this category. Human Resources is another risk area and the PHDP is concerned that issues being agreed at national level regarding the role of Health Care Officers (HCOs) must also be discussed with the POA locally. What these issues are is not elaborated upon. The third risk area is recruitment. The PHDP calls for the PCT to work with prisons to make GP and nursing jobs look interesting as well as to work with other PCTs on recruitment. Again, no details of what this may entail are given.

At the time the PHPD was being put together the PCT was also working with both prisons to produce a comprehensive picture of health care funding which would then

be used to plan for future provision. The aim is to ensure that the prison population is able to benefit from mainstream NHS modernisation programmes including, where feasible, developments around access, choice and booking. Lastly, a skills mix review of both nursing and GP services is to be undertaken.

Turning to mental health there appears to have been some progress being made in that a new Mental Health In-Reach Manager is in place and a new Working Group is being established to devise a mental health strategy based on a newly completed mental health needs assessment. However, it is very difficult to tell from the manner in which the PHDP has been produced exactly what these changes mean in terms of quantifiable progress because the PHDP Action Plans are not designed to highlight outcomes.

While the PHDP engages with issues such as health promotion much of the planning is at the aspirational stage. Clear gaps in education have been identified, for example, on sexual health promotion, however, for all the positive rhetoric advancing the whole prison approach seen in the HNA, a health promotion group has yet to be established. Indeed, this PHDP is perhaps more notable for what has not been mentioned. For example, items which featured in the HNA such as physical education, diet, literacy and engaging with prisoners are all omitted. Similarly there is no evidence that the plan to undertake a health care user survey has been taken forward. Also, no reference is made to the smoking cessation programme which was suspended during the production of the HNA. However, the PHDP does mention promoting the use of condoms in Prison C.

In sum, the PHDP is a very different document from the HNA. It makes no attempt to set out the health status of prisoners although it does make reference to a number of assessments which have been carried out such as the mental health needs assessment. In addition, many of the items identified as noteworthy from the public health agenda and which were given substantial coverage in the HNA, for example, literacy and physical exercise, are not addressed. The paper itself represents an action plan for two years, (2004/05) and therefore tends towards the aspirational rather than identifying what is actually going on in the prison at the time the PHDP was produced. Finally, it

is noteworthy that the PCT/prison was not selected as one of the first wave prisons for transferred commissioning of Primary Care services in April 2004.

PCT 3 in partnership with Prison D

The PHDP beings by stating that it will build upon and take into account the earlier HNAs. It also states that the plan aims to ensure that planning arrangements for prison health care are fully integrated and mainstreamed with NHS national and local priorities. Although these national and local priorities are not set out specifically as in some HNAs they emerge within certain sections of the plan. The PHDP then goes on to outline the structure of health care within the prison as follows: Strategic Policy Group, Workforce Development, Public Health, Health Promotion, Communicable Disease Control, Mental Health In-Reach, Primary Care Team Development, Finance Commissioning, Information Management and Systems and Clinical Governance.

The PHDP then aspires to engaging with the *Health Promoting Prison: A Shared Approach* and states that the prison ought to aim for specific goals in keeping with the decency in prisons agenda as well as improve dissemination of information and good practice, develop evidence based practice and agree a standard for health promotion (Department of Health, 2002a). This section is concerned with how the HNAs and PHDPs engaged with the wider public health agenda and focuses on issues such as 'general well-being', education and literacy, alongside initiatives to tackle communicable diseases.

However, although the PHDP notes that some work is taking place in this area it also states that health promotion activities at Prison D would benefit from further development. For example, while the existing programme is nurse led and focuses on disease prevention the feeling is that Prison D needs specialist public health/health promotion intervention to develop a whole persons approach to health promotion more comprehensively.

It then moves on to communicable disease issues noting that the number of prisoners requesting testing for Hep B/C and HIV has more than doubled over the previous two years. However, the number actually receiving a test in 2003/4 was low. The PHDP

then suggests that the reason for the increased requests may be that prisoners confuse STDs and BBVs. This seems to indicate that sexual health/communicable disease education needs to be improved but this is not mentioned. In 2003 testing for syphilis was introduced due to increases in positive cases observed in the population. The result is that the clinic is now so busy that the lead nurse, who previously had other responsibilities, now works solely on this project.

This situation is compounded by the sensitive nature of the topic which requires appropriate confidential facilities where counselling may take place. However, the present infrastructure is inadequate. It is noted that unsuitable facilities links directly into the decency in prisons model and can have serious consequences for how patients/prisoners are treated by their peers on return to the wings thus directly affecting their well being.

Although a number of barriers to providing improved health care are identified, for example, the difficulties in organising escorts to the GUM clinic in the evenings, the plan does not set a specific agenda for dealing with the issues. Indeed, looking at public health more specifically, while the PHDP makes a number of references to engaging with the relevant reports and documents produced in this area, these come across as general aims and no specific details as to how they are to be achieved are given. In sum, the impression is that this PHDP does not represent a principal guiding document either for the prison or the PCT. Rather, the structure which I have identified at the beginning is to be entrusted with taking forward each member bodies' area of responsibility.

## 6.3 Summary of documentary analysis of HNAs/PHDPs

Taking the more positive aspects first, the documents demonstrated an engagement with important official papers on the subject of both proactive health promotion issues as well as reactive clinical interventions. For example, they usually begin by quoting policy guidelines, such as *The Future Organisation of Prison Health Care* and/or *Health Promoting Prisons: A Shared Approach* (HM Prison Service & NHS Executive, 1999, Department of Health, 2002a). The subsequent rhetoric is supportive of the aims of these reports.

However, although some of the data collection and presentation is in line with directives made by the *Toolkit* for producing health needs assessment in prisons, overall there appears to be limited engagement with it. This is most especially evident in the failure to compile comprehensive and accurate pictures of current need which I deal with in greater detail below.

On the other hand, and consistent with mainstreaming principles, there is significant evidence of moves towards a nurse led service, with nursing skills upgraded and more responsibility to be taken by nurses. This is in line with changing roles for nurses in the NHS more generally. In addition, looking at attitudes to prison health care, there is a recognition of the prisons' and the PCTs' responsibility to patients/prisoners which transcends the prison walls and the HNAs/PHDPs contain an element of what implications there may be for the wider community as a result of the criminal justice system. They therefore do not see themselves as operating in isolation. Also, most documents contain references to initiatives for upgrading infrastructure and training staff.

Lastly, HNAs priorities were usually in line with the main government objectives, i.e. primary care, mental health services, substance misuse, and health promotion although dentistry appeared to be lower down the lists of priorities, at least as far as the HNAs were concerned. In addition each prison cited other local needs such as staff training, developing IT, reception and discharge arrangements as of particular importance to their operational priorities.

However, there are several important shortcomings. Firstly, HNAs regularly state that their data are collated from incomplete sources. On one occasion 'anecdotal' evidence was used, while others were compiled using data from prescription records and poorly maintained IMRs. Also, Prison A and B's figures on mental health illness issues are significantly less than and out of synch with national statistics (Marshall et al, 2000). Underreporting of illness, poor patient records and the absence of a comprehensive audit of mental health need appear to contribute to this and the other two prisons demonstrated similar difficulties.

Secondly, in contradiction with the acknowledgement in most documents of the importance of the whole prisons approach and the decency in prisons agenda it is evident that the dominant model of care is the medicalised one. The situation at Prison A is a good example where the HNA lists numerous upstream public health issues which need to be addressed but the PHDP recognises the need to focus on reactive clinical interventions on STDs and BBVs. This is understandably said to be because of the need to prioritise certain issues in a situation determined by scarce resources.

Thirdly, although plans for initiatives are mentioned these are rarely set out in detail. Indeed, there is evidence that commitments made in HNAs are not carried through to PHDPs. Examples here include the new health care centre at Prison A which has not materialised and Prison B's proposal to increase contact for prisoners with their families, friends and contact in the community.

Furthermore, PHDPs are not designed to disseminate outcomes or the rationale behind the plans which have been formulated. Perhaps this is understandable given the aspirational nature of action plans in the first place but it does leave gaps in the analysis in that there is no way of knowing from them whether or not planned projects have been taken forward unless they, for some reason, decide to mention them further down the line. In addition, it is difficult to tell from the manner in which the PHDP has been produced exactly what these changes mean in terms of quantifiable progress.

Also, when claims are made about the existence of certain facilities it is difficult to tell how effective or useful these may be. For example, when a HNA states it has a gym or education department, there is no way of knowing how good it is, how many people use it and so on. There therefore appears to be a degree of separation between health care and other departments which may inhibit developing an upstream public health model.

Similarly, the HNAs/PHDPs state that NHS staff would need to be educated with regard to 'jail craft' but specific mention of classes or courses is not provided. That said they do recognise that prison service medical staff operated in professional isolation from health care for many years and that this gap must be bridged through training. The mainstreaming agenda is therefore present in the documents.

Finally, it is noticeable that certain issues are coming to the fore as barriers to the implementation of the mainstreaming goal. For example, there is consistent mention of the following issues as being problematic: escorts, difficulties with the allocation of time for upstream interventions such as smoking cessation within meaningful activities, cost and shortages of GPs and appropriate nursing staff.

In short while the documents appear to be honest, reflexive, self-critical and conscientious appraisals the various HNAs were based on incomplete data. This can only be seen as a serious weakness which may impact negatively on mainstreaming goals and result in implementation gaps; two of the key conceptual frameworks guiding the research. In addition, while some recognition of directives made in the *Toolkit* are evident, engagement with the assessment instruction tool is limited. Indeed, only one document mentioned it specifically. Setting this finding in the context of the issues raised by the third conceptual tool, the street-level bureaucrat concept, it appears that a degree of flexibility in constructing the documents somewhat divorces them from the *Toolkit* model and illustrates the relevance of the concept in highlighting the emergence of actual policy at ground level in the first instance.

Also, difficulties surrounding the PHDPs with regard to an absence of detail on how plans were going to be achieved and within what timescales mean that their usefulness is also somewhat limited. Having noted these limitations in assessment and planning I will now move on to the findings which emerged from the fieldwork and an exploration of how policy initiatives were being played out 'on the ground'.

Chapter 7

# Policy in Practice

This chapter presents the main research findings which emerged from analysis of the data gathered during the fieldwork. Again, the focus is very much on issues related to implementation. I begin by noting the importance of the 'receptive environment' for any social policy initiative before describing findings related to respondents' attitudes to mainstreaming as a worthwhile and achievable policy objective in the first instance. I then outline the importance of the implementation gap concept and why identifying shortfalls is important to the thesis as a whole before moving on to provide specific examples implementation weakness at each research site which fall into one of two categories; 'explicit failure' and 'problematic but being addressed'.

The chapter then focuses on specific issues which emerged as challenges and barriers to the implementation of broadly equivalent health care in the prisons. These will be seen to have their roots in both internal (traditional working practices) and external (funding) variables which influence the degree to which implementation has been achievable across the research sites. Next, noting the importance placed by respondents on care pathways, I move on to describe somewhat mixed and contradictory views on how care pathways both within and outside the prison system are operating.

The following section returns to the street-level bureaucrat for the purpose of examining how health care professionals and security staff utilise various strategies or coping techniques in their efforts, in Lindblom's (1959) terms, to 'muddle through' policy implementation and manage the problems identified thus far. These will draw on both organisational initiatives as described by respondents during interviews as well as 'ethno-depictions' which emerged from more observational data gathering during the fieldwork.[57] In this way street-level bureaucracy may be where we can discover how, to some extent at least, implementation gaps are bridged by day-to-day coping.

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[57] I am grateful to my external supervisor, Dr. Catrin Smith, for introducing 'ethno-depiction' as a useful term for describing the ethnographic observations made in the field.

Following on from this areas where the prison service is argued to be outperforming the NHS (and vice versa) are presented before the penultimate section briefly discusses what implications these findings may have for mainstreaming itself as a desirable policy outcome. The conclusion will draw the above together as well as raise questions which will be explored further as the thesis develops.

## 7.1 A receptive context?

Beginning then with varying receptive contexts, as outlined in the introductory chapter, the Prison Service and NHS Executive Joint Working Group was established for the purpose of considering the recommendation made in HMCIP's discussion paper *Patient or Prisoner?: A New Strategy for Health Care in Prisons* that responsibility for prisoner's health care should be transferred from the Home Office to the NHS (HMCIP, 1996). It is important to note, however, that there were other forces interested in prison reform. For example, concerns were also expressed by bodies external to the operation of the prison estate such as the Prison Reform Trust, the Howard League, prisoners' families and pastoral interests, for example, the Bishop of Jarrow was also significantly involved in campaigning for reform. In addition, inmates themselves expressed resistance to prison regimes through a series of protests at various prisons in the late 1980s and early 1990s (Cavadino & Dignan, 1997). Subsequent media coverage of prisoners atop rooftops, for example, at Strangeways prison, Manchester in 1990, then introduced the issue to the consciousness of the wider public.

While these factors were local to the UK, it is also important to note the work of movements in other countries which lobbied for equivalence. For example, Odem (1992) records how the women led parity movement in America in the 1970s began by challenging sex discrimination within prisons and demanding equal facilities. While some advances have been made, particularly with regard to 'vocational and educational opportunities and the improvement of physical facilities and medical care for female inmates' (Odem, 1992, p.357) Rafter illustrates how the movement has been frustrated by a reliance on 'institutional solutions' for women prisoners (see also Rafter, 1990, cited here).

Turning to supra-national organisations, the United Nations (UN) has been campaigning for advances in prison health for over 50 years. The approach here began with adoption of the Standard Minimum Rules for the Treatment of Prisoners in 1955. Since then numerous other resolutions with regard to prisoner welfare have been formulated (United Nations, 2008). Indeed, in the context of the UK's membership of the European Union and members' obligations to comply with supra-national legislation, it is also worth noting that the Council of Europe's European Prison Rules (1987), stated that '[t]he [prison] medical services should be organised in *close relation* with the health administration of the community or nation' (Council of Europe quoted in HM Prison Service and NHS Executive, 1999, p.5, italics author's own).

While a number of interested bodies are therefore identifiable as driving forces in bringing prison health onto the political agenda, in producing *The Future Organisation of Prison Health Care* the Joint Working Group invited the views of a wide range of stakeholders working within the prison estate. For example, Governing Governors, prison service and NHS health care professionals and the Prison Officers Association (POA) were all included in the review process. Policy was to be based on evidence gathered on the ground and their final recommendations followed research conducted in a 'broadly representative sample' of 38 prisons. In order to obtain an understanding of the issues all prisons were either visited or interviewed by telephone. In addition, thirteen of the prisons were visited by NHS members of the working group and external consultants were also used at a number of locations (HM Prison Service and NHS Executive, 1999).

As stated in the recommendations section the options available were to either maintain the status quo, move the system to a partnership arrangement which would adopt a more collaborative and coordinated approach with primary care resources remaining with the Prison Service, or full transfer to the NHS. As we now know the final recommendation which was accepted by government was the partnership arrangement with budgets to remain with the Prison Service for a period of time before being formally handed over to PCTs.

Noting the emphasis placed by the Joint Working Group on taking into account the views of professional stakeholders prior to implementation, the nature of the receptive environment was felt to be an important part of the research. Therefore, a specific focus on how respondents felt about the mainstreaming initiative in the first place was included in the research questionnaires. As such the receptive environment sits as a sub-theme within one of the main conceptual frameworks which guided the research; mainstreaming.

This section therefore revisits the locales of implementation, the host institutions themselves, for the purpose of examining how the policy was received on the ground. The findings are presented on a site by site basis using each PCT area as the primary site identifier. In order to contextualise the findings a brief description of each prison will be provided which outlines its security status and operational capacity.

PCT 1

Firstly, PCT 1 has responsibility for two of the prisons who agreed to host the research. Prison A is a Category B local prison for adult males with an operational capacity of less than 1,000. Prison B on the other hand is a male high secure estate prison with an operational capacity in excess of 700[58]. Here, the *Framework* analysis tool indicated a strong positive attitude towards mainstreaming among both senior respondents and those managers charged with the implementation of policy.

As Pettigrew et al (1992) identified in their study of strategic service change by health care organisations a key factor differentiating lower from higher performers is the existence of key people leading change (especially within a multidisciplinary team). The receptive context in PCT 1's area indicated a close fit with this model as a prerequisite for seeing through change. Indeed, this commitment to mainstreaming had already manifested itself in operational terms. For example, a methadone maintenance programme based on a model of what would happen in the wider community was already in place in Prison A.

[58] In order to comply with guarantees of anonymity for the host institutions which were a condition of ethical approval (see Chapter Two) exact operational capacities have been approximated.

To elaborate, a number of respondents pointed to an environment which contained a 'critical mass' (R7) of health care and prison service professionals who were committed to taking on board the principles outlined in *The Future Organisation of Prison Health Care* (HM Prison Service and NHS Executive, 1999). They ascribed their positive attitude to a number of things. Firstly, it was generally recognised that health care provision in the prisons had developed in isolation from wider advances in the NHS. It therefore lagged behind practice in the community with both nurses and doctors adhering to sometimes archaic rules and practices which owed much to institutionalised, 'handed down' methods of health care provision. For example, doctors described how they would be required to tick boxes confirming it was permissible for a prisoner to have an additional pillow.

In addition, it was recognised that the 'skills mix' for both nurses and doctors was out of sync with both developments in clinical governance as well as government policy on public health. For example, none of the prisons which participated in the research had a designated health promotion specialist prior to the transfer of commissioning. The service was essentially reactive and did not fit current thinking on the provision of a proactive, upstream service model which sought to pre-empt ill health through exercise, diet, literacy, and the more holistic public health model. It was also envisaged by respondents that prison service health care staff would have increased opportunity for both career development and enhanced training in the context of the new arrangements.

Furthermore, senior managers in both local institutions within PCT 1's boundaries saw prison as an opportunity for enhancing health care provision for a section of the wider community which had little or no interaction with primary care services in the community in the past. Common among their responses was a sensibility to the importance of prison as a conduit back into the community. In addition, respondents argued that prison offered a positive opportunity to improve life chances for prisoners. The importance of the prison as a locale for health promotion and the potential for knock on positive effects for broader public health, for example, BBVs which may otherwise have gone undetected, was therefore another important issue contributing to the receptive context mentioned above.

In sum respondents at senior level were very positive about what was happening. They identified a core group of key personnel who both professionally and personally felt that the changes proposed by central government were the correct way forward. Critically, this was true for both the Governing Governors and senior NHS PCT 1 staff. This recognition was then developed through a number of senior level meetings which sought to understand the critical issues, 'from the perspective of the other' (R19). This was the beginning of building what has emerged as a close, though challenging partnership in PCT 1's area, which recognised the context and circumstances of the partner body. As R1 described how the partnership ought to work put it;

> 'I don't think one should overrule the other. They necessarily must exist and we have to find ways to make them co-exist in comfortable ways. And that really requires in organisation theory terms, a sort of, contingent approach which says, 'in what circumstances, for whom, will this work and in what circumstances will that work?' and to follow that…(R1).'

Working with the 'other' then called for patience, understanding, compromise and 'hard graft'. The challenging nature of the partnership between the prison and the PCT is illustrated by how a number of respondents detailed doing the 'hard yards'. Often it was seen as just 'putting in the hours' (R19), i.e. listening when what was been spoken about was not particularly interesting or relevant, speaking when it seemed that others were not that interested or when they, in turn, did not see the point. The important thing was therefore not necessarily making imaginative or ground breaking progress at these early meetings but to establish personal relationships, to be seen to be genuinely interested to listen and contribute, to understand difference and share knowledge. These early encounters and the willingness to engage were seen by respondents across institutional boundaries as critical to building partnership relations and providing a constructive receptive context for policy implementation.

Turning to senior respondents, again, the attitude to mainstreaming was positive. As *Framework* indicates all interviewees were supportive. Resistance centred on issues such as pensions arrangements (R9) and staff morale (R24) rather than the principle of working towards providing broadly equivalent services. However, respondents across

professions were also careful to qualify their comments by making the point that it would be difficult to justify spending on programmes for prisoners where the PCT in question did not have sufficient resources to provide equivalent services for the community at large (R13). For example, concern was expressed about the screening of inmates for Hep B, an immunisation programme which is offered to prisoners on reception into custody at Prison A which does not happen in the community[59].

In conclusion the principle of broad equivalence was seen as the way forward: it was the 'right thing' to do. As pointed out by two respondents, inferior health care is not part of the sentence (R1, R13). Organisationally, putting in place a solid partnership early was seen as critical in taking the agenda forward. This partnership building provided the 'foundation blocks' as one PCT respondent (R23) put it which, allied to the critical mass of already committed individuals within both the PCT and in leadership roles in prison health care, provided the necessary conducive variables ensuring that policy implementation had a 'soft landing' in PCT 1's area of responsibility.

PCT 2

Prison C is a male resettlement institution with an operational capacity of over 200 places. In this case the number of respondents is heavily biased towards PCT 2 by a ration of 3:1. In addition, the health care respondents were either just appointed or seriously considering leaving their posts. I feel that this is significant because, in the case of the new appointment R23 (who declined to have the interview taped) knowledge of the system was, by the respondent's own admission, limited. With regard to the other respondent, R24, the sense of disillusionment with their professional position and they way in which PCT 2 had approached 'taking over' health care in the prison had led to them actively seeking alternative employment. Indeed, some colleagues had already left and nursing staff at the time of the interview was significantly depleted. While staffing issues are addressed in more detail below it was felt that these circumstances ought to be highlighted before beginning the discussion of the receptive environment in PCT 2's area.

[59] It was noted by R13 however that the number of prisoners who are screened was dependent on how busy reception was. High turnover of prisoners therefore inhibited immunisation programmes.

Beginning with PCT 2, as can be seen from *Framework*, the attitude to mainstreaming was very positive. The main issue here, however, was a strong sense that they were very much abandoned by central government and simply 'left to get on with it'. Consistent in PCT 2 respondent replies was a sense of prisons as an 'alien' environment. They pointed to the lack of educational material available from Prison Health on issues such as 'jail craft', i.e. how inmates may try to manipulate health care professionals as well as a lack of directives on resource issues such as who should pay for cleaning the health care centre. Indeed, practical solutions had to be found for this and the PHLM (who as noted earlier was only appointed on a secondment with no managerial powers) ended up having to clean the centre herself. Such items were not blamed on the prison regime, however, but rather back on a lack of leadership by government.

Turning to Prison C health care staff, the idea that prisoners should have access to broadly equivalent services was something which was already well developed because of the particular purpose of the prison as a resettlement facility. Here, as soon as prisoners had attained Category D status (the lowest level of security risk) they could attend the community GP clinic which is located outside the prison. They were also registered there rather than being registered at the jail. While some security issues remained, mainstreaming itself would not make a great cultural change to the prison. The issue, however, was not one of working towards equivalent services but rather for different employers. Indeed, it is noteworthy that a proportion of prison health care staff left the NHS because either they felt they were poor employers or the NHS did not see them as quality employees in the first place and neither party was enamoured with the prospect of renewing their professional relationship.

In any case, while respondents were again in favour of mainstreaming in principle, this distrust now presented a big problem for staff on both sides. While the PHLM at PCT 1 (R5) actively sought to engage ex-NHS staff who were willing to bring training skills up to date and saw them as a positive resource, staff at Prison C were overtly dismissed by a senior PCT official as 'useless' (R24). The effect on morale was significant and illustrative of the antitheses of another key factor identified by Pettigrew et al. (1992) in producing positive outcomes: cooperative inter-

organisational networks. Health care staff became preoccupied with job insecurity and two left. The effect on the other was very negative and served to distract from the mainstreaming policy agenda. Indeed, although possibly unrelated, it is worth noting that PCT 2 did not make the first tranche of PCTs taking over primary care services in April 2004 (Prison Health Newsletter, 2004).

PCT 3

In this instance the prison is a male YOI with an operational capacity of less than 500. Here respondents in PCT 3's area of responsibility claimed to be actively working towards the mainstreaming model prior to NHS involvement. However, the manner in which the policy was received is different again from the other two PCTs. While individual resentments will be noted as contributing to this environment more structural explanations will be offered in the conclusion.

Beginning with PCT 3 the dominant discourse is one of functional compliance, i.e. a hierarchical management model. For example, R26 stated that they had been given a policy to adopt and they would see that it would be carried out. There did not therefore appear to be the same proactive approach as was evident at PCT 1. This, however, is not to imply that PCT 3 was dismissive of the policy. On the contrary, the attitude at senior level in the PCT was positive. The difference is the level of embeddness of mainstreaming within the discourse and, as we shall see below, engagement in partnership building with the prison.

Turning to Prison D, prison health care very much wanted to 'get on with what they were doing' (R27). While the PCT just took the policy on board as it was something they were directed to do, prison health care services were explicitly resentful of the involvement of PCT 3. In addition, the prison stated that they had already moved down the road towards mainstreaming well before the NHS got involved and pointed to a national award they had received in recognition of their achievements in a particular area as evidence of their competence in the face of what they saw as an interfering 'we know best' attitude (see *Framework* 'miscellaneous' table, Appendix 4).

On the other hand, PCT 3 respondents were keen to describe efforts they had made in arranging meetings between senior prison service and PCT staff with senior PCT staff visiting the prison as part of a familiarisation process. However, the impression from both sides was that interpersonal engagement was significantly less well developed than at PCT 1 and there was little reference to building personal relationships which was so prevalent during the interviews at PCT 1 and its related prisons.

With regard to general attitudes to the transfer of commissioning all levels of staff were open and receptive. However, reaction to PCT 3 and mainstreaming in general was distinctly dismissive at senior level in the health care centre. For example, running through the rhetoric at Prison D was a sense of annoyance that they were now being told to work in ways which *they* had already initiated. In addition, it was felt that the most important driving factor was having a 'good Number 1', i.e. a Governing Governor who understood health care and was committed to maintaining and supporting a progressive health care regime, not necessarily via NHS directives from central government. It was also felt that the PCT's involvement had led to significant additional bureaucracy and inefficiencies.

> 'You are already working in a difficult environment and you have to work between two organisations where I am now pleasing two masters, two sets of policies, two sets of procedures…[ ]... when I have an accident I have to involve two organisations you know and it has created its own inefficiencies…' (R2)

In addition, they felt that NHS nursing training was not geared towards working in the prison environment. Also, while opportunities may arise for prison service nurses to broaden their experience through secondments in the wider NHS they did not believe that the arrangements would be reciprocated and therefore such training opportunities were not being utilised significantly.

Furthermore, the prison health care personnel were very resentful of PCT 3's perception of their professional abilities. They believed that the PCT saw them as refugees from the NHS who could not cope with working in mainstream health care settings. They were very defensive about this and were keen to demonstrate their

value in the interviews, for example, by pointing to the significant reduction in appointments required at the health care centre since the existing management team took over. While they said they felt that PCT 3 was a 'decent PCT' (R27) in general, the attitude was more one of 'let us get on with it'.

In sum, while PCT 3 and Prison D therefore demonstrated both a positive attitude towards and a willingness to take forward mainstreaming goals, it was not demonstrated with the same level of partnership working evident between PCT 1 and its prisons. This sense of at least relatively lesser engagement with Prison D was mirrored by the prison wanting to be left alone to get on with the job. This desire was exacerbated by their perception that the PCT did not respect their professionalism, would not reciprocate with regard to nursing staff taking up secondments in the wider NHS, increased bureaucracy, and restrictions on career development (rather than the promised possibilities for career development which mainstreaming was supposed to offer).

In conclusion the extent to which each site offered a context receptive to mainstreaming differed. While the principles underpinning mainstreaming were seen by all respondents as positive, local circumstances began to influence a number of significant foundation blocks which Pettigrew et al (1992) identified as important in driving through change. Here, staffing issues, distrust of the 'other' and resistance based more on the manner in which mainstreaming was being introduced from above than the principle itself, are significant.

In addition, another important factor determining how mainstreaming was to be received may be the size and nature of each PCT's prison population. The question therefore is whether or not larger problems were addressed more urgently? From the sample it does indeed seem that PCT 1's reaction was based on an early identification of need due to the significant concentration of prisons within its boundaries and a critical mass of key personnel who had an ongoing personal and professional interest in prison health care. However, PCT 2 also contains another Category B male local

prison with an operational capacity of almost 1,000 which did not provoke the same degree of partnership building[60].

With regard to PCT 3, which is responsible for a notably smaller inmate population with very different health care needs, we have seen how Prison D sought to get on with their work and maintain distance from the PCT. Again, this raises a question as to how much this may actually suit the PCT's 'functional compliance' perspective allowing them to adopt a laissez-faire stance as long as the prison continued to perform. Were this to be the case then it would not fit with the proactive NHS model.

## 7.2 Attitudes to mainstreaming

As identified earlier respondents were very positive about the mainstreaming goal as a policy objective as indeed were they in their belief in the right of prisoners to proper health care services. Here, the research looked at how they felt working towards how mainstreaming was working on the ground. Using *Framework* to quantify responses it is evident that most did not identify a large difference in services.[61] Indeed, while nine were non-committal eight gave the impression that things were about equal on both sides.

Of those who argued that services were better one way or the other (all of whom worked in the prisons) a further four, three of them present NHS employees, felt that services were slightly better in the prisons while two others felt the balance was reversed. More interestingly, those who expressed strong views in favour of wider NHS services were mostly NHS employees who either worked in the prisons themselves or had very close ties to them in their professional roles, for example, R4 who Chairs PCT 1's Prison Health Steering Group. NHS employees who worked primarily or exclusively on the outside were more neutral.

The one respondent who strongly favoured prison health care services was an ex-Prison Service employee who did not feel the need for the NHS to be interfering in

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[60] A request to carry out fieldwork there was declined.
[61] The reader is reminded of the caveats outlined in Chapter Five of the limitations of *Framework* as an analysis tool for a sample of this size.

their worksite in the first place. It seems therefore that the strongest indicator of an attitude which favoured the wider NHS was a health care professional from the NHS who spent a significant amount of time working in the prisons or whose professional role was closely tied to the prison estate. No-one who worked solely on the outside expressed an opinion that services were better in prisons.

Turning to the relative importance of organisational culture as a defining variable facilitating moves towards mainstreaming, respondents' *Framework* scores were significantly higher on their assessment of the influence of prison culture and organisation on outcomes[62]. Taken as an average among the 25 interviews which merited a score, the NHS' influence is rated by *Framework* at 63.6%[63]. Those who rated the NHS as less influential were generally prison service employees or those who had worked for the prison service in the past. That said the score for three respondents currently employed by the NHS averaged 60%. In contrast and using the same method, the weighting attached to the importance of the prisons emerged at 75.4% with high scores being found across professional and employer variables. In short, the influence of the NHS on outcomes was perceived to be somewhat lower.

While this finding is perhaps unsurprising it nonetheless raises a number of questions. Firstly, to what extent does the prison service remain the dominant player even though responsibility for commissioning primary care has been transferred to PCTs?, i.e. how equal is the partnership in reality? Also, what does this mean for achieving mainstreaming in the longer run? Does the prison now effectively hold a position of power *over* without primary responsibility *for,* health care and, if so, what does this mean for the delivery of services in general and mainstreaming in particular[64]?

These questions will be considered in more detail as the thesis progresses. For the moment, however, I will turn to how respondents felt progress towards how mainstreaming was developing. Again referring to the *Framework* analysis tool a

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[62] Respondent's perspectives of the varying 'cultures' of both organisations is explored in detail in Chapter Nine.

[63] Each respondent was allocated a score between 0-1 depending on how strongly they felt the NHS influenced outcomes in the prisons with 0 equating to zero influence and 1 indicating full control. The respondent's scores were then added together and divided by 25 (see *Framework*)

[64] It must be noted however that final responsibility for prisoner's health still rests with the Governing Governors. Indeed, one stated that health care will now become 'one of my priorities' (R8).

positive picture emerges with an average score of 67.1% among the 21 interviews whose responses were suitable for quantification[65]. The more positive respondents were a GP who worked in a clinic providing services on the outside for inmates from a resettlement prison and a health care centre manager who felt their service was already up to speed well before and without the assistance of the PCT.

How positive were respondents though about actually achieving mainstreaming in the long run? Scores here were actually higher reflecting a general optimism that mainstreaming could be achieved which is consistent with interviewees' receptive attitude to the policy in the first instance. The figure here was 73.5% with high scores again coming from professionals across the board. Those who were less optimistic displayed no occupational consistency and no significance is therefore attached to their professional background or sites of work either inside or outside the prison environment.

Before moving on to the next section on service comparison another pattern, which is important from the point of view of inter-personal relationships in the working environment and also as a possible barrier which needs to be addressed in order for mainstreaming to be achieved, emerged. When conducting the interviews a repeated view was expressed that the attitude of what I am terming 'general prison service staff' towards mainstreaming was not always positive.

While *Framework* illustrates that senior staff emerged with high positive scores, the view of other staff, both from the perspective of senior Prison Service employees, a PO and NHS staff was, on the whole, less than fully supportive. Taking the *Framework* scores, it emerged that the average score allocated to the attitude of general prison staff, (0 = negative, 100 = positive) was just 47.1%. The highest score of 7 was associated with one Governing Governor who provided a number of positive examples of what the Prison Officers were doing in the prison, in particular with regard to the whole prisons approach.

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[65] Clarification note: this is not to be taken to mean that respondent's believed that the service in prisons was 67.1% of that offered in the wider community. Rather, it is a reflection of their view on how moves towards mainstreaming is progressing in the prisons.

This finding, however, comes with a number of qualifications. Firstly, it is worth recording that respondents also commented on changing attitudes and the need to recognise that mainstreaming and the public health agenda was something new to many prison staff who had been working in a very different environment for many years. In addition, it must be pointed out that only one Prison Officer, albeit a shop steward and therefore deemed capable of providing a reasonably representative view of his member's feelings, participated. However, even in this case, there was an articulation of resentment at improving services for prisoners when Prison Officers themselves did not have such relatively easy access to them in the wider community. In any case, having looked at the environments and attitudes which the mainstreaming agenda encountered during its initial stages, I will now move on to a consideration of the importance of the implementation gap to my thesis as a whole before outlining instances of explicit failure and identifying areas where problems are evident but are nonetheless being addressed.

## 7.3 Considering the implementation gap

Why then is it important to identify where and why policy is not being implemented? The principles underpinning mainstreaming have been outlined above. Primarily health care services which are available to prisoners should be the same as those available to citizens outside the penal system. This includes those clinical interventions as well as upstream services as described in Chapter Three under the public health agenda. However, not only does this assume that mainstream NHS services represent an ideal model of health care to which health care professionals within prisons should aspire, but also that environments in which those services are delivered are no different from those on the outside. Moreover, it follows that mistakes made on the outside may well be replicated inside.

This thesis will argue that taking community based services as a model for services delivered inside prisons is untenable on both levels. While it is recognised that aiming to improve care in prisons is absolutely laudable, worthwhile and progressive and is being taken on by dedicated and professional staff I will argue that failing to acknowledge structural, environmental, operational and interpersonal differences between health care provision in prison and in the wider community is leading to a

situation where implementation gaps are apparent and opportunities, as laid out in *The Future Organisation of Prison Health Care* (HM Prison Service & NHS Executive, 1999), are being missed. I will also propose, however, that this failure to recognise difference is producing local initiatives which, following Lipsky's street-level bureaucrat model, illustrate that policy in practice may also emerge locally[66].

Many issues were raised by respondents which point to areas in which health care services within the host prisons are failing to match services available in the wider community. In writing this chapter it became apparent that a number of qualifications were worth making. Firstly, it needs to be noted that implementation is an ongoing process. Progress towards NHS standards, for example, PCT 2's work on clinical governance were at an advanced stage but had not, at the time of the fieldwork, yet achieved parity. Does this then still represent an implementation gap? In addition, it is worth noting that instances of progress such as the building of a new health care centre at Prison A which would replace an archaic facility failed to progress due to budgetary constraints and the prioritisation of funding for a different prison whose need was deemed greater.

Were the interviews to take place during the planning stage of this facility then it would have appeared as if progress in the direction of 'broad equivalence' was being achieved. However, as illustrated, the work did not go ahead. Lastly, it needs to be acknowledged that implementation gaps are in no way necessarily down to the host organisations themselves. As will be illustrated there are specific contradictions between mainstreaming and practice as dictated by Home Office policy which makes some implementation gaps inevitable.

In short, adjudicating on whether or not implementation gaps exist is not just a subjective exercise but also one carried out in the context of a fluid environment where advances may be initiated but subsequently reversed, where the host organisations had varying levels of ground to 'make up' on the NHS and each PCT/prison area had different resources with which to initiate change. I have therefore taken a 'relativistic' stance whereby issues which have been addressed as important by

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[66] It should also be noted here that forums such as the annual Prison Health conference at York exist for the purpose of sharing good practise nationally.

respondents for achieving broad equivalence but which have not been acted upon are categorised as 'explicit failure' to implement policy. These will be dealt with first.

The next category describes issues which have been identified as 'problematic but being addressed'. Areas where prison health care is described as already equivalent or better than services in the wider community will be described in Chapter Seven under outcomes. A continuous theme in this chapter will be an emphasis on differences which have been identified between prisons as environments where health care is provided and delivery of services in the wider community.

### 7.3.1 Explicit failure

Taking explicit failures to implement policy first I will begin with the example used above regarding infrastructural deficiencies. As noted by Morgan a substantial part of the physical environment of the prison estate in England and Wales is a legacy of building and design dating back to the Victorian era (Morgan, 2002). One of the prisons hosting the research, Prison A, is a product of this time. The need to update health care infrastructure was therefore seen as a priority by the combined membership of the PCT 1/Prison A prison health partnership. Various respondents recounted how plans were agreed at Home Office level for the building to go ahead, however, these were subsequently scrapped and the funding was reallocated elsewhere. What is also interesting about this episode was how respondents reacted to the negative outcome and what it told us about different organisational cultures.

To elaborate, a number of respondents were quite exacerbated but nonetheless were open in articulating that they understood that funding should follow greatest need. There was a resigned nature about their acceptance of events. One respondent (R9), however, laid the blame squarely on PCT/NHS involvement in the bidding process. R9 stated that the Prison Service would have approached getting the new centre in place very differently from the NHS. He added that he believed that the NHS did not have the experience necessary for working with the Home Office when applying for funding. The crucial difference as he saw it was that the Prison Service would have got the basics in place first, i.e. funding for the fundamentals would be applied for. Once walls, beds, essential equipment were acquired, they would then reapply for the

next level of equipment. In the eyes of the Prison Service bidding was an incremental process.

However, the reason why a facility everyone agreed needed to be built never materialised was that the NHS were used to an application process whereby they bid for everything at once, all the 'Gucci stuff', as R9 put it, included. Different organisational cultures were therefore seen to be relevant to a specific implementation gap failure at this site. Instead of working towards an NHS standard facility incrementally Prison A continues to provide health care services in an outdated unit.

Indeed, other respondents articulated further difficulties regarding premises and facilities. For example, basic rooms for initiating group sessions for inmates with mental health difficulties which respondents identified as beneficial for people in their care are simply not available (R16). Incompatible, non-existent and inadequate infrastructure is therefore one major failing in attempts to move towards mainstreaming within the institutions which hosted the research.

Next, I will outline a number of national Home Office policies which are in place for security reasons and because, according to respondents, of political sensitivities. These are services which, in contradiction of mainstreaming principles, are available in the wider community but not in prison (R4, R9). First is the difficult question of needle exchange. Straightforwardly, if services in prisons are to be mainstreamed then needle exchanges would be available in jail (Kirkby Community Drugs Team, 2006). However, such a development was argued to be very difficult politically as it was an admission that intravenous drug consumption takes place in British prisons.

In addition, it was argued by the Prison Service respondents that it may lead to an increase in drug taking as needles would be perceived to be safer. They were also concerned about risks to their own health as needles may proliferate and represent a danger to Prison Officers searching cells as well as the possibility that they may be used as weapons. Against this, health care officials argued that needles would be better controlled and that such a scheme would assist with reducing the transfer of BBVs and STDs. Whatever the merits of each position the absence of needle exchanges is in direct contradiction of the mainstreaming principle.

Allied to this because of their relationship with BBVs and STDs, condoms are freely available in the wider community (R2, R4, and R25). However access to them is limited (R27) or only in the early stages of development in the prisons (R6). Again, security issues are relevant as they may be used to conceal drugs. However, in one instance health care staff were concerned at the attitude of denial that sexual activity takes place in prisons displayed by one senior Prison Service official (R27) which was given as the reason why condoms would not be made available.

Next I will turn to prisoners themselves. While it is acknowledged elsewhere that a major gap in this study is the perspective from inmates nonetheless respondents were asked for their observations on how prisoners experienced health care. Taking national NHS policy first, in the introduction to *Creating a Patient-led NHS: Delivering the NHS Improvement Plan* the Department of Health states;

> '…the ambition for the next few years is to deliver a change which is even more profound [than initiatives since 2000] – to change the whole system so that there is more choice, more personalised care, real empowerment of people to improve their health – a fundamental change in our relationships with patients and the public. In other words, to move from a service that does things *to* and *for* its patients to one which is patient-led, where the service works with patients to support them with their health needs' (Department of Health, 2005e, italics author's own).

*Choosing Health: Making Healthy Choices Easier* also places choice for and feedback from patients as central to how the NHS delivers health care (Department of Health, 2004). However, given understandable security issues, it is difficult to see how choice of service provider, for example, can be extended to inmate/patients. This therefore is a clear and possibly unbridgeable service implementation gap. On the other hand, it would appear to be feasible to both obtain feedback regarding prisoner health care needs and also take the results into account when developing health care plans. However, as the *Framework* analytical tool (Appendix 4) illustrates only 5 of the 27 respondents articulated instances where prisoner feedback was proactively sought.

Connected to this is the contrast between how patients experience health care in prison compared to the wider community. For example, prisoners who are to be escorted outside the prison for secondary or specialist care may or may not be told when and where they are going depending on their security risk assessment. Again, this goes to the heart of the tension between security and health care provision. Fears surrounding attempted or successful escapes dominate this issue and respondents related how prisoners who may have been waiting for appointments outside have simply refused to go when they become available because they may be unprepared to face whatever treatment has been arranged, because they have a visit due, or because they may need to see their solicitor.

Another issue surrounding health care which was provided by interviewees as an example of difference in both delivery and consumption of services is that of the doctor/patient consultation where it is necessary for a member of security staff to be present. Here, issues such as how open the prisoner may wish to be given the presence of a third party, the confidentiality of the discussion and the GP's relationship with the security regime may all play a part in the fact that delivering services are different in prison. As R7 put it

> '…there is this discomfort about the level of confidentiality [ ] you have got…I mean a lot of our patients are suffering from Hep C and trying to have a discussion about sexual health or your injecting habits is very difficult. So, there is a dampening aspect to the consultation because of that (R7).'

Similarly 'on the outside' patients are allowed to self-medicate. However, as pointed out by R1 'this is just not on in prison' because 'almost every pharmaceutical product of one sort or another is currency' which may have implications for interpersonal relationships between prisoners and order within the prison. Prisoners may also overdose if stocks are hoarded. Again, this is a specific and perhaps obvious example of an instance where the mainstreaming of services is not taking place in the prison environment.

### 7.3.2 Problematic but being addressed

Starting again with infrastructure, as illustrated in the chapter on the documentary analysis of the initial HNAs the poor condition of IMRs posed a number of difficulties. In order to bring record keeping up to date with data collection and retrieval in the wider NHS new IT systems are being introduced to the prison system to replace old paper based systems. However, although all respondents welcomed this development progress has been excruciatingly slow.

The relevant issues here range from difficulties encountered in negotiations with the private provider, Electronic Data Systems (EDS) an American technology services company, who hold the government contract for installing the prisons' computer systems. The problems encountered here are as follows: Firstly, because EDS control access to conduit points PCT 1's attempts to install the computer system it purchased for Prison A required drawn out negotiations with EDS in order for work to go ahead. Secondly, the security aspects of allowing contractors in and out of prisons alongside the associated escort costs placed further pressure on moves to improve IT infrastructure. Lastly, because of these delays staff training which took place in anticipation of the installation of new systems became obsolete as it was given well ahead of installation and may be forgotten by the time actual hardware becomes available.

Indeed, one respondent stated that it was still easier to try and access the old records rather than access the new computer system. As pointed out in Chapter Eleven this is critical for both the current provision of care and also planning services in the future. However, though IT in the prisons remains significantly behind what is available in the wider NHS the matter is being addressed albeit at a slow pace.

Related to this issue is the problem identified by PCT 1 at Prisons A and B of poor systems of administration (R5). Not only was there a general absence by NHS standards of a workable bureaucratic framework, what was in place was administered by qualified nurses who ought to be doing just that, nursing. R5 argued that without such a system, properly ran by appropriate staff other systems would lack a solid foundation for their operation and would fail. PCT 1 therefore prioritised getting a

robust administration system in place and this was hailed by respondents as an important successful outcome of PCT involvement.

Next I will introduce an issue whereby services may actually be cut back within the prison because of the introduction of broader NHS policy. This 'unintended consequence' was related by R14 at Prison B who identified a reduction in qualified health care centre staff of almost 50% since PCT 1 took over (Morrison on Weber, 1997). When asked about training opportunities R14 stated:

'I think it is a difficult one because the PCT have come in and they have looked at reflecting what is happening in the NHS in terms of how we deliver health care. We have the introduction of things like support workers and so at the minute I suppose when the PCTs came into the prison the staff...they were starting to change things. Because of that there has been a massive reduction...sorry, not massive, but there has been a reduction in qualified staff. And we have seen from a number of about 20 qualified staff we are now reduced to 11 qualified staff.'

This has caused resentment towards the PCT, adversely affected staff morale and also reduced the amount of training done by the remaining staff as they do not have time to take part in skills enhancements which were available in the past. Indeed, barriers to anticipated opportunities for better training for what were perceived to be sub-standard nursing staff is a common theme. For example, a respondent at Prison D demonstrated how they are reluctant to let staff go on training or placements in the wider NHS because they do not believe the staff will be covered and that placements will be reciprocated. Implementation gaps in this instance therefore relate to *reducing* numbers of skilled staff and the non-materialisation of opportunities for training which are argued to be more accessible for staff in the wider NHS.

The next implementation gaps which will be addressed are issues pertinent to the public health agenda. Here, upstream NHS policy as outlined in *Choosing Health: Making Healthy Choices Easier*, in conjunction with the *Health Promoting Prisons: A Shared Approach* set out the importance of prevention rather than cure and how health care services would work towards creating environments in which individuals could

lead more healthy lifestyles (Department of Health, 2004, 2002). Alongside this, it should also be noted that responsibility for making these choices is identified as lying with the individual. It is not seen as enough for services to be provided as a right, users had a responsibility to avail of them although this could require measures to improve access and utilisation. As the latest Wanless report *Securing Good Health for the Whole Population* states:

> 'Individuals are ultimately responsible for their own and their children's health and it is the aggregated actions of individuals, which will ultimately be responsible for whether or not such an optimistic scenario as 'fully engaged' unfolds. People need to be supported more actively to make better decisions about their own health and welfare because there are widespread, systemic failures that influence the decisions individuals currently make' (Wanless, 2004).

The potential benefits lie not only in making people healthier but in anticipated cost savings downstream, as clinical and medical interventions are reduced. In addition, the public health agenda emphasises a holistic approach which encapsulates a person's general well-being rather than just the absence of illness, i.e. access to literacy, employment, and housing. As mentioned below prisoners come from mostly disadvantaged socio-economic backgrounds and have lower literacy rates as well as poorer health, housing stock and higher levels of unemployment.

However, as the *Framework* tables indicate, the medicalised model dominates respondents' discourse (see Appendix 4). Indeed, it is interesting that (respondents with specific responsibility for public health, e.g. R2, R4 and R21 aside and one exception, R7) the upstream public health model was significantly less evident in the responses of health care professionals when asked what they considered the principal health care issues in their places of employment. For example, little mention was made of items such as housing, employment, diet or exercise.

Furthermore, the research found that although not termed 'the public health agenda' explicitly, it was respondents from the Prison Service who did not have specific responsibility for health care who spoke about the more holistic model expressing

deep concerns about issues such as housing and employment. In addition, only one PCT had appointed a full-time health promotion specialist while the others drew on what staff they had who had some health promotion training but nothing specific was in place. Some efforts were therefore being made but given the focus on public health in health care generally this appears to be a significant implementation gap[67].

Moving on to ethical and professional gaps in treatment between what would happen in the wider community and prison a number of health care professionals identified serious concerns about ethical choices and dilemmas they faced because of the prison environment (see *Framework,* Appendix 4). Chief among these was the question of doctors being responsible for adjudicating on the suitability of a prisoner for punishment. As pointed out in Chapter Two on the history of prison health care this role is a historical legacy of practice which has dated back to the initiation of incarceration in England and Wales. In short, the Governing Governor has the power to 'imprison within the prison', i.e. to segregate dangerous, problematic and violent inmates from the general population.

This power is both a deterrent to behaviour which may upset the routine working of the prison and also a punishment for doing so. However, before a prisoner is sent to the segregation unit a doctor is called upon to confirm that they are in a fit state. Stating and signing that an individual is 'fit for punishment' poises ethical dilemmas for practitioners and would not happen in the wider community. This issue was not addressed in *The Future Organisation of Prison Health Care* and, although it had been taken up by the British Medical Association (BMA), had still not been resolved at the time of the research (HM Prison Service and NHS Executive, 1999).

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[67] It is noted that only one health care respondent mentioned diet when asked about the public health agenda. This is dealt with in more detail in Chapter Eight on public health.

## 7.4 Challenges and barriers to implementation

This section will summarise responses from interviewees when asked what implementation gaps existed and why they believed gaps remained. The *Framework* document illustrates these and they can be divided broadly into five categories: funding issues, the security/custodial environment, national policy directives including a lack of educational and directional support from central government, the nature of the inmate population and staffing issues (see Appendix 4).

### 7.4.1 Funding

Firstly, funding featured regularly in responses. The problem most commonly cited is that what the PCTs received, even allowing for the projected £46 million 'top-up' by 2005-06, was only what the prisons were using historically to fund a service which was deemed inadequate (Department of Health et al, 2002)[68]. As R3 put it;

> 'We inherited funding associated with the out-turn on an antiquated and somewhat retrograde service, there was some growth added…does that make it a viably funded service? Answer, no (R3).'

However, as recognised by the Joint Working Group prison health care services were already substantially behind NHS delivery (HM Prison Service & NHS Executive, 1999). In addition, this implies that the gap could be bridged through the introduction of £20 million into the equation. However, no evidence is available as to how this figure was arrived at. In any case, 22 respondents related instances where they were unable to carry out policy because of resource issues (Gunn, 1978). These ranged from initiatives which had to be abandoned such as a detoxification unit within PCT 1's area of responsibility and the new health care centre at Prison A to the provision of adequate dental services at Prison C.

[68] This received little sympathy from R9, a prison service employee, who argued that the local PCT benefited from the closure of prison wings which were only later repopulated.

Taken in the context of ever growing numbers of prisoners it was argued that it was a straightforward 'no-brainer' that the service was under funded[69]. In addition, some specialist areas were of particular concern such as longer term chronic disease management at Prison B, dentistry (R22, R24), upstream mental health (R16) and staff and training (R5). Quoting R3 again; 'we know it [health care] needs more funding in the community so why would it not need more funding in the prison? So that is a given really.'

Of course, the nature of the prison population determines that proactively addressing both medical problems of a clinical nature and the amelioration of need in the sense of well-being introduces the resource problem characterised as finite resources chasing infinite need (Petersen & Bunton, 1997). In short, the more health screening that is done the more issues will emerge increasing pressure for intervention under duty of care ethical principles. The problem of resources is obviously therefore of great concern here. As one respondent put it, 'just because you have a good idea it doesn't mean that there are people out there lining up to give you money to support you on it' (R8).

### 7.4.2 Security/the custodial environment

'Everything takes second place to security' (R2)

Firstly, a strong sense emerged that the prison, as well as often being an unhealthy environment, was quite simply a different setting for the provision of health care compared to the wider community. Not only that, it was one which posed particular challenges which may mean that equalisation of services is a relative, rather than an absolute, possibility. Beginning with care itself, respondents pointed to the limited 'windows of opportunity' for offering services. This is a straightforward consequence of the institution's need for routine and the imperative of maintaining order. Prisoners are locked in their cells at exact times each day. While they may subsequently call a

[69] The prison population as at 6th October 2006 stood at 79,843 (Howard League, 2006). Although the crude nature of the calculation is acknowledged this equates to an additional allocation of just £192 per inmate per annum over 3 years.

Prison Officer or a nurse on a wing for assistance, this is not the same as it would be in the community.

Another aspect of prison life which identifies prisons as different settings is the phenomenon of a 'lockdown'. In this case, as the name implies, the prison population is confined to their cells as a result of some kind of emergency. This situation may be precipitated by a breach of security, disturbance between inmates or inmates threatening or attacking prison or health care staff and so on. Any medical treatment which was either planned or was being administered ceases until the situation is under control. This not only has an impact on services but, as a number of respondents pointed out, would need to be factored in when setting health care targets.

Routine also impacts on when medicine may be available. For example, Prison B organises two rounds whereby a HCO will visit a wing offering medication such as tablets for headaches. All very well. However, if someone does not have a problem at the time and the HCO round is completed then that individual must wait until the next round. While they may call a Prison Officer or nurse the suspicion was raised that Prison Officers would only take the matter further if they believed that the inmate was not 'acting'. They were thus perceived to be, at least in some circumstances, performing diagnostic duties in their own right.

Staying with the role of Prison Officers, although it was not seen generally as a major problem, the need for prisoners to be escorted to the health care centres or to facilities on their wings could lead to delays or cancellation of clinics and appointments where sufficient staff were unavailable to facilitate the movement of patients. Again, while this is an inevitable consequence of the custodial environment, it nonetheless affects both health care provision and the experience of both the health care professional in administering it and the patient in consuming it.

Furthermore, respondents pointed to the ever increasing prison population as a difficult environmental factor inhibiting the provision of broadly equalised services. Indeed, during the research, one prison's population was increased by roughly 200 inmates when a previously evacuated wing was repopulated. Also, R7 made a direct connection between the quality of service and numbers of prisoners. A practical

example of this was provided by R6 who cited the reduced numbers of Hep C vaccinations associated with periods of high turnover on reception into custody.

Turning to doctors' appointments both health care professionals and security staff mentioned the relatively large numbers of 'did not attends' (DNAs) which occurred. The reasons given for this were the fact that other priorities such as prisoners' families who may come to see someone 'on spec' or a patient/prisoner's meeting with a solicitor which would mean that the appointment would not be kept. If someone in the community failed to keep an appointment there are sanctions which would be applied, however, in prison, even though Prison A stated that PCT A1 initially felt that some sanctions ought to be applied, this simply could not be done given the special circumstances present in the jail.

This alternative/different experience of health care from both the health care professional's and prisoner's perspective was highlighted further by the special arrangements which sometimes necessitate the presence of a security officer or HCO during consultations between patients and doctors. Here, a number of respondents raised concerns about confidentiality with one describing the effect of the presence of third parties as affecting what would emerge from the consultation. Furthermore, anecdotal evidence suggested that nurses were, on occasion, required to provide 'look out' services during consultations which clearly fall outside normal nursing duties[70].

Also, R7 pointed to the 'wearisome' element of constantly having to be aware of security issues when providing care. This was seen to have practical outcomes and also pose problems with regard to relatively high rates of staff turnover (R5). In short, both health care professionals' and patients' experience of health care supply and consumption are qualitatively different from that which they would provide and receive on the outside. Indeed, it does not appear unreasonable to argue that this may have quantitative outcomes as well in terms of the type and amount of medicine /clinical intervention subsequently prescribed.

[70] The reason for this was believed by the PCT concerned to be cost. It should be noted that such anachronistic 'customs' were being addressed by the PCT concerned at the time of the research.

Secondly, issues mentioned under the prison environment included inadequate exercise areas (public health agenda), detachment from families and other primary support groups and the inappropriateness of the prison environment for treating prisoners with mental health issues. In addition, questions of who should actually pay for building new premises arose. Who would actually be responsible for paying for cleaning health care premises, for example? Also, as outlined elsewhere security is the number one priority in prison. In this instance respondents spoke about difficulties with organising escorts, transferring prisoners outside the prison for secondary and specialist treatment and the hand-cuffing of patients.

Moving on to environmental issues R18 from the PCT 2 gendered the discussion in seeing the prison as very much a 'male environment'.[71] Here, the respondent was not referring to the number of male POs working in the jail but rather the mechanical, hierarchical, domineering environment she experienced. Whether this is stereotyping male and female characteristics or not the point is that prisons are a very different environment from working in the headquarters of the local PCT and where staff were left simply to 'get on with it'. As R17 stated, people were reluctant to even enter the prison environment, let alone want to work there. This then led to delays because the PCT encountered a steep-learning curve before it could even begin to plan services in what was an alien environment.

### 7.4.3 National policy directives

Turning to a lack of support on issues which needed national directives and could not be resolved entirely locally, 20 respondents specifically identified a lack of direction from central government about matters such as what would happen to ex-prison service employee's pension rights when they transferred to the NHS and what would happen to HCOs under the new arrangements?[72] This was particularly evident in regard to PCT 2 and Prison C where respondents' language was laden with an 'us' and 'them' style discourse.

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[71] Please note that Britton also writes about the prisons as 'gendered organizations' in America – see also Table 9.2, p.218 (Britton, 2003).

[72] HCOs were Prison Service staff that had responsibility for security but also held some nursing qualifications. Some HCOs transferred to the NHS during the research but others resisted strongly.

The mainstreaming goal headlines national policy on prison health care. However, respondents raised a number of areas where specific national policies contradict this aim. In addition, implementation of guidelines on issues such as issuing condoms and whether or not to maintain prisoners on methadone are left up to institutions themselves with the result that actual practice on the ground is significantly at variance with what happens in the wider community.

Taking specific national policies first, R5 gave an example of how the national set of protocols on clinical teams delivering substance misuse services is actually at odds with what is the best practice in the wider community. In addition, there is the obvious example of there being no needle exchanges in prison. Also, as R16 pointed out, certain medicines, for example those with particular use as currency in the jail or containing opiate related substances such as codeine, will not be prescribed even though they may be the most appropriate medication as well as being what would be issued in the wider community in a particular instance.

Next I will turn to an area which lacks clear national guidelines and also illustrates the unique and sometimes autonomous nature of each individual prison establishment. First the science bit. Methadone is one of a number of synthetic opiates that are manufactured for medical use and have similar effects to heroin. However, although it does not deliver the same degree of buzz or high like heroin, it can be highly addictive. It allows people to tackle their psychological addiction and stabilise their lifestyle and when used as a substitute for heroin in treatment it stops often traumatic withdrawal symptoms, one of the principal reasons advanced for using it instead of detoxification (Executive Office, 2000). The dose can be reduced slowly until the user is off the drug completely (Talktofrank, 2006). However, whether methadone is administered or whether prisoners who have substance misuse issues are sent for straight detoxification depends on the prison to which an inmate is received into custody.

Moving on to methadone maintenance the research evidence suggests that it is up to the individual prison, which effectively means the Governing Governor, as to whether or not a prisoner is thus maintained. In the community that is what is available so, if mainstreaming is to be achieved, then it should also be available for inmates.

However, there is resistance to this because straight detoxification is seen as a better option given the manner in which the patient is 'cleansed'[73]. Some prisons therefore have such programmes, some do not. Summing up, R21 stated;

> 'There is not a national guidance at…in particular…for example, if you go into the community, the drug service would prescribe say…pick methadone…would prescribe as high as required. Initially you could not get it in the prison…now you can get it but it is a limit of max. 40 mls. So if somebody is on 100 mls just to come down to 40 mls in a day is a big difference so it really is a big issue and that's still being addressed so if you are getting different amounts [ ] and the prison [ ] you cannot provide the course so where is the equity of treatment? What is the whole purpose of what is being addressed…so that people would get the same level of treatment and that is why you have to look at both sides. [ ] I want to continue on 100 mls but the prison policy does not empower you so what do you do? Where is the equivalence? (R21)'

In short, there are clear areas where the specific and particular nature of administering health care in prison means that alternative means of providing such care are found.

Turning directly to the host research institutions, Prison A initiated a methadone programme as a local strategy. While this is not common practice in the prison estate, it is largely in line with what would happen in the wider community. However, not all professionals in the security setting are comfortable with this. For example, as a matter of principle, R9, the POA representative, spoke of how his members saw their role as one where inmates would be returned to the community drug free. The way to achieve this was through detoxification, not replacing one drug addiction with another. This was a source of frustration for R9 in how they defined their role as a public servant.

In addition, prisoners who are on methadone programmes are 'blocked' from being transferred to other prisons who do not administer methadone. The consequences of

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[73] The arguments for and against methadone maintenance are detailed under Implementation Gaps.

this are not measured in a quantitative manner by the research. However, respondents stated that this could stop prisoners from being transferred to prisons which had better training for release programmes or to prisons nearer their families. Local initiatives may therefore not only be contentious locally, they may also affect wider systems in unintended ways which were not accounted for when the original programmes were implemented.

Other locally devised policies, however, may stand in direct contradiction of national guidelines. Here, PCT 1 took a stance against a national guideline which stated that one way of protecting prisoners who may be intravenously using drugs was to provide bleach tablets to enable them to sterilise their needles. Indeed, prisons have a health care standard which says that bleach tablets should be used in this instance. However, in direct contradiction of mainstreaming principles, this is not what happens in the community. The PCT argued that there is no evidence-based research to suggest that bleach tablets are effective in the first place.

Their availability may therefore encourage people to use and share needles in prison when the PCT would not countenance such practice in the wider community. As R4 pointed out; 'this is clearly a situation where the national policy is at variance with what we know locally to be good practice'. Rather, in the community, what would happen is that intravenous users would be given whatever support they could be given to stop using, however, as this obviously does not always work clean needles are then made available as part of a needle exchange programme.

While the PCT was not willing to administer bleach tablets, they also recognised that the Governing Governor was bound to comply with the relevant prison health standard and the matter was still being discussed at the time of the fieldwork. In short, this initiative had a different character from those described above. It was a reaction to a national directive which contradicted what they believed to be good practice and the initiative therefore took the form of resistance rather than the more proactive examples previously outlined.

That said, because of the new partnership arrangements it could not be acted upon unilaterally and therefore must be seen as being acted out in the context of a contested

environment. Lastly, and related to the comments made about the strong partnership building blocks which were developed between PCT 1 and Prisons A and B in Chapter Seven, it is worth noting that discussions regarding this were described as of 'an understanding nature' with each side taking on board the concerns of the other.

Having noted the sometimes contested nature of policy implementation with partner bodies' guidelines set in direct contradiction of each other, it was interesting to note how street-level bureaucrats were beginning to use directives laid down by the other organisation in the partnership when their own guidelines either did not carry sufficient weight or they needed to 'manage' a situation. The example I will provide concerns an NHS health care professional faced with a patient who demanded certain treatment. While the treatment would be available under NHS guidelines the official felt that it was inappropriate given the patient's circumstances and used prison service directives to justify why it could not be administered. In short, even though the individual now faced two sets of guidelines, 'two masters' (R25) as it were, there were cases where this actually allowed more freedom to produce desired outcomes.

Before concluding I will now briefly outline two administrative innovations which are being enacted locally which have been argued by the respondents concerned to represent important successes. Firstly, PCT 2 identified the difficulties they sometimes faced with having prisoner/patients escorted to the health care centre from the wings. They also noted that the treatment subsequently required either did not merit seeing a GP in the first place or could have been taken care of by nursing staff. The simple innovation was to make each wing its own mini-health care unit where appropriate nursing staff would carry out triage before any transfer took place.

Secondly, the Governing Governor at Prison B (R13) noted that there was a lack of clarity about line management and responsibility for health care. The arena appeared to be dominated by a Governor grade who was 'somehow' seen as the health care Governor although they had other responsibilities and a Principal Officer grade who also had some health care responsibilities. If people had health care issues which needed discussion or resolution they tended to go to these security staff. Missing from the scenario, however, were the managers of the health care centre itself.

In order to address this, the Governor grade was promoted to take into account their health care responsibilities and, crucially, health care staff were included in planning meetings. R13 pointed out that seeing nurses representing the medical side of prison life at high level meetings was a major step forward and was something which would not have been encountered even a few years back. The innovation here therefore was raising the profile of the health care centre staff as more equal partners in health care management.

In conclusion a number of initiatives have been introduced in response to locally identified need. For example, the hospital appointments system at Prison A, piloting health trainers at PCT 2 or developing full-time posts such as the health promotion specialist role by PCT 1. Furthermore, there is the interesting phenomenon whereby individuals utilise the rules and regulations of the partner organisation when and where it may suit their day to day activities. Also, as in the case of bleach tablets, it is evident that local initiatives may emerge as a negative reaction to national guidelines where central directives are believed locally to be quite simply inappropriate. How effective these initiatives have been will be dealt with later under outcomes.

However, given the extent of implementation gaps, and the dominating effect of local context which nevertheless has space for a variety of local coping styles, where does this leave any meaningful achievement of 'mainstreaming'? I will therefore next turn to the issue of mainstreaming more specifically and findings which emerged from the fieldwork.

### 7.4.4 The inmate population

Having looked at the restrictive nature of the custodial environment I will now turn to concerns raised by respondents regarding the nature of the inmate population itself. As documented elsewhere prisoners often have little previous engagement with health care services. They are also seen as a high risk, vulnerable group whose lifestyles have led to poor physical condition, with addiction and mental illness common both as sole issues and multiple problems. It is therefore a particularly difficult and needy population cohort compared to that which the NHS services in the wider community (Department of Health et al, 2002).

For example, reflecting on prisoner lifestyle R13 stated that

> 'We do have a lot of prisoners who lead a very unhealthy lifestyle. They cook a lot of food for themselves and they cook too much and they do not cook it in a healthy way and you should see the volumes that people eat! And quite a lot of prisoners are not exercising very much. [ ] Over a 10 year period how much weight they can put on and that happens in the community as well but it almost like an accelerated program. So there is something about living an unhealthy lifestyle as well, diet, lack of exercise…' (R13).[74]

Indeed, this also raises similar issues to findings by Smith writing on the use of food by female prisoners as a 'powerful source of pleasure, resistance and rebellion' (Smith, 2002, p.197). Does this also apply to the male prison estate? Is 'bulking up' a 'macho' means of reclaiming the self in a restrictive environment for male inmates and, if so, is this just applicable to the prison environment or does it have broader implications for the promotion of the public health agenda in socio-economically deprived areas? Unfortunately, the scope of the research did not allow for an in-depth focus on these issues which would have necessitated interviews with prisoners but it would certainly appear to be an area which further research may consider.

In any case, it is also relevant that the prison population is also a transient one. Many are in prison for less than six months. Setting in place programmes which may be seen through to satisfactory conclusions is dependent on factors over which the provider may have no control. For example, the early release of a prisoner or their transfer to another facility. While patients may be discharged for whatever reason or simply move residence in the wider community these are generally things which may be planned for. However, intensive need, in a custodial setting where patients may be moved without warning is again a qualitatively different proposition from providing services outside the prison setting.

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[74] For a counter argument to this see Chapter Eight, section 8.3 on 'moves towards the public health agenda' where R13 also proposed that opportunities to lead a healthy lifestyle also existed in prison.

### 7.4.5 Staffing issues

With regard to staffing issues, it became evident from speaking to the PCTs that they were not happy with the existing skills mix (for nurses and some doctors) in the prisons. This led to resentment on both sides as illustrated in Prison C above. In addition, some 'pockets of resistance', particularly with regard to longer serving HCOs, emerged which took substantial management time and resources to address in PCT 1's brief at Prison B before NHS systems could be put in place. Also, placement opportunities in the wider NHS do not appear to have materialised for Prisons C and D at PCTs 2 and 3.

### 7.5.1 Care Pathways: external

This section addresses findings reflected in the *Framework* analysis tool in respect of the existence of care pathways for inmates moving both within the prison estate and on release and how effective inter-departmental working within the prisons was perceived to be by respondents. In all 12 interviewees expressed concern about care pathways, 3 did not comment while the remaining 12 felt that adequate arrangements were in place. Turning to inter-agency working, of the 7 who addressed the matter, all identified short comings of varying degrees. Some, as indicated in the quote below from R5, expressed grave concerns.

However, others could see substantial improvements under way. Indeed, it was interesting that some respondents working in the same institutions expressed varying assessments of how well both internal and external partnership working was progressing. In addition, it is worth stressing here that while the focus of this section is on implementation failure and/or progress towards implementation, evidence of cooperation between departments was also available and is highlighted below. The picture is therefore somewhat mixed and as such is also included in the category 'problematic but being addressed' but given a separate section due to the involved nature of what emerged.

While evidence of established links with outside bodies such as the multi-agency meetings which assess prisoners on release at Prison B were in place a sub-theme

characterised by scepticism about the effectiveness and provision of throughcare services was common[75]. Indeed R13's comment that 'care pathways [are] probably not very well developed' typifies the perception among those who expressed concern. Even where specific pathways such as a close relationship between Prison B and mental health support through the Care Programme Approach (CPA) were highlighted successes were cited alongside failures.

In this instance not only did the respondent (R14) display concern that there was no clear guidance on how pathways could be followed for mental health issues they also stated that in terms of non-mental health issues there were 'very little' linkage systems. Here the respondent said that the problems were associated with both the dispersal status of Prison B and ex-prisoners not actually knowing who their GP was (if indeed they were ever registered with one, R21) or where they might be located on release. While the Medical Centre was happy to issue discharge letters as well as letters to GPs these issues made maintaining a link with services difficult.

Another problem with linkages which emerged was that even in circumstances where specific connections were in place, for example, between Prison B and a local GP practice which also provided services for registered substance misusers, respondents were unaware of any links with broader services which concern the public health agenda such as housing or employment. In addition, this example of incomplete joined-up servicing was further compounded by the transitory nature of the ex-prison population.

This issue of information communication between institutions and community services was articulated regularly and most particularly with regard to links between discharge and accessing the offender's GP (R20). Respondents also felt that much more in terms of education on how services may be accessed could be done before release. As R24 pointed out many prisoners have been in custody for a significant period of time. Even those who had used services before being locked up had now become virtually totally dependent on having things done for them. Not only had

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[75] The National Offender Management Service (NOMS, 2006a) now plays a key role in overseeing and commissioning post-release services for prisoners, however, neither NOMS nor the Probation Service were included as participants in the original research proposal (see also Methodology chapter regarding the research focus on prison settings).

service provision changed during their term in custody but their ability to obtain it is likely to have been diluted at least to some extent. Concern about unaddressed need therefore not only applied to the provision of throughcare agencies but to the ability of potential users to access services.

The importance of information was also highlighted by both R18 and R3 who brought up the issue of the delayed introduction of an integrated IT system which would link with the wider NHS. R3 saw substantial potential benefits such as immediate access to accurate information accruing from this but cautioned that throughcare depended on establishing a 'pattern of behaviour which can be translated outside' in inmates. Effective aftercare was therefore not just a matter of having systems in place but also very much dependent on the offender themselves.

Therefore, seeing care pathways as part of the broader 'well-being agenda', R3 stated that whatever has been worked on while the offender was in custody must be available and willingly accessed by prisoners on release. The circumstances needed to produce care pathway outcomes as opposed to merely care pathway services were therefore seen as requiring the user to be an aware, competent, pro-active consumer of those services[76].

Another difficulty raised by R4 concerned the lack of a population match between PCT boundaries and their prisoner population. Prisoners are moved about the country for many reasons, such as overcrowding, their own safety, as part of the dispersal system for high security inmates or because they are troublesome. PCTs therefore find themselves with migrant populations temporarily in their care for whom they then, in partnership with the prisons, need to co-ordinate services nationwide.

This raises practical problems such as actually knowing what services are available elsewhere and establishing relationships with them. While such difficulties are not seen as insurmountable they nonetheless act as an obstacle to delivery. Of course, returning to the mainstreaming research question this may also be a problem for PCTs when a patient moves to another part of the country. However, the peculiarities of the

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[76] No evidence of patients exercising choice, apart from 'did not attends' (DNAs) for GP appointments emerged during the research.

prison population, for example, with regard to issues such as housing and not having accessed services in the past, exacerbate the problem.

Also, R10 found that the existence of different agencies servicing multiple needs produced inefficiencies related to service co-ordination and increased bureaucracy. Citing involvement with agencies such as DATs, therapeutic communities (sometimes at other prisons), housing associations and charities such as Turning Point, R10 stated that 'you can get wrapped up with one inmate's care provision and then all of a sudden you are getting behind on the rest of the work'. Finally, as R19 citing an annual turnover of 7,000 inmates at one prison within Prison B's area asked 'how many can realistically be dealt with by the CARATs team?'

On the other hand, however, a more positive picture is outlined by R4 who stated that throughcare had been 'revolutionised' since the introduction of the PCTs into the process. Indeed, 12 other respondents pointed to specific care pathways that were in place in their areas (see *Framework*, Appendix 4). Why though is there such variation in opinion on the existence and/or effectiveness of care pathways? Reference to *Framework* indicates no consistent pattern across either professional or administrative boundaries. It therefore appears to depend very much on one's own perception of throughcare, acquired by personal professional experience or hearsay and this may be highly subjective. In sum while evidence of linkages with throughcare agencies exists, the overall picture is characterised by a mixture of belief that pathways are in place resting alongside scepticism about the levels to which joined-up services are working.

### 7.5.2 Care pathways: internal

Turning to inter-departmental working within the prison estate, the need for close cooperation between service departments within the prison system is acknowledged by both Health Service and Prison Service official documents (HM Prison Service and NHS Executive, 1999; Prison Service et al, 2003). This is underpinned by health need audits which have identified multiple health care issues among prisoners (Home Office et al, 2002). Here, a similar picture to the care pathway issue emerges. While some respondents felt that there was co-operation between internal agencies, for example, R10 described how detoxification liaised with the CARATs team at Prison

A, others had serious reservations about how such linkages failed to operate in practice. The question, of course, is why some work and some do not?

The situation, as described below by R5 at PCT 1 is reflective of this and also of the point that interviewees (often working in the same environment) related divergent views of how well systems were operating. For example, responding to a question about how effective different departments were at coordinating services for individuals with multiple need R5 stated; 'It's a shambles! It's an utter shambles! Not because people do not want to work together, it's the system that has been set up works in silos!' Importantly this comment is directed at the system rather than the individuals who administer it. R5 goes on to identify the fact that some departments have specific targets, for example CARATs who are driven by a need to see so many prisoners, that they lose sight of other issues[77].

Turning to R14, who also worked within PCT 1's area, they cited an improvement in coordinating mental health services but stated that inter-departmental working within prisons was also dependent on issues such as the confidentiality of information and that 'historically in the prisons this has been a big thing' which drove wedges between people. That said R14 went on to describe moves towards greater cooperation giving the example of how the CARATs team are now also involved with Mental Health and take part in a weekly multi-disciplinary team meeting.

However, R18 at PCT 2 describes inter-agency cooperation for their prisons as 'ad hoc, they tend to work separately [ ] without a system to have regular contact it is difficult for cross-linking to develop really.' Again, this is backed up by R20 who commented that '…at Prison C there is very little working together'. Here, at least partly to blame was a perception that because the nursing staff are part-time they do not have a strong enough commitment and will only turn up to meetings in which they may have a personal interest.

However, R24 who works at Prison C outlined the deep resentment felt by the prison nursing staff towards the PCT which may explain their antipathy towards what they

[77] R19 and R18 also used the 'silos' analogy when describing prison services.

saw as extra duties in a context where they felt they were being badly treated in the first place. Actually, R24 introduced another issue, that of a change of infrastructure which meant that their CARATs team were relocated away from the health care centre. Whereas the staff at the centre would meet CARATs workers on an informal basis in the past this was no longer the case. While stating that it was a 'daft' reason for a lack of interaction, the combination of resentment towards the PCT and the elimination of informal relationships with the other department were nonetheless contributing factors to the 'silo' effect.

Turning to transfers within the prison system, R22 expressed extreme frustration that prisoners must sign a disclaimer stating that they relinquish follow-up care if they are being transferred, even when they have been on a waiting list for secondary care at a local hospital. However, this contrasts with the admissions management role which was established at Prison A (see below) to manage prisoners' appointments through the system and further illustrates the divergence of service between institutions[78].

In conclusion then a mixed picture emerges. Some state that the systems are working or improving and point to evidence to support their claims (R27, R4). Others working in the same environment, though mostly for different organisations, state the opposite. One consistency between respondents therefore is *who* they actually work for, mediated through *where* they work. Thus, an NHS employee who worked consistently within the prison was seen to identify with and be more sympathetic towards the prison environment, for example, R2 and R6. Although it is a generalisation interviewees who most closely identified with the prison system generally pointed to the positives (R2, R6, R13, R14, and R27), those from the NHS mostly identified the negatives (R4, R5, R18, R19, R20, and R25). To elaborate respondents from the prison service would more readily acknowledge progress even when admitting failures. On the other hand NHS employees were more critical.

These findings are too consistent to be random. Something is going on here with the principal independent variable being the respondent's main employer. It may also of course be that differing standards apply to how each interviewee adjudicates success,

[78] See Section F, p. 147 on local initiatives for more detailed explanation of the admissions management role at Prison A.

progress and failure. In turn this may be coloured by both their expectations and the expectations of their employers. In addition, there may also be an element of who controls the agenda involved. Actors will have specific interests to protect, such as the nurses at Prison C, who are concerned about their jobs.

Also, at the level of the organisation issues such as who should manage linkages and who should pay for them are also relevant. The more pejorative language used by the NHS and more defensive posture taken by Prison Service employees when discussing care pathways and inter-departmental cooperation may therefore be symptomatic of how the overall partnership is developing. This will be further explored as an important sub-theme as I continue to describe the research findings.

## 7.6 Street-level bureaucrats: local initiatives and 'bottom-up' policy making – coping with the implementation gap

Having illustrated areas where implementation gaps exist, identified specific challenges and barriers to implementation, issues concerning care pathways I will now turn to specific initiatives or strategies which have emerged locally in response. Such 'bottom-up' policy making was elaborated upon in Chapter Four in connection with the street-level bureaucrat concept and this section will provide a number of examples where local actors either developed responses in direct contradiction of centralised directives, adopted national policy to suit local need or produced innovative systems in recognition of local need.

In addition, as is evident from *Framework* (Appendix 4), it is interesting that these initiatives emerged within a context which respondents believed to lack opportunity for agency. They consistently noted that the prison regime was a strict one, based on routine and played out in accordance with PSO and PSI directives. In addition, it was seen to be hierarchically structured ('following a naval model' R3/R7) and standing in contrast to the more dispersed decision making and consultative procedures of the NHS. Nonetheless, a number of policy initiatives and ways of working were developed locally and I will now describe these as well as the circumstances in which they emerged.

The first example concerns the difficulties surrounding prisoners who are on a waiting list for secondary care but who are transferred to another prison while waiting for the appointment. In order for the transfer to go ahead the prisoner must sign a disclaimer to say they no longer require the secondary care appointment. In addition, they do not receive any credit at their new location for time spent on the initial waiting list. Basically, they have to start again. R22 describes this situation as 'appalling'.

However, in order to address similar problems which were identified at Prison A, R7 described a specialised post which has been introduced whereby all prisoners' hospital appointments and secondary appointments are managed by an appointments manager. While this system did not eradicate the need to forego appointments it did enhance the chances for patient/prisoners to remain within a coordinated system rather than turning up 'cold' at a new establishment. The prison in question has a relatively high turnover of prisoners and planning their care pathways within the prison estate was deemed to represent a specific need.

Staying with innovative staffing each PCT identified a need to create and develop a PHLM position. While initial partnership building at senior level was recognised as important for driving through reform, links also needed to be made at ground level and between ground level and senior posts. What is relevant here, however, is that while PCTs 1 and 3 made the appointment permanent (with the role at PCT 1 having explicit decision making power to establish a significant presence within the health care/security community in Prisons A and B), PCT 2's appointment was of a somewhat diluted nature.

To elaborate, R25, the PHLM at PCT 2, was a seconded position with a defined contractual tenure. The position also carried no decision making power. At the time of completing the fieldwork, R25 was about to leave to post and no appointment had been made to fill the vacancy. The response to the PCT 2's efforts to communicate its plans for ground level staff at Prison C were derided by R25 which led to deep mistrust of the PCT among the prison nursing staff. Local initiatives may therefore emerge but whether or not they are seen to make a positive difference or be significant indicators of successful 'bottom-up' policy creation and implementation not only

depends on identifying need (PCT 2 clearly did this) but applying adequate power, weight, resources and commitment to the innovation are also critical.

Another staffing initiative, this time related to *Health Promoting Prisons: A Shared Approach* and PCT 1's commitment to public health, involved the appointment of a health promotion specialist whose job entails working in the prisons developing and coordinating health education (Department of Health, 2002a). As observed at the prison health meetings which I attended the worker has strong support within the PCT and the role is line managed by the PHLM. At a more micro level, innovations within the innovation are evident. For example, the job has involved amending existing health promotion literature so that it may be understood by prisoners whose literacy skills are often negligible. Again, this development is a local initiative and, perhaps surprisingly, not part of national guidelines.

Not all initiatives are specifically local innovations however. In the following instance PCT 2 is adapting a broader policy strategy, one which was not specifically designed for the prison estate, but which they believe would be appropriate to the prison setting. As background, in the *Choosing Health: Making Healthy Choices Easier* White Paper the government introduced the concept of 'health trainers' (Department of Health, 2004). These health care professionals would be largely drawn from the communities in which they would work and be accredited by the NHS to have proven skills in supporting people to making lifestyle changes in local communities.

The White Paper calls for the introduction of these health trainers in the most deprived areas of the country from 2006 onwards, thus targeting 'areas of greatest need' (Department of Health, 2004, p.106). Led by the Director of Public Health, PCT 2 has taken up this idea and is working on introducing trainers to the prisons for which they are responsible as part of their general commitment to the public health agenda. Although in the early stages of planning it illustrates how local actors may creatively engage with existing national policy initiatives and apply them to meet local need.

Lastly, two ethno-depictions are appropriate here. Both concern the role of custody officers as street-level bureaucrats and came to light during informal conversations and guided 'tours' around the prisons. The first instance concerns a walk past an

inmate who appeared to be in his early 20s who was standing, motionless, in the prison garden. He was just staring into space as we passed and I asked the PO what he was doing. In reply the discipline officer said that he was working on the garden, to which I replied, 'but he's not really working on it'. The PO looked back at him and said, 'Oh, he's often like that'. This wasn't said in a particularly uncaring manner but rather as something which did not concern him directly in his work. It was someone else's responsibility. Moreover, this 'regularisation' of the prisoner's behaviour also came across as a technique for coping with his own inability to do anything to do anything about it.

Secondly, also reflecting a coping strategy, is an anecdotal account of a prisoner with a good record who was just six weeks away from release after serving a four year sentence who committed suicide. The PO was at a loss to explain why but still felt the need to rationalise what had happened in the absence of any indication that the inmate was in distress. After some consideration he came up with 'perhaps he could not cope with going back outside'. It seemed that this need to find some coherent explanation (which may, of course, have been absolutely correct) was an important mechanism with which to 'get through' his professional life. Indeed, this explanation resonates with a recurring 'theory in use' articulated at the resettlement prison about the anxieties associated with release and the seemingly paradoxical situation whereby the possibility of release at times results in poorer 'well-being' at a resettlement prison as opposed to a high security facility.

This finding is backed up by Crawley (2004b). Here, working in prisons is seen to raises issues which involve the investment of much 'emotional labour' and coping strategies to assist in rationalising the environments and work discipline officers have to do. Crawley also counters notions of prison officers as a homogeneous group and expands on prisons as working environments. Here, the need for officers to 'perform' the discipline officer role is seen as key to how they manage relationships both with the prisoners and between themselves. In addition, and with particular significance for how inmates see the prison environment, her findings suggest that the performance of 'presenting the self' for inmates contains a significant element of 'domesticity', i.e. behaving as if one was at home with attendant props such as the keeping of pets (Crawley, 2004a, pp.128-130). Importantly, Crawley's work also focuses not just on

the tasks Prison Officers are required to carry out but also on 'how they feel about their work and how they act when they are doing it' and suggests a strongly reflexive element to their professional lives (Crawley quoted in HM Prison Service, 2004, p.1).

## 7.7 Comparing prison health care and NHS Services

> 'Yeah, certainly you can see a GP within 12 hours; you can see a dentist within 3 days maximum. If you have a crisis you see a mental health nurse within 2 minutes, if you try to put a noose around your neck you have got a full team straight away, if you want to see a psychiatrist you will see them within 2 weeks…I mean Joe Public…' (R27).

The problem remains, however, of how do we know when broad equivalence has been achieved? Here I will provide evidence, based purely on respondent's evaluations, as to how well each organisation is performing in comparison to the other. Table 8.1 (below) has been compiled from an analysis of respondents' answers to questions which targeted the relative merits/achievements of the partner bodies. It has been divided up by PCT area for the purposes of comparison. As will be evident there are a number of areas in which prison service health care is out performing the wider NHS and this issue is discussed further in the final section in this chapter, mainstreaming problematised, which follows.

Table 7.1 Comparison of NHS and Prison Service health care as identified by respondents Area A

| **PS better Area A** | **NHS better Area A** | **Equivalent Area A** | **Diverse but changing in Area A** |
|---|---|---|---|
| GP appointments – quicker to arrange than in the wider community | NHS Direct, Walk-Ins. Better environment in terms of infrastructure and consumption environment, e.g. confidentiality | Health Promotion secondary to medical model in both | IT system to replace IMR/clinical records |
| Access to nursing – at times immediate access via Pos | An individual may self-medicate, self-care | Some prisons have methadone | Attitudes to inmates improving; decency in prisons |
| Psychiatry access – on displaying symptoms a prisoner will receive attention rapidly. Not so in the broader community. | NICE guidelines, Clinical governance – these are being developed in the prisons but still catching up with broader NHS practice | Different service levels across prisons, like post-code differences | Clinical governance |
| Dental services | Sexual health, availability of contraceptives | Smoking cessation (for caveat see Chapter Eight) | Better infection control services |
| Waiting times generally | Choice, administration, needle exchange | | Condom distribution |
| Health care screening | Upstream mental health | | Additional transfers to secure mental health facilities (but not enough) |
| | Better patient records | | Introduction of nurse led clinics |
| | Superior medicines (restrictions on some in prisons) | | Supportive ethos to substance misuse rather than punitive |
| | | | Mental Health |

Table 7.2 Comparison of NHS and Prison Service health care as identified by respondents Area B

| **PS Better Area B** | **NHS Better Area B** | **Equivalent Area B** | **Diverse but changing in Area B** |
|---|---|---|---|
| GP and specialist appointments | Dentistry (local issue, specific to HMP B1) | Treating HMP B1 as a GP practice; same appraisal system | Mental Health |
| | Quality and Outcome Framework (QOF) in place | Services also stretched on sexual health in the community | Trying to move towards NHS target system |
| | Auditing systems | | |
| | Resettlement prison; inmates registered with GP practice in the wider community which gives them better continuity of service on release | | |

Table 7.3 Comparison of NHS and Prison Service health care as identified by respondents Area C

| **PS Better Area C** | **NHS better Area C** | **Equivalence Area C** | **Diverse but changing in Area C** |
|---|---|---|---|
| GP, physiotherapy, optician, GUM, other specialist appointments quicker | None mentioned during interviews | Mainstreaming achieved before changes | Improvement in respect for prisoners but could still be better |

To sum up then there are a number of areas where prison health care is identified as being better than that available on the 'out'.[79] In particular, appointments and gaining access to services is often ahead of the wider community. This, however, is not without difficulties, for example resentment among Prison Officers and the dilemma raised by R12 about the allocation of resources in the context of the wider community.

In addition, as summarised in Table 7.1 improvements are being made in a number of areas such as mental health. However, there are also particular problems locally, for example, access to dental services at PCT 2 which are proving difficult to resolve in the context of limited budgets and PCT deficits. More broadly, mainstreaming itself may have unintended consequences which will result in more overcrowding, the classic 'victim of its own success' scenario. Alongside this, however, claims that

[79] Common prison vernacular for the wider community.

services are moving towards mainstream services were strong. Indeed, the very fact that all PCTs are now commissioning services is itself prima-facie evidence that mainstreaming is occurring.

However, it is also evident from the lingua franca of policy documents, such as '*broad* equivalence' and '*close* relation' (italics author's own) that recognition exists that actual equivalence is not possible given the constraints imposed by the custodial setting. Success may therefore be more realistically achieved in relative terms rather than any absolute state of provision. Also, it is often difficult to say whether some things are/have improved because of the PCT or were happening anyway because of the whole prisons approach, decency in prisons or more progressive regimes i.e. 'is it post hoc or proctor hoc?' as R7 put it. Furthermore, it is evident that provision of services cannot be seen in isolation from the environment in which they are delivered and the influence of the prison security regime as well as the detrimental effect on health of the custodial environment. These mean that the delivery of services is markedly different from what happens in the wider community.

Lastly, while the resettlement prison demonstrated the closest relationship to how services are delivered in the wider community, it was not possible to illustrate a clear linear relationship between category of prison and delivery of mainstreamed services. Instead a more complex picture emerged whereby it was more difficult to work towards mainstreaming in the Category B local prison (unstable, overcrowded, transient population serving relatively short sentences in a dated physical environment) than among the stable populations associated with the high security estate. In addition, Prison D's population had very different needs, for example, chronic disease was not a problem, mental health needs were less prevalent and mainstreaming was stated as having been achieved before the involvement of the local PCT, thus liking it more to the possibilities offered by the resettlement facility.

## 7.8 Mainstreaming problematised

Throughout the research, while respondents were consistently in favour of the mainstreaming principle, they also identified areas where the unintended consequences of mainstreaming were problematic. For example, three respondents (R12, R8, and R7 see below) expressed their opinion that one of the consequences of improving mental health care and substance misuse services in prisons was an increase in custodial sentences[80].

Due to the importance of these views for not alone individual prisoners but also the way in which the penal system in England and Wales is evolving I have quoted these sources at length:

> 'No, well, I think we have seen it a bit with drugs. I think we have seen some courts, both magistrates and crown sending people to prison because they need treatment for drugs and they know that those services are available in prisons to quite sophisticated levels and in the community they are patchy (R12)'.

> 'Care in the community which patently does not work and it has also been said that some Magistrates believe that people with mental health needs or general well-being needs in front of them, that there would be better care in the prison or better direct care in the prison, so they send them to prison whereas they might not otherwise have done so (R8).'

> 'We are getting better mental health services than we had and there is a fundamental risk in that and the fundamental risk in that is that as the courts hear about improved mental health services in prison [ ] are better they will send sentence people to prison because they are ill. Not, and we have had it, we have had people sent into prison because they are mentally

[80] As mentioned under Implementation Gaps, care needs to be taken with this finding. It is no more than the expressed *belief* of respondents and careful and difficult research would be required before it could be verified.

> ill. Sending someone in who turns out to be mentally ill, that's different. So that is happening (R7).

Ironically then, in order for mainstreaming to be achieved it would be necessary to cut back services in the prisons to levels of (in)efficiency more usually seen in the wider community.

Also, some respondents identified what they saw as the dilemma of providing services for prisoners when they were not available outside the prison walls. Two examples were given. Firstly, all inmates are given a health care screening on reception into custody. Thus, once a problem has been actively identified, under 'duty of care' ethics it must be treated. Secondly, it emerged that all female inmates receive cervical cancer screening, something which must be proactively requested in the wider community.

Indeed the possibility of this becoming a moral issue and one which the public may have a significant interest in was raised by R12:

> 'Engaging [the] individual in the community is more difficult. So you could end up in a situation where prisons became almost your perfect screening systems, you know, that you screen for all the things you would like to in the community but you have no mechanism in the community to do so. And you do not have the resource to do it and that is the other issue, whereas you could take the focus in prisons and say yeah you can and we can find the money for it. Increasingly equivalence will become a moral argument (R12).'

In short then, the issue of mainstreaming is not a straightforward one. It may have unintended consequences such as actually working to increase the prison population as well as result in resentment towards a section of society which is hardly popular in the first place.

## 7.9 Conclusion

In conclusion the above findings may be briefly summarised as follows. Firstly, while varying receptive contexts were identified they did not represent critical variables determining whether or not mainstreaming aims were pursued. For example, while PCT 1 and Prisons A & B proactively embraced the policy initiative and the relationship between PCT 3 and Prison D was somewhat less involved, this did not mean that each prison was avoiding taking on board the policy initiative. Rather, implementation was being addressed within different 'working accommodations' between stakeholders.

Secondly, overall, attitudes to mainstreaming were on the whole positive though some resentment manifested itself in the case of descriptions of POA resentment to prisoners receiving services better than they themselves received in to wider community. Also, a number of instances of explicit failure to implement policy were identified as well as issues which, though causing difficulties, were being addressed.

In addition, respondents described a number of challenges and barriers to implementation which ranged from externalities such as funding difficulties and overcrowding to internal matters such as the peculiarities of custodial settings themselves. Alongside this, the research findings also serve to illustrate how, at both organisational and personal level, service providers seek to deal with these implementation gaps through innovative coping strategies and resource management.

Indeed, it was evident that this is not a one-way street where a hitherto isolated health care service is always playing catch-up with a modernised NHS. There was clear evidence that, in some circumstances, services in prisons were better than those available to the wider community. This, in turn, was argued to have the potential for actually increasing the prison population as well as instigating a broader moral and ethical debate which could have consequences for progress made to date in the long run (R7).

Finally, none of these findings can be seen in isolation from an environment where security is prioritised over health care. The challenge for PCTs therefore is to provide

services as the organisation of secondary import in the custodial setting. The NHS took 60 years to get where it is today and achieving mainstreaming, i.e. bridging implementation gaps, is acknowledged by respondents to be an extremely challenging goal. In addition, the belief that incarceration is now being seen as a means to treatment raises serious questions about both the *raison d'être* of the prison service and how society is managing marginalised and vulnerable communities in the first place. These broader contexts will be explored more fully in the discussion chapter. For the moment I will next turn to findings more specifically related to the public health agenda which serve to highlight its marginalised position within the prison estate.

Chapter 8

# The marginality of a public health agenda

Having outlined the background to the public health agenda in Chapter Two, taken it forward into the prison system and discussed some of the current issues and criticisms I will now turn to the findings from the research itself about this issue. This chapter is set out as follows: I begin by highlighting the continuing dominant nature of the medicalised approach to health care in prisons. Next, specific barriers to introducing a more balanced health care system which includes more of the public health agenda are identified.

Noting that these impediments do not represent the full picture I then discuss a number of initiatives which are taking place which link directly to the upstream health care model. A other areas which may have been expected to be in the forefront of thinking on public health but remained either totally omitted or received only limited attention by interviewees are then briefly identified. Before concluding I address smoking cessation, mental health care and make some brief comments regarding the nature of the language used by respondents when discussing public health.

## 8.1 The dominant medical model

Firstly, it is important to point out that while the public health agenda was seen to score highly in respondents' aspirations (*Framework* average 7.9, Appendix 4) the dominant model both in terms of what was happening in health care generally and with regard to the public health agenda in particular was the medicalised/clinical model. Thus, for example, interventions such as immunisations were more in evidence than education on risk behaviour. However, this was seen to be consistent with the NHS more generally. As one respondent put it 'public health, not even in prison, even within the NHS is not always seen as a priority' (R21). That said, while others argued that it was 'very slow going' and that existing upstream mental health was 'not preventative in any way' (R14) it was also argued that the introduction of a public health agenda into the prisons was still 'in its infancy' (R3).

## 8.2 Barriers to implementing more comprehensive public health programmes

A common complaint received during the interviews was the issue of staffing. Firstly, it was stated that public health issues were seen as an adjunct to peoples' primary function, i.e. the delivery of reactive health care. This was justified by references to the substantial workload already facing staff. For example, one respondent described how nurses who spend their time 'running from cell to cell cutting ligatures off people' may have limited time for developing the upstream public health agenda (R5). The irony of course being that were an upstream agenda in place there may be less need to attend to such cases in the first place.

In any case, although staffing was a common problem, Prison D addressed the issue by having generic nurses specialise in one area of public health promotion, for example, sexual health. They then ran clinics on their specialised subject. This approach, however, was in sharp contrast to difficulties at PCT 2 where it was argued that the health care staff were uninterested in participating in training or public health meetings, whereas the nurses said they were treated dismissively by the PCT. R22 also bemoaned the lack of public health training opportunities and the difficulties involved in accessing those that were available.

On a more positive note while efforts to obtain funding for a specialist at PCT 2 & 3 were unsuccessful, PCT 1 appointed a nurse with a background in drug clinics in the wider community as the lead in introducing and coordinating health promotion activities. This move has led to a number of initiatives across the three prisons, often in tandem with co-workers from the wider PCT (R2). However, they also noted that it was sometimes difficult to get people from the PCT to go into the prisons because they are an intimidating place to visit (R2, R17, R27).

Looking at the broader policy questions then, is obvious that some client prisoners are receiving different services in different PCT areas. While this may be argued to reflect the so-called 'post-code lottery' of health care more generally it also calls into question the equity of devolving policy making to local actors. As respondents relate there is no clear national policy on providing specialist health promotion workers in

prisons with the result that universal access is dependent on an uncoordinated alignment of all PCTs to identify need, respond to that need, allocate funds, bring the prisons on board and develop the service. However, as we can see this is not happening.

It is therefore by no means clear that such policy will necessarily result in local actors developing solutions appropriate to local need. As such, devolution at least in this case not only means that local actors are free to make their own decisions; it also leaves them free not to make them. In the context of a health care policy which supposedly champions the upstream public health model, the absence of a national directive on the mandatory appointment of public health promotion specialists in each prison therefore appears both contradictory and neglectful.

Moving on from staffing and financial resources what other barriers exist? Well, beginning with the physical environment of the prison, the reality of life in cellular confinement is itself described by respondents as unhealthy (R7). A lack of fresh air, poor budget for food, restrictions on exercise all contribute to a detrimental physical living space. This is partly due to the design of prisons that still use buildings constructed in Victorian times but also to the security and control requirements of the denial of liberty. This has consequences not only for the need to maintain a routine to prison life but also for controlling how prisoners behave which, in turn, has consequences for the public health agenda. For example, making condoms readily available may assist with the prevention of BBVs but it may also increase risk as prisoners can put them to a myriad of uses such as hiding drugs and medication.

This tension between 'discipline, harm minimisation and risk reduction' (R7) also applies to the issue of having needle exchanges in prisons. A number of PCT respondents (R7, R2, R6) related how they believed they would be a good thing because they would reduce the risk of infection and passing on BBVs. On the other hand Prison Service staff argued that they would both increase usage and pose an additional danger to their working environment as prisoners may hide more needles which may be used as weapons or cause lacerations when searching cells. R9 also

stated that having them would legitimise the use of drugs and that was certainly not the role of prisons[81].

In addition, as R2 put it prisons do not like change. Releasing prisoners for extra activities both disrupts routine and will often involve the use of Prison Officers as escorts who may not always be available. Also, a number of respondents pointed out that attending health promotion classes has its own opportunity cost (R2, R24). This, I believe, is a very important point. The research shows that the public health agenda is, at least in some cases, being allocated time from other meaningful activities not *in addition* to them. For example, R24 recounted how it was very difficult for prisoners at the resettlement facility to attend smoking cessation classes because they would have to get time off from their jobs outside the jail in order to attend. This would mean losing income at a time when they will shortly be returning to the wider community with all the costs that that involves. A strong incentive not to participate therefore exists. Also, R2 illustrated how they would need to get escorts to accompany people from the gym so that they could attend smoking cessation. In these cases health promotion is a zero-sum game whereby gains on the one hand are set against losses on the other.

Furthermore, respondents point to the fact that most sentences are short-term in nature. Not only do many inmates pass through the prison system in less than six months, programmes may be interrupted due to transfers between prisons during that time (Department of Health, 2002a). Addressing need over such a limited timescale is not only difficult it comes second to the priority of initially stabilising the inmate, acclimatising them and looking after acute need. There are also practical difficulties; inmates may start a course but then be transferred to another prison, they may be released from prison at short notice, remand prisoners may be acquitted, appeals upheld and so on.

Staying with the particular nature of the prison environment, an individual's family and friends often contribute significantly to the person's sense of well-being.

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[81] However, needle exchange is what happens in the wider community (see mainstreaming findings in Chapter Eight).

However, visits notwithstanding, this informal support network is mostly absent in prisons both because of the nature of confinement itself and the manner in which prisoners are transferred/dispersed around the country (R7, R11). Obviously, this is a fact of prison life, but nonetheless it is a barrier to the more general aim of improving an inmate's sense of well-being.

Finally on the prison environment, the system is well documented as being overcrowded (Howard League, 2006, Prison Reform Trust, 2006). Providing what is seen as an additional service on top of the acute agenda is made much more difficult in these circumstances. R4 put it thus: 'the public health solution to many of the problems is to have less prisoners'. This is no glib statement rather, it is based on a belief that many, such as those with mental health issues and non-violent offenders, should not be in prison in the first place. More specifically, R6 pointed to the problem that a busy reception into a custody environment reduces the opportunity to proactively offer immunisation because the priority is control.

Next I will turn to the issue of participants' attitude to the public health agenda. While *Framework* illustrates a generally positive stance across professional types respondents went on to cite instances when colleagues either from their own organisation or partnership bodies expressed scepticism about the agenda. This negative attitude was also argued to apply to the public's views on prisoner welfare. Firstly, R2 related how Prison Officers were resentful of prisoners who managed to give up smoking. They were also seen as unhappy with services that prisoners get for free. More generally, R17 saw difficulties with getting both the public at large and also some of R17's own PCT colleagues on board because of perceptions that prison life should be 'difficult' and the 'why should they get services free when it is often more difficult for taxpayers to get them on the outside?' attitude. Furthermore, a PCT respondent found it difficult to sell the public health ethos to Prison Officers even though the agenda was setting out to 'improve prison life, not just the life of the prisoner' (R7).

Also, it was noted that some 'recalcitrant' prisoners straightforwardly did not want to know about the public health agenda and refused immunisations (R6). Interestingly, there was also anecdotal evidence that prisoners did not want to be treated with more

'decency' (R16). Prison Officers were not seen a potential 'buddies' and they wanted to keep them at a distance. Unfortunately, investigating the underlying reasons for this behaviour are beyond the scope of the research but it would seem likely that it has to do with the construction of group identity, maintaining one's position within one`s community and the construction of the 'Other' (Said, 2003). Whatever the reason, even though it was policy at Prison B for Prison Officers to make contact with two or three inmates for a short, informal daily chat this was resisted by some. Thus a progressive attempt which chimed with the 'decency in prisons' ethos was not entirely successful (see also Crawley, 2004a).

Moving on, R27 spoke of a climate of denial regarding sex in prisons. In this instance a senior Prison Service Governor refused to believe that it was possible for sexual relations to occur. There was therefore difficulty in getting condoms distributed at all in the jail. Also, there was a general feeling that other issues such as the PCT's 'core business' of providing reactive health care was more important. In sum then although *Framework* illustrated a positive attitude to health promotion and decency in prisons there remains a sceptical side to both health care and security professionals' attitudes to its provision. One went so far as to make an example of a comment 'what's the point?' as illustrative of attitudes in general.

Next, I will turn to barriers related by respondents which apply to the client group itself, i.e. the prisoners. Firstly, as is well documented the vast majority of prisoners come from socio-economically deprived backgrounds with associated conditions such as poor diet, low income, difficulties with literacy and problematic housing to which they are likely to return (Department of Health et al, 2002). In public health terms they are therefore already well 'downstream' when they are received into custody. Many respondents therefore highlighted literacy and education in general as being a major problem when trying to promote healthy lifestyles. Handing out leaflets with what R7 called it 'sonorous' information was therefore ineffective. Classes need to be tailored to the audience and this involved substantial work in producing course materials and the introduction of innovative teaching methods such as visual aids at Prison D where literacy was estimated at between the ages of 8 and 10 (R27, R20).

Furthermore, as R1 stated, it was not enough to get inmates to adopt a healthier lifestyle in the prison these programmes could only be seen as effective if they were followed through when the ex-offender returned to the community. Measuring their effectiveness therefore was very difficult (R6). In addition, some of the material under discussion is very intrusive and personal. For example, health promotion classes at Prison D met with silence when topics such as STDs, sexual behaviour and hygiene were brought up. This also extended to GP/client consultations in the case where the security regime believed that condoms should only be available on prescription if a risk of the transmission of infection was believed to exist. However, as R7 put it: 'Well, what do you do? Ask?' and what consequences may that have for the GP/client relationship in the future?

Other respondents pointed to the fact that lifestyles in contradiction of public health principles were the only discretionary behaviour tolerated within the prison walls, for example, smoking as a tool for dealing with stress. Indeed, there was also seen to be a contradiction with regard to the resettlement prison where increases in stress associated with immanent release and the anxiety of facing the 'outside world' made it difficult to give up smoking. In sum then the client group's circumstances pose substantial difficulties in carrying forward the public health agenda.

Next I want to turn to the issue of problems related to keeping what R3 termed 'stellar groups' on board. The difficulty here is maintaining contact between the central organisation, in this case the PCT, and other groups who may have some connection with public health. PCT 1 had real difficulty focusing on its 'additional' responsibilities when the 'core business' required so much resources and effort. People may turn-up at a public health meeting, for example, and talk about the need for proper housing for released prisoners but may not be seen again. Keeping all this activity in a manageable loop was proving very difficult. This was also seen as a major difficulty at PCT 2 where its management would have been a key part of the health promotion specialist role had such a position been funded.

Before concluding this section on barriers, a number of other points emerged from the research. Firstly, six respondents mentioned that lack of clarity on the issue from central government was an issue. Mostly, they were told, 'well, here is the *Health*

*Promoting Prisons: A Shared Approach* document, it chimes with the public health agenda, get on with it' (Department of Health, 2002a). They also stated that there was a limit to the amount of change that could happen at one time and that this agenda represented a situation where the partnership was being asked to 'run before it could walk' (R13). Services in the community such as the sex advice clinic on PCT 2's patch were already stretched, for example, and R18 found it difficult to see how in the context of scarce resources they could also allocate resources to the prisons when the need was so great in the wider community.

## 8.3 Moves towards the public health agenda

While the above section concentrated on barriers to change here I move on to highlight initiatives which are in keeping with the public health agenda, the mainstreaming goal and *Health Promoting Prisons: A Shared Approach* (Department of Health, 2002a). The one caveat to these programmes is that it is difficult to ascertain whether they would have been enacted or not if the PCTs had not taken on primary care in the prisons. As R8 stated with respect to decency in prisons 'it is an approach that would be shared whether or not commissioning had gone to the PCT or not.' In any case, the work which was identified by the research is as follows.

Taking medicalised interventions first, during the fieldwork Prison A was working on the introduction of a comprehensive Hep C screening programme and had seen its immunisation numbers increase generally over the past few years (R6)[82]. Looking further upstream each site outlined what health education was taking place in their institutions. Although literacy was regularly cited as problematic, innovative ways of teaching were being pursued such as producing visual aids (R27) and redesigning health promotion packs completely (R7, R2). Indeed, a number of respondents also pointed to the improving education and promotion options for staff as indicators of taking on board the public health/decency in prisons agenda (R21, R6, R13, and R27).

[82] While the other sites referred to immunisations Prison A came across as the most proactive in this area. That said, this could well be down to its status as a local training prison.

Turning to improvements in skills, as mentioned previously, PCT 1 has funded a specialist health promotion role whose job is initially focussing on BBVs and STDs. The position is seen by the PCT as crucial to driving forward the public health agenda and has also been welcomed by the prisons within their boundaries. Prison C, given its status as a resettlement prison is different again, as some prisoners can self-medicate (Category Ds) and its particular 'open' environment therefore has its own public health advantages such as more time out of cells. Also, PCT 2 has a visiting health promotion nurse who runs some clinics. Turning to PCT 3 here, as mentioned, nurses have taken on specialised public health subjects and run clinics dealing with their own particular area of expertise. In addition, cooperation between their CARATs team and the gym on a healthy lifestyle project were given as an example of engaging with health promotion initiatives in general.

Other improvements included better relations with Prison Officers when organising escorts for health promotion classes (R2) and some relaxation classes, 'but still a long way behind what should be available' operated by mental health teams (R14). Also, there was stated to be 'good' accessibility to condoms at Prison A as well as smoking cessation programmes at all prisons. Furthermore Prison D had strong links with a local higher education college to address issues such as literacy (R20)[83].

R13 also described how Prison A is trying to reorganise the population to enable more time to be spent on meaningful activities while R1 argued that the 'very popular' parenting programme at Prison B helps ameliorate prisoners' low sense of self-esteem[84]. Also, R26 stated that they had received an award for the quality of the diet in their prisons and were looking to pilot a 'health trainer' programme in accordance with proposals contained in the *Choosing Health: Making Healthy Choices Easier* White Paper for communities more generally (Department of Health, 2004).

Moving on to respondents' attitudes to prisoners themselves, a strong element of the need for individuals to take personal responsibility for their health and general life

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[83] It is important to note that the degree of success of some smoking cessation programmes was questioned by some respondents. Please see Section E below for a more detailed discussion.

[84] A more cynical view on the parenting service suggested that it was being used as a means to pass illegal substances between children and inmates. However, the point was also made that the service also had beneficial effects on inmates' families further illustrating the point that prisoners are not isolated members of society.

styles emerged from the research (see *Framework*, Appendix 4). Here, almost a third argued that imprisonment may be an opportunity for inmates to reflect more about their well-being. Another saw this more reflective thinking as happening because when they were in the wider community they were often 'out of their heads' (R2). Having undergone detoxification in prison they were argued to be in a much better state of mind to make positive life choices.

Thus some saw the sentence itself as thought provoking and this, allied to a new ethos of 'bringing health out into the prison and getting everybody involved rather than just me and the health care people' (R2) opened up possibilities with which some prisoners were engaging (R13). Lastly, R2 proactively sought out prisoners' opinions on what they wanted from health care and, although focussing on BBVs and STD initially, PCT 1 aim to take these into consideration when planning programmes in the future.

Turning more specifically to facilities, R26 stated that some 'embraced' the gym noting that their friends who had been in prison built up muscles and a fitter physique whilst inside[85].

> 'There is a cardiovascular type facilities in the main gym, a sort of annex with exercise machines and so there are actually good facilities for people to exercise. I mean there are prisoners who walk around who are very fit because they have made that lifestyle choice just like there are people who aren't and they exercise a lot and weight-lift a lot as well. There are plenty of people who do that and I think there is plenty of opportunity for people to do that. I don't think the constraints of our security or even being in prison stop people having a reasonably healthy diet and lifestyle if you choose to.' (R26).

However, resonating with the paradox commented upon elsewhere that behaviour which would be considered to be in contradiction of the public health agenda, such as smoking, is an important coping strategy for inmates, ethno-depictive evidence

[85] Some anecdotal evidence suggested that this may also be down to the use of steroids.

suggested that even the existence of a well-equipped gym may be problematic. In one instance while on a tour of the high security facility the discipline officer accompanying me showed me the gym and related the story of how a long-term inmate, a stereotypical 'Glaswegian hard-man', who was now growing old and no longer capable of lifting the weights he could in the past, was now the subject of bullying associated with this deterioration in strength (and thus his 'masculinity'). It is not therefore enough to judge the success of a public health related initiative by the fact that it is in existence. Rather, a more thorough-going evaluation which takes into account the complexities of inter-personal relationships *within* such programmes needs to be assessed.

Why though were some programmes being initiated and working in some places and not progressing so well in others? R13 pointed to the importance of the initial partnership building which took place between Prison B and PCT 1 as being very important in taking the agenda forward. There has also been something of a 'rubbing off effect' identified by R13 at Prison B whereby the very introduction of the PCT has helped to introduce more of a public health culture which dovetailed well with the whole prisons approach and an ethos of promoting decency in the prisons. In addition, complementing their partner PCT's approach R1 emphasised the importance of the appointment of a health promotion specialist who was responsible for identifying need, initiating programmes and coordinating those programmes in terms of bringing on board supporting personnel.

To sum up then, there are a number of instances where moves towards the public health agenda are underway. Higher levels of immunisation, improved health education, availability of condoms and the introduction of smoking cessation programmes were all given as examples of taking the agenda forward. Furthermore, local initiatives such as the appointment of a health promotion specialist by PCT 1, the development of a health trainer role at PCT 2 and the parenting project at Prison B all represent positive steps orientated to advancing the public health agenda in the prisons. In addition, prison itself (though we do not know if the prisoners would agree) is sometimes seen as a potentially positive experience where the opportunity to make healthy choices and reflectively engage with one's own well-being are also possible outcomes.

However, none of the respondents felt that what was being done was enough. The size of the task means that only some get immunisations, only some receive adequate education, only some will get a health trainer and so on. While not criticising the efforts of those who carry out the above work, the impression was that what is being done takes second place to the need for medical interventions and a distant third to the security imperatives. That said, something is going on with these agendas, work is being done. This in itself illustrates that it is possible to bring prisons more into line with the public health agenda in the wider community though what is being achieved appears to be occurring in spite of conditions in prisons rather than because of them.

## 8.4 Discourse of engagement

This section looks at the language used by respondents when addressing questions about the public health agenda. Illustrative of perceptions are the following descriptions of how interviewees felt about the public health agenda as applied to prisons and their employers' approach to it: 'challenging', 'we do what we can', 'moving slowly', 'trying to run before you can walk', 'sorry, I do not think it will happen'. Other issues, however, take priority, i.e. the medicalised health care model and security. Given the positive attitudes displayed generally to the idea of public health and its role in prisons it therefore appears that the actual reality of its successful introduction poses practical difficulties.

In addition, what is *not* mentioned by many respondents is interesting. For example, only three mentioned alcohol as a public health, or indeed, any kind of health issue[86]. Money was virtually absent. It may well be feasible to access a free gym but how many will have such facilities on return to the wider community? Furthermore, only one spoke about ageing and its consequences, only three spoke about diet and none about spiritual needs[87].

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[86] Alcohol related services in prisons include alcohol awareness programme, Alcoholics Anonymous services are available in 50% of prisons and CARATs teams also offer some services. Issues related to alcohol are also included on some offender behaviour programmes. Finally, the Prison Service Alcohol Strategy was launched in 2004 (Prime Minister's Strategy Unit, 2004).

[87] It is interesting, from a public health perspective, that high security prisoners at Prison B could earn the right to cook for themselves through good behaviour. However the quantity, method of cooking and types of foods they choose to cook were anathema to the public health agenda (R13).

Only three respondents raised the matter of staff welfare and just one of those identified specific on-site programmes which addressed them. In addition, issues such as housing, employment, and families were more often raised by respondents who were either from the Prison Service or who occupied more administrative roles in the NHS, such as clinical governance leads, than medical care personnel themselves. While that may be because of their professional focus it does raise some questions as to how deeply embedded the public health agenda stands in their consciousness or list of priorities.

## 8.5 Smoking cessation

A ban on smoking in enclosed public spaces is due to be implemented in England in 2007. Central to this exercise is the public health principle that someone does not have the right to endanger the health of others (Department of Health, 2006b). Places of work such as restaurants, public houses and offices where the public come and go of their own (relatively) free will are areas where this will apply. However, as pointed out by Goffman defining what he called a 'total institution' a prison is:

> 'a place of residence and work where a large number of like-situated individuals, cut off from the wider society for an appreciable period of time, together lead an enclosed, formally administered round of life' (Goffman, 1968).

The critical word for us here is 'enclosed' with the important difference being that inhabitants are not there of their own free will. Prisons are not alone places of residence (which directs us towards their 'private' nature) but also places of work (the 'public'), for example, for health care professionals, prison officers, cooks, builders and maintenance staff. The problem this raises is therefore how to legislate for this particular alignment of the public and the private. The solution, in common with similar bans in Ireland and Scotland as proposed at present, is that prisoner's cells will be considered as their homes, i.e. private (Pierce & Ford, 2006).

This raises a number of issues, however. For example, the role which tobacco plays within the prison estate as a currency, its usage as a relief from boredom and its use as an antidote to stress all need to be taken into account (Department of Health & HM Prison Service, 2003). In addition, there are questions related to the smooth running of the jail and the maintenance of control were tobacco to be unilaterally banned. On the other hand, prisons nonetheless appear to offer a good opportunity to put an important element of the public health agenda into practice by offering smoking cessation clinics and free NRT to inmates. This is also consistent with the mainstreaming goal whereby PCTs support smokers who wish to quit in the wider community. In addition, it fits with the upstream public health agenda with its aim of 'prevention better than cure' ethos. The issue is therefore, as with much in prisons, not straightforward.

How big is the problem though? Here it is noteworthy that smoking rates among the prison population are substantially higher than among the population generally. A national survey of prisoners in England and Wales found that 78% of male sentenced prisoners were smokers while 85% of remand prisoners smoked. This compares with levels of around 26% of men in the wider population. In addition, it is substantially higher than rates found by studies in deprived areas. For example, a study in a low-income area in Scotland found smoking rates among men of 56%. They are, however, more consistent with findings among groups termed as living 'extremely difficult lifestyles' such as the homeless who registered a 74% smoking rate (Department of Health, 2003a). Indeed, this also applies to findings from research on mental health which identified higher incidents of mental illness in disadvantaged areas compared with more affluent populations (Chartered Society of Physiotherapy, 2006).

The aim of this section is to outline both the successes and pitfalls of promoting smoking cessation in the host prisons as related by interviewees as well as raise questions which relate to how far mainstreaming such services can be effected in the context of the prison environment. Firstly, although one programme had been suspended due to budgetary issues at the time of producing their HNA, by the time the fieldwork commenced each prison was running a smoking cessation programme. It was also a topic to which respondents were highly sensitised and was seen as an important, practical and quantifiable example of how the public health agenda may be introduced into the prison environment. Indeed, in contrast to alcohol which was only

mentioned by three interviewees, tobacco use was raised during the majority of interviews in relation to questions on the public health agenda. As alcoholism is still a major issue for the prison population, this absence of alcohol in health care and security staff's thinking is indeed striking (Marshall et al, 2000)[88].

In any case, while varying degrees of success were recounted, a number of respondents also commented on practical issues which needed addressing. Firstly, cessation programmes take place over a twelve week period. This necessitates the provision of not only a room: it also requires that each individual prisoner can attend the class and also, where escorts are needed, that they are available. Achieving this coming together of resources and consumers was seen as an achievement in itself due to pressure on facilities, Prison Officers availability and the possibility that prisoners may simply not want to attend.

In addition, and in common with the government's own findings, there is the issue of the role which tobacco plays in prison life. It was seen by respondents as one of the few areas where an inmate could still exercise discretion (R11, R1), as a currency (R6), as a facilitating factor in the smoking of cannabis (R10), as a coping mechanism for stress (R24) and as an important element in the peaceful operation of the prison, i.e. as an agent of control (R10). While it was common therefore for respondents to advocate cessation for health reasons they nonetheless recognised that the nature of living against one's will in a highly restricted environment allocated tobacco symbolic importance as an expression of choice (agency) as well as a functional role, i.e. as an agent of control for prison authorities. Not only that but it also acted as an exchange mechanism (currency) facilitating an unauthorised internal market for prisoners. Furthermore, it was argued that smoking provides psychological support for inmates.

Indeed, a parallel exists here between ministerial thinking on smoking in socio-economically deprived areas and conditions in prison. As then health secretary, John Reid (somewhat controversially) put it;

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[88] This may be because alcohol is not generally present in prisons due to its bulk and the associated difficulty with smuggling. However, illustrating the inventive nature of prison life, R16 related that inmates have recently producing alcohol using Lenor fabric conditioner.

> 'I just do not think the worst problem on our sink estates by any means is smoking, but it is an obsession of the learned middle class. What enjoyment does a 21-year-old single mother of three living in a council sink estate get? The only enjoyment sometimes they have is to have a cigarette' (Reid, 2004).

Alongside this respondents related a number of disincentives for prisoners to participate in smoking cessation clinics. For example, they pointed to the fact that smoking cessation classes are being offered as an alternative to meaningful activities rather than as an additional life enhancing feature of prison meaning that some other potentially beneficial engagements suffer. Unless smoking cessation classes are provided in addition to other activities therefore there is at least some element of an opportunity cost to their operation.

Also, and possibly in a related manner, there may be alternative incentives for inmates to participate in addition to or in place of actually stopping smoking. For example, other activities may not be to their liking or attending a class in itself may relieve boredom or get one out of a cell for a period of time (R27). Furthermore, an ironic mainstreaming parallel exists between some workers in the wider community and inmates in a resettlement prison in that they would have to forego wages in order to attend smoking cessation clinics. Lastly, R24 identified the stress associated with imminent release from a resettlement facility as further disincentives to participation in cessation programmes.

What does this matter though if people are actually giving up and statistics may be produced to illustrate progress? This is where the more sceptical argue that inmates may manipulate the system by simply stopping smoking for a period before their carbon monoxide test in order to continue receiving NRT (R6) [89]. Indeed, another unintended consequence of having smoking cessation classes was pointed out by R2 who stated that Prison Officers were both resentful and sceptical about successes.

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[89] This test identifies whether or not the smoking cessation scheme participant is smoking or not. However, its effectiveness is limited and R2 stated that stopping smoking for 48 hours before the test would be sufficient to indicate that the person was not smoking.

While the thinking behind the scepticism has just been outlined, the resentfulness comes from prison security staff (R9, R12) who point out that they do not get the same service in the prison where they work in a smoking environment.

Furthermore it is difficult for them to access such services on the outside where attendance at clinics is difficult due to the very fact that they are in employment (i.e. unlike the inmates) and cannot so easily avail of PCT services[90]. That said, while a number of respondents acknowledged the difficulties of giving up smoking for prisoners (a 'brave choice', R6) they were still concerned about whether statistics collected on the numbers who claimed to have quit completely were accurate.

There are therefore a number of problems with the implementation of smoking cessation in prisons. Firstly, while the health improvement aspect is readily accepted by health care professionals they do not have the resources to run clinics for all those who want to attend (R27). Policy implementation here is therefore partial. Also, the idea of giving up needs to be sold to those who actually smoke: given the nature of the prison environment this is a very difficult task and is acknowledged as such by respondents.

In addition, turning to the consumers of the service, their participation is sometimes viewed with scepticism and resentment by some health care professionals and security staff resulting in a concern for the relationship between inmates and security staff. Lastly, though now being addressed, there was the question of why workers should have to work in a smoking environment when other citizens' right to be employed in a smoke free environment is being written into law? Indeed, taking the matter further, is not obliging a non-smoker to share a cell with a smoker officially sanctioned passive smoking?

Of course, it also needs to be recognised that this is indeed an excellent opportunity to introduce smoking cessation programmes in line with what is available in the community. A number of success stories were related. For example, Prison B has

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[90] That said, although it was not well developed at the time of the research, R21 related that they were looking at ways of providing smoking cessation for prison workers themselves.

established a successful protocol which was the subject of much interest at the Acquitted Conference I attended in 2003 and one respondent was particularly impressed with the numbers who had quit (R22) (Department of Health, 2003a). The concern, however, is that while prison offers a good opportunity to address high levels of smoking, the environment mitigates against successful outcomes and therefore requires innovative thinking which may not follow standard NHS practice.

## 8.6 Mental Health

Here, the sobering statistic that '90% of prisoners have a diagnosable mental health (including personality disorder) problem, substance misuse problem or both' serves to highlight the urgent need of the prison population for successful health care interventions (Home Office et al, 2002). This statistic is much quoted in the literature on prison health and points to an alarming issue of not only single diagnosis but multiple difficulties for many prisoners (see also Singleton et al, 1998).

In addition, it emphasises the scale of the challenge for health care professionals in prisons, security staff, families, friends and the general inter-personal relationships of these individuals. It also brings to mind the fact that prisoners are not cut off from society. The vast majority will eventually be released (Keavney, 2004). Alongside the question of whether or not this criminalisation of the mentally ill is acceptable the question of in what state they are returned to the wider community is central to the justification for incarceration in the first instance.

This section, however, only partially addresses mental health care in prisons and it does so from a limited respondent cohort. Although a number of attempts were made, including phone calls, the sending of participant information sheets to the Mental Health Care leads and exchanges of e-mails I was unable to gain access to Mental Health In-Reach teams. The reasons given were pressures of work and it is also seemed relevant that I was not allowed access to the main prison where the mental health team which provided services to Prisons A and B was based.

In addition, as prison psychology departments remain within the remit of the Home Office and are therefore outside PCT control they did not fall within the boundaries of

the original research proposal. That said, although only two respondents had some direct professional experience of working with mentally ill inmates on mental health issues the majority spoke of their experience of mental health and the findings from these interviews are outlined below.

Referring to the *Framework* analysis tool then, 16 of the respondents placed mental health at the top of their concerns when asked what they considered to be the main health care issue in prisons (*Framework*, Appendix 4). Those who did not prioritise it were either associated with institutions which would not be expected to house populations with a large proportion of mental health suffers, for example, the resettlement prison, or whose job descriptions focused them on particular areas of responsibility in administrative roles such as clinical governance leads.

Beginning with negative perspectives the issue of incarcerating individuals with mental health issues was raised by a number of respondents. In line with HMCIP Anne Owers' call for mentally ill people to be taken out of prison altogether, R7 and R15 questioned why such individuals were in prison in the first place (Seenan, 2004). The broader context of caring for mentally ill patients (and those with substance misuse issues) was cited as a causal factor in this as respondents related a deep concern that people were being 'dumped' into the prison estate as a result of a severe shortage of suitable facilities to care for them in the wider community (R12, R7). Indeed three respondents voiced their belief that the courts may be handing down custodial sentences precisely because standards of mental health care was improving in the prisons. While these anecdotal claims would need to be backed by robust supporting evidence it nonetheless identifies a worry among both health care professionals and security staff that this, at least in some cases, is what is happening (R8). R7 put it thus:

'The other concern I have is mental health problems. We are getting better mental health services than we had and there is a fundamental risk in that, and that is that as the courts hear about improved mental health services in prison [ ] they will send [ ] people to prison because they are ill. Now, and we have had it, we have had people sent into prison because they are

mentally ill. Sending someone in who turns out to be mentally ill, that's different. So that is happening (R7)'.

This view that mental health services are improving and indeed exceeding what is available in the wider community was backed up by a number of respondents. For example, R3 stated '…if you have a mental health crisis in Prison A, I will put a pound to a penny you will be seen by a specialist service more quickly in 9 times out of 10 than you would be here in the community.' (R3). This view was also expressed by R21 and R27. The question this raises for the research then is what this says about the mainstreaming goal. Indeed, in this instance, for broad equivalence to be achieved such access to services ought to be downgraded (or those in the wider community improved) for parity to be achieved.

The condition of mentally ill individuals which manifests itself in the form of behaviour which is subsequently criminalised and punished by the allocation of custodial sentences is therefore seen to be contributing to overcrowding which, in turn, is making it more and more difficult to deliver services. As respondents see it then, the criminalisation of the mentally ill (or providing environments which may be conducive to the development of mental illnesses) is resulting in even higher rates of self-harm, attempted suicide and suicide as well as overcrowding of an already overcrowded system.

Mentally ill behaviour which manifests itself in acts which are subsequently designated as 'crimes' also raises the question of whether or not the individual was actually criminally culpable in the first place. Of course, this issue is meant to be dealt with at sentencing or on reception into custody on remand but even if one takes the unlikely position that such adjudications are faultless, the question of why so many develop mental illness after admission to prisons is interesting to say the least[91]. As R8 and R11, both quoting R7, a GP working in Prison A, put it:

[91] As at July 2006 approximately 17% of the prison population were remand prisoners (NOMS, 2006b).

> '10-15 years ago [Prison A] was full of prisoners some of whom had mental health needs, now it is full of people with mental health needs some of whom are criminals (R7)'.

Furthermore, R11 stated that this is being exacerbated by the fact that it is more difficult to find a place in a secure mental health facility for those already incarcerated than it is to have a non-criminalised individual housed in the wider community. This, according to R11 was due to the fact that the individual in question was already separated from 'the public' and was therefore adjudicated to be less of a priority. In addition, R7 was concerned about the broad continuum of mental health issues seen in prisoners and said that the funding for Mental Health In-Reach teams was for 'severe and enduring mental illnesses' which eliminated a large proportion of the prison population because they were, in effect, not sick enough to receive treatment. As R3 stated:

> '…we have probably got an under-reported level of need around common mental health problems, so what hits us in terms of CPA is the severe mental illness but underneath that there is a large amount of low-grade anxiety, depression, relatively low-grade, neurosis and things like sleepless and so on (R3).'

In short, as prisons become more overcrowded the numbers of inmates with mental health issues is increasing and possibly at a higher rate than is actually recognised.

On the other hand respondents were also very positive about recent improvements such as the introduction of Mental Health In-Reach teams. Indeed, referring to successful partnership building with Prisons A and B the PCT's involvement in the introduction of the Mental Health In-Reach teams was used as an example of positive cooperation between the institutions. In addition, the Mental Health In-Reach teams were seen in all prisons as useful in improving links with outside agencies such as the Care Programme Approach (CPA) in the community.

Also, the very presence of Mental Health In-Reach teams was seen as an educational tool for Prison Service staff as well as have a positive effect by providing

'professional comfort' to health care staff and security workers who were untrained in mental health issues. For example, R13 described how extreme, 'abnormal' or disruptive behaviour displayed by an inmate may well be seen as a challenge to authority rather than the manifestation of an illness. This may then have disciplinary consequences for the prisoner which would have been wholly inappropriate.

Other positive developments noted were the building of a new Dangerous and Severe Personality Disorder (DSDP) facility at one of the host prisons. However, it was also noted that the unit quickly became a magnet for transfer requests from other jails: again an indication of the huge demand for but limited supply of mental health care services.

To sum up then, respondents related a situation where some progress was being made but which was nonetheless characterised by massive and perhaps under reported need. Interestingly, some services such as having immediate access to psychiatric services (R3) are described as actually better than those available in the wider community, with the Mental Health In-Reach teams coming in for substantial approval. The move towards mainstreaming must therefore be acknowledged as producing positive outcomes. However, the widespread concern demonstrated by interviewees that prison was an inappropriate place for treatment in the first place indicated that these efforts may be no more than crutches propping up a failing system.

In the context therefore of a punitive criminal justice system, a growing prison population and a lack of adequate facilities for those with mental health care needs outside of prison, how failing to tackle these issues fits with mainstreaming goals is difficult to envisage (see Newman on 'popular punitiveness', 1997) . Also, with regard to the public health agenda there was virtually no evidence of upstream mental health provision such as stress coping clinics available. While respondents point to improvements, the question is would individuals in the community be subjected to such conditions as part of their treatment regime?

In conclusion, although progress is acknowledged, respondents state that mental health services in the prison estate fall well short of what is required. In order for those services to be improved a number of areas need to be addressed. Firstly, the

progress made by the Mental Health In-Reach teams must be built on through the application of additional resources. Furthermore, they need to be provided with a wider remit so that lower level mental health illnesses as well as upstream preventative care are included in their work. In addition, the question of whether or not custodial sentences are being handed out for the reasons mentioned above is a very controversial issue but one which seems to merit investigation[92].

Turning to high level need, the demand for places at the DSDP unit mentioned above illustrates inadequate provision right across the estate for patient/prisoners thus classified. Also, noting the belief that mental illness is actually under-reported, a comprehensive audit of mental health is required so that resources may be planned accordingly. Lastly, the broader context of a lack of appropriate non-penal mental health care facilities in the wider community, overcrowding and the debilitating nature of the prison environment itself must also be included in planning for an area of prison health care which respondents identify as being of critical importance.

## 8.7 Conclusion

Before concluding, it must be acknowledged that other departments besides those under the aegis of the PCTs offer services which link in with public health. Prisons, for example, have education departments, libraries and psychology departments (which are funded by the prisons not the PCTs), all of which contribute to the public health agenda. Specific instances of links between the PCTs and these agencies were, however, rarely mentioned by respondents. The findings here could not therefore be seen as, and are not presented as, a complete picture of what is happening in the prisons.

To conclude then, firstly, it needs to be pointed out that respondents with a long history of service in the prisons were keen to illustrate how much worse things were with regard to the public health agenda in the past. As R12 put it;

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[92] This issue is one of a number raised under calls for further research in the final chapter.

'There was not a health strategy there was a prison health section, we had a medical officer for the Prison Service and there were about 40 people who worked in the section and policy was directed by 'Dear Dr.' letters but most of that, as I say, was about dealing with the problem with the prisoner when the patient presented themselves so we did not have health promotion classes, we did not have testing and screening programmes and I don't think that picked up, it seems strange to say, in the last century (R12).'

As illustrated above then work is being done in this area. However, making significant advances faces a number of substantial barriers. Firstly, the prison population, in public health terms, is already well downstream when it encounters the public health agenda. Inmates come from mostly deprived socio-economic backgrounds with the associated dietary, lifestyle and deprivation issues. Assisting them to make better lifestyle choices and then carry those through when they return to the environment which produced them in the first instance is a challenging task indeed.

Then there is the prison environment itself. A number of issues are important here. Firstly, the attitude of some Prison Officers was questioned as they were argued to resent care given to prisoners which they found difficult to access themselves. In addition, inmates do not have the informal support offered by those close to them as is common in the wider community. Next, cellular confinement, limited exercise and so on are in direct contradiction of the public health agenda. Indeed the very existence of prisoners in overcrowded conditions means that the amount of health promotion that can be done is more limited as are the number of immunisations which can be administered. The argument that prisoners as a population cohort are more accessible for health care services than they were when in the wider community just because they are in prison therefore only carries limited weight.

Next, there is the prioritisation of security. This in itself has implications for limiting initiatives such as needle exchanges which could have a positive impact on BBV transmission but cannot be introduced: a clear difference from what happens in the wider community. There is also the obvious question of where resources to fund the

agenda come from? As illustrated above, PCT 1 appointed a health promotion specialist with positive results. PCT 2 wanted to but needed to prioritise resources elsewhere. As is to be expected many other areas are competing for these monies including the general public. Indeed, one respondent questioned smoking cessation funding when other areas were needier. Furthermore, there is the issue of the zero-sum game played out between public health activities when there is limited meaningful time available. As illustrated above participation in one programme may mean withdrawal from another. Lastly, there is the not inconsequential matter of whether or not prisoners actually want to engage with the service in the first place.

In short, from the research sites I worked in then, while all agreed that the public health agenda is worthwhile, that decency in prisons was a laudable goal and the whole prisons approach was the way forward, the practicalities of delivering the upstream public health model within the context of an overcrowded, under resourced system, which services a community already well downstream and possibly close to the tidal estuary in public health terms, means that it presently occupies third place behind security imperatives and the medicalised health care model. The irony, however, is that there are few areas where it is more needed.

It is not enough, however, to leave it at that. As illustrated in Chapter Seven under receptive contexts, policy initiatives and goals are not introduced into a vacuum. Organisational environments are comprised of factors such as alternative power structures, differing professional imperatives, varying infrastructure, competing interest groups and diverse *modus operandi* all of which emerged within different historical contexts and external influences. In addition, the weight in terms of the influence of each on operational outcomes will change over time. Put simply numerous variables come together at a particular time to produce an outcome within space.

In policy terms the degree to which initiatives are successful will therefore depend on the peculiarities of each environment as well as the relevance and robustness of the programme in the first place. Understanding the character of these environments as well as how they are managed is therefore of great importance in the process of policy

implementation. It is therefore to how we may understand this complex picture that I will now turn beginning with an exploration of what is meant by operational culture.

Chapter 9

# Organisational culture and managing change

> 'Organisational life…is pluralistic, multi-faceted and multi-layered, inhabited by people who have differing perceptions of 'reality' and where there are inevitably complex patterns of cause and effect. It also accepts the dynamics of changing, as planned changes confront time delays, unintended consequences and successive redesign of interventions' (Wilkinson, 1997, p.509).

As argued in Chapter Seven the character of the environment into which a policy initiative is introduced is of central importance in producing outcomes. Essentially, implementation becomes a dialectic process whereby the policy message needs to be communicated and acted upon through an active dialogue between the key actors. However, given the complex nature of not alone each organisation but each institution within each organisation, policy outcomes are unlikely to be uniform. In terms of noting both facilitating factors and barriers to implementation it is therefore important to first examine the 'culture' of both the NHS and the Prison Service as it is within the contexts of these complex organisations that policy is delivered.

Noting the complex nature of 'organisational life' outlined here by Wilkinson I will begin by providing an overview of the literature on organisational culture and change. The primary source for the material is Prosser et al (2006). I will start by looking at perspectives on organisational change and the contexts (external and internal) within which it occurs. The discussion will go on to differentiate between different types of change, for example, change as a continuous process and change as a one-off event.

Next, I will turn to organisational culture beginning with the debate over what constitutes culture in the first place before moving on to outline the theoretical divide between an organisation as *having* a culture and the organisation as being a culture in *itself*. Issues such as leadership will also be addressed, albeit briefly. Throughout, the complex nature of change and culture will be stressed. The ideas outlined here will then serve to inform the empirical findings section which follows.

Beginning with perspectives on change Prosser et al (2006) identify three aspects of change:

1. Changing (a continuous process) and change (a one-off event).
2. The context of change.
3. The complexity of organisational life.

The text then goes on to outline a number of points about change which may be of relevance for the research. Firstly, change is argued to be an ongoing process which may take years before an impact may be identified. Also, change may be defined by different actors differently and how well 'resources, activities, outputs and outcomes' match policy goals is difficult to measure because the 'productive function of many public services is unknown' (Prosser et al, 2006, p. 24).

Furthermore, what exactly constitutes change may vary over time. For example, the linearity of change is questioned and progress may become a consultative issue based on pilots and interpretations of events from the perspectives of 'losers and winners' (Prosser et al, 2006, p.25). This rationalisation process may also yield unexpected results (see Morrison on Weber, 1997 on the unintended consequence of apparently rational action) whereby 'one set of paradoxes' is swapped for another (Prosser et al, 2006, p.25, Kimberly & Quinn, 1984).

Prosser et al also comment on the 'multi-dimensional' nature of change and the different challenges it offers. For example, managing developments in IT may generate different issues from amending management structures. Furthermore, it was found that the more change is associated with 'management structure and process issues, the greater the difficulties in introducing change because of their heterogeneous and unspecified nature' (Hennings et al, 1991, p.378). Here, the focus is on particular concerns over management change which may be viewed suspiciously by other staff. For example, attempts at improving public services by NPM may be interpreted as threats to public service employees' jobs and understandings of their roles resulting in resistance. A number of factors therefore affect change which means

that major change at times is 'incoherent, complex and chaotic, with shifting rationales and challenges' (Prosser et al, 2006, p.25).

In addition, change is argued to be influenced by factors internal to the organisation as well as variables which originate outside the boundaries of organisational administration. Following Dawson (1994) these are:

Table 9.1

| **External context (environmental factors)** | **Internal context (nature of the organisation)** |
|---|---|
| Legislation | Organisational culture |
| Social mores | History |
| Technological innovations | Operating structure |
| Political developments | |
| Economic developments | |

The external and internal contexts of change, adapted from Dawson (1994)

## 9.1 External context

Taking the external context first the environment in which the organisation operates has 'long been recognised as the key contingency which generated the need for organisational change' (Prosser et al, 2006, p.14). It is therefore important to note that change occurs within environments which themselves are subject to change. For example, in the context of the prison health research, government policy and court interpretations of sentencing directives will have an influence on the number of people in prison which will in turn influence planning decisions and the delivery of services. On the NHS side guidelines on modernisation, for example, mean that the broader NHS is also changing at a time when it is taking on new responsibilities within the prison estate. Change is therefore not taking place in isolation but within wider amorphous circumstances.

However, not all aspects of an organisation will necessarily change because of a particular initiative. Some may remain static while others need to adapt; the 'continuity and change' model described by Rawlings (2003, p.17). Here the author

goes on to describe the interplay between the two as being at the centre of all 'basic constitutional development' which is then argued to be extended to all organisational and managerial issues. Indeed, turning to the evaluation of change Pollitt et al (1999) point out that most audits of public service initiatives 'remain[s] processional and compliance driven' as opposed to focussing on to what extent original policy goals have been achieved (Pollitt et al, 1999, p.56).

There is also the issue of how we understand context for it seems reasonable to assume that a Prison Service employee will have a different perspective on prison life than one from the NHS. For example, the 'public service' ethos of a Prison Officer may include considering elements of the system as both punitive and geared to rehabilitation, whereas the NHS medical professional will concentrate on an individual's health. It is also therefore necessary to consider the existence of differing understandings of context, themselves mediated through personal experience and organisational and professional paradigms.

Another aspect of introducing change is elaborated on by Christensen (1997) who differentiates between 'sustaining and disruptive innovations' (Christensen, 1997, p.67). The difficulty identified here is that 'radically new ideas' may not be adopted because they may not be clearly understood. As we shall see from the empirical findings this has particular resonance for the introduction of mainstreamed NHS services into the prison setting. Similarly, individual resistance may occur when 'theories in use' developed by managers charged with implementation do not fit with new paradigms (Argyis & Schon, 1978 cited in Prosser et al, 2006, p.15). These views were identified as being stubborn and resistant to change even when 'demonstrably wrong' (Johnson, 1990 cited in Prosser et al, 2006, p.15).

## 9.2 Internal context

Turning to the internal context Prosser et al (2006) begin by making the point that it is more difficult to effect change in large, more complex organisations where the range of tasks undertaken and the geographical spread is great. At first glance this may be a model for both the Prison Service and the NHS. However, as the responsibility for affecting change has been delegated to local areas, many of which are characterised by

one PCT commissioning in one prison, then this may not be expected to be of as much of an issue. On the other hand, positive outcomes will depend very much on the efficacy of local partnerships.

In addition, the literature suggests that large organisations tend to be highly incremental and pluralist in their decision making (Ashburner et al, 1996). This is then argued to slow down change and a situation characterised as 'muddling through' is predicted (Lindblom, 1959). However, decision making in the Prison Service takes place in a much more hierarchical, command structure. It would therefore be expected that its less consultative nature may produce quicker action on the ground. On the other hand, the NHS operates via 'directives' and 'guidelines' with significant local managerial and practitioner autonomy in how these are actually implemented which, if the predictive model is correct, would indeed lead to slower, more step at a time, policy implementation. In both cases 'the intra-organisational context' is seen as important.

The final point I wish to make about internal contexts takes us back to Lipsky who, though concerned primarily with the perceptions of lower level operatives, argues that theorising about the organisations' role is argued to apply throughout the organisation. Thus, Chief Executives and Governing Governors may be expected to have their own view on their institution's role within broader legal and policy frameworks (Ferlie et al, 2003). For example, NHS directives on the administration of methadone differ from the approach taken by many prisons and this will reflect how each regime views the strategic purpose of the organisations for which they are responsible. Thus internal contexts and external goals are also further mediated by the personal perspectives, beliefs and goals of senior executives working in each organisation.

To summarise this section then it is clear that whether or not organisations change, to what extend change is effected or resisted and what outcomes policy decisions have is a highly dependent matter. Expecting full implementation of social policy right across the board appears then to be an unrealistic goal. Different environments are argued to produce different outcomes. The question then becomes to what extent mainstreaming can be achieved? Or, have outcomes been more akin to Hood's description of the evolution of cricket in the Trobriand Islands where the rules as introduced by

Methodist missionaries evolved to include numerous additional players and umpires as magicians? (Hood, 2001).

In order to explore this further I will now move on to describe what emerged from the research as the peculiar cultural traits associated by respondents with each partner body[93]. Beginning with a brief discussion of what is meant by 'culture' in the first place, the chapter then turns to findings from the research which are specifically related to the issue of culture and which I argue have a direct influence on mainstreaming outcomes. In the final section I return to the arguments outlined above on organisational culture and the management of change and question the validity of their conclusions in the context of the research findings.

## 9.3 Culture

Firstly, 'culture' itself is a difficult concept to pin down. Indeed, Alvesson (2004) states that there is no agreement as to its meaning. How then can we speak of an organisational *culture*? From the literature it is evident that while some emphasise the importance of maintaining it as a necessarily vague term (thus allowing one assumes for emergent forms, see for example, Smircich, 1983) others focus on shared 'meanings, values, beliefs, myths, stories, as well as the rites, rituals and ceremonies that abound in organisations' (Frost et al, 1985, p.45).

While the definition of culture is therefore disputed the methodologies practised in seeking to obtain an understanding of it have also been varied. For example, an approach which seeks to identify how members utilise shared values, signs and symbols to understand each others' allegiances to a 'culture' takes a symbolic interactionist approach whereby culture is acted out in public (Blumer, 1969). For example, symbolic power such as the holding of keys may be seen as important in the subordination, ordering and operation of daily life in the prisons. Importantly, Frost et al (1985) also propose that culture and how events are interpreted are influenced by the groups within which people live, i.e. their communities. In short, this view sees

[93] This returns us to the fifth research question about management of change and the identification of the partner organisations as 'different'.

culture as something the organisation *has*; 'the social or normative glue that holds an organisation together' (Smircich, 1983, p.344).

Alternatively, culture is held up as a means for understanding organisations, it is what the organisation *is* (Bate, 1994). Here, the approach focuses on the unconscious process of people creating their own worlds through an organisational reality which places particular, organising, meanings on events and interactions (Weick, 1979). Ideally it should be one culture, all pervasive and consensual which will be expected to create a more competitive and successful organisation (Newman, 1996). It is therefore seen as critical to strategic management as a malleable tool for achieving organisational efficacy. In this view an effective leader may create a unifying organisational culture[94].

However, it is also argued that organisations are not the stable mono-cultural entities that company mission statements, share prospectuses and CEO statements would have us believe. As evidence Prosser et al cite work by Peters and Waterman (1995) based mainly on statements made by senior executives about the state of their companies which gives the impression of coherent cultural environments are the norm. However, Riley (1983) states that:

> '…increasingly people are warned that organisations are not the rational monoliths they appear, but complex mixtures of game-playing, rule-following, self-promotion, competition, and hidden agendas' (quoted in Prosser et al, 2006, p.21).

It is also interesting that these competing or different cultures are not necessarily unproductive. Indeed, as Garratt (2003) points out they may have functional properties as instigators of innovation and act as barriers to organisational stagnation.

Another layer of cultural strata are the professional groups within organisations such as the POA which will also have their own agendas. Here, Prosser et al (2006) point

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[94] Indeed, the role of the Governing Governor and how they viewed the health care changes emerged as an important variable in taking forward the mainstreaming agenda (for a more detailed discussion of the literature on leadership see Prosser et al, 2006, pp.26-30).

out that those cultures may develop in different ways with some professionals more likely to comply with professional standards than others. To the extent that they do, professional sub-cultures somewhat equivalent to street level bureaucratic practices, may develop. However, alternative and sometimes subversive counter-cultures may also emerge.

Furthermore, seeing culture as a socially constructed entity, long-standing members of an organisation will have different values, histories and meanings which must be passed on to new generations if they wish to recreate and maintain the established culture. People working in different geographical locations but working for the same organisations (which seems to fit the model the research is looking at) may therefore develop different cultures because of the variance in location (Hood, 2001).

Using the example of the Welsh Assembly, Prosser et al (2006) make the point that the Welsh Office had been in existence for over forty years and had therefore built up a significant cultural reservoir which, in common with other organisational cultures of long standing, may be strong on performance but weak when it comes to implementing change (Metcalf & Richards, 1984). Indeed, they go further to argue that new approaches will be 'filtered' through these older belief systems thus generating 'systems of disbelief' which will, in turn, act as barriers to change in themselves. Lastly, Prosser et al (2006) place the organisation within the wider community (or 'sets of communities') of which it is a part. Again, these will influence the organisations' culture, for example, how the NHS is meant to be more responsive in offering consumer choice in the context of viewing the patient as a customer (Department of Health, 2000).

This then seems to suggest that not all cultures are simply the domain of senior management to mould at will. There are competing voices, counter-cultures, professional sub-cultures, historically held norms, cultures of disbelief, client expectations, legal structures, policy directives and so on all of which influence what may be described as the organisational culture. How much this is may be held to be the case in the hierarchically structured prison environment will be elaborated upon in the cultural findings section which follows this.

The approach I have taken in seeking particular organisational cultures is to identify from the interviews commonalities in discourse as well as empirical examples which, when set in opposition, serve to highlight difference and draw out characteristics and beliefs which may not be found in the partner organisation. In that way, i.e. through a process of differentiation, models (ideal types) of cultural difference will be identified (see Burger on Weber's 'ideal types', 1976). In addition, where common approaches or belief systems have been evident these will also be commented upon as part of a nascent partnership culture which may be emerging dialectically but which may also at times be unilaterally driven due to the prioritisation of security.

In conclusion, it is apparent that the related matters of change and culture are complex. Change may be non-linear, dependent on both factors external to the organisation and internal variables. In addition, it may be a 'one-off' development or proceed in an incremental manner. Furthermore, it is seen as multi-dimensional encompassing and demanding flexible responses to different 'change types'. For example, changes in management structures in contrast to structural modifications. Linked to this is the issue of organisational culture/s which has its own complexities as outlined above. The above perspectives will now be used as aids for exploring the empirical evidence.

## 9.4 Findings

Coming to the research from the outside I viewed the NHS and the Prison Service as identifiably different organisations. It was a phrase which originating in my limited knowledge of how prisons operated, evolved through a sceptical viewing of media representations, *ER* vs. *Porridge*, *Bad Girls* vs. *Jimmy's* and the like, serious news stories about overcrowding, rioting, and books both fictional (Bunker, 1994) and sociological (Goffman, 1968). However, I had never been in a prison.

How then did I *know* there were differences aside from what impressions I got from the above? I had made the assumption without any personal experience. It was something I took for granted. What differences was I talking about? Apart from the denial of liberty (which may also apply in the hospital setting), coercion of abode (but you are told which bed you occupy in hospital), the abdication of many aspects of

self-care (you can't cook in hospital), restrictions on visitors but there *are* certain times for food, for exercise, for visits…hang on…this was not progressing as simply as I originally believed.

Could not examples of many aspects of prison life also be found in a hospital setting? For example, segregation, isolation, relinquishing responsibility for the self to professionals and professional expertise, loss of independence, separation from family, friends, surveillance (external and internal) and the very personal experience of observing the outside world through visitors stories, the media and the room window without being able to participate in it all seem common ground for individuals in each institution.

While this is obviously not to raise the idea that they are identical organisations or to regurgitate Goffman, nonetheless it does raise relevant issues for the research. For example, how would any differences that exist affect the possibility of mainstreaming health care services in the prison estate? What about the 'culture' of each organisation and their decision making processes, how may they affect outcomes? Who has most capital when it comes to driving the agenda forward or indeed blocking it? It therefore seems even more important now to identify these differences as they are likely to have a direct effect on the degree to which mainstreaming may be advanced.

While aspects of prison such as the custodial environment and the prioritisation of security considerations have been dealt with elsewhere, here I will concentrate on outlining findings which pointed to two very different cultural organisation styles. I will begin by describing cultural differences, move on to discuss what impact this has on the mainstreaming agenda, inter-personal staff relations and partnership working before concluding with a discussion of what this may mean for the mainstreaming goal in general.

## 9.5 Different organisational cultures

The most obvious difference between the two entities was the contrast between the hierarchical, 'command and control' model (R21) associated by respondents across professional divides with the Prison Service and the more 'collaborative and diffuse' character of NHS decision making (R13). Indeed, a number of interviewees, again from both sides, likened the Prison Service to a military or naval model where PSOs and PSIs are issued centrally, mediated through the local 'admiral' (R25 on the role of the Governing Governor, the 'No. 1', 'Sir') and strictly followed by Prison Service staff in a bureaucratic, structured manner.

The language used is also instructive. Prison service staff are '*officers*', the system is '*regimented*' (R13), other staff are '*civilians*' (R10) while R12 'joined the *service*' (italics author's own). In addition, the NHS receives directives and guidelines while the Prison Service operates on orders and instructions. Interestingly, one respondent (R17) characterised the prison environment as a 'masculine/male' one which contrasted with the 'female' milieu of the PCT office where she worked. The following descriptive model has taken this analogy further, stereotyping each organisation as 'gendered' for the purpose of demonstrating difference.

Table 9.2 Organisational Duality – Gendered Institutions?

| Prison Service (Male) | NHS (Female) |
|---|---|
| Army/Navy/Admiral/Captain/Sir | People/civilians |
| Surnames/numbers | First names |
| Hierarchical | Dispersed power |
| Routine | Flexible |
| Discipline | Flux |
| Instructions (PSIs) | 'Directives' |
| Orders (PSOs) | 'Guidelines' |
| Segregation | Integration |
| Life limiting | Life enhancing |
| Monologue | Dialogue |
| Exclusion | Inclusion |

In addition, respondents felt that there was little or no culture of personal improvement, i.e. proactively looking for training, in Prison Service health care staff's thinking prior to NHS involvement whereas the culture in the NHS demanded that employees look to gain more skills as their career progresses and, indeed, for the purpose of career progression.

Furthermore, the decision making process in the NHS was characterised as 'diffuse' and 'consultative' with the need to involve an array of professional bodies in the process as important in achieving a form of consensus (R13). Here, participants expressed the capacity to question decisions and also display some personal initiative. They felt that this was not possible in the prison and people who tried to make a difference either ended up leaving or were 'ground' down by the system into a state of resigned compliance (R25).

It was suggested that these different approaches could lead to difficulties in meetings between the two sides. For example, R25, a PCT employee, leading a brain storming session with Prison Service staff, related how this technique may produce interesting outcomes and a free flow of ideas in an NHS setting but when introduced at a meeting with the Prison Service produced nothing from lower ranking staff until a Governor made their feelings known. The Prison Service staff then proceeded to agree with the Governor. Also, whereas decisions may be challenged in the NHS (at least to some degree) this would not happen in the Prison Service. As one respondent put it 'nothing happens in the prison without the Governing Governor's say so' (R10).

This, however, is not to say that there was no resistance to change. Operationally, the running of the prison followed the No. 1's directives, however, on the health care side the PCTs encountered difficulties relating to health care workers (many of whom were ex-NHS employees who left the NHS because they saw it as a poor employer) either resenting the fact that they were now obliged to return to the NHS or as being seen as an unnecessary additional 'master' (R27). On the other hand, the NHS saw the prison as 'not liking change', or 'outsiders with new fangled ideas', i.e. 'we have always done it this way, why do we have to change now?' Relating this to Pawson on reasons and resources the PCT was left with the challenge of demonstrating why health care needed to improve (Pawson, 2002, 2006).

Resistance was also seen to take some peculiar forms. For example, some HCOs said they did not want to move over to the NHS at Prison B because they would lose their boot allowance, a traditional extra introduced in the past as compensation for poor wages. This, however, was seen by the PCT as merely an excuse, the real agenda was not to become (re)employed by the NHS. Indeed, this issue of using time as an indicator of progress was also prevalent in NHS respondents' discourse describing prison variously as: 'like walking into the 1940s', 'looking at GP practices 10 years ago', and 'way behind the times'.

Turning to the public health agenda, NHS respondents while acknowledging some improvement were still concerned about a culture of denigrating prisoners via techniques such as only referring to them by either their prisoner number or surnames, for example, 'we do not have a Mr Smith here, only Smith 1234' (R27). The issue of how somebody was addressed in the workplace provided further contrasts and meant an additional adjustment PCT employees had to make when entering the prison environment. For example, R17 observed how she would refer to her colleagues in the NHS by their first names but it was different in prison with the use of terms such as 'sir' common. Respondents stated that they needed time to 'get their heads around it' (R2) and this period of assimilation was compounded by errors made by NHS staff on the security side in the initial stages. Indeed, this constant need to think security first, treatment second was another significant cultural hurdle which remains an ongoing issue.

Staying with the issue of contrasting environments respondents pointed to the attitude among Prison Service security staff that health care was 'separate', 'down there', 'ah health care!' followed by a dismissive gesture (R2, R14). It was seen (at least in some cases) as secondary, the poor relation and as such experienced poor relations with security staff. Given R2's ambition to bring health care to the rest of the prison (which is in accordance with both the decency in prisons and public health agendas) this seeing health care as the 'other' may also be seen as a manifestation of resistance to change[95].

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[95] See also Chapter Eight on the public health agenda and Prison Officers resentment.

The introduction of the NHS into the Prison Service has therefore resulted in something of a culture shock for both. R13 put it:

> 'the line from the centre is that all of these things are to be worked out locally with local partnerships…you know do not look to us to tell you how to do it, that is not how this is going to operate. That was a culture shock to the Prison Service (R13).'

On the other hand, as R13 pointed out, the introduction of a more proactive, upstream health care model fits neatly with the whole prisons approach and the public health agenda and was very much welcomed by senior prison sector staff at Prison B.

Before moving on to a discussion of what this means for the practicalities of mainstreaming, a number of items relating to 'prisoner culture' are relevant as having an important influence on what may be achieved in prisons and how services are delivered. Firstly, R6 expressed the concern that because of the majority of prisoners' backgrounds, i.e. poor socio-economic circumstances, they did not have a culture of demanding services or engaging with professionals in their normal daily lives. This led to a situation where they may not always be comfortable with addressing their problems to a doctor in the way that a 'more educated' population would do.

In turn there is the danger that they would only be given what they expected and not what they would actually receive if they were from a different background. One respondent also reflected on what he saw as a culture of suspicion among some of the inmate population who believe that medical staff are holding back medication (R6). Obviously while further research would be required to substantiate this view, it is nonetheless an interesting issue with regard to the standards of service provided when variables such a class are considered.

The final prisoner related cultural issue which emerged relates to the concept of 'jail craft'. Here, NHS respondents criticised the lack of educational facilities which would have been useful in coming to terms with 'tricks' such as how to look out for prisoners regurgitating tablets and storing them for use (sale or consumption) later.

Interestingly, however, no respondent mentioned the existence of the nationally accredited NVQ in Custodial Care (Edexcel, 2006, Prison Health, 2000).

## 9.6 Discussion

The question then is how do very different cultures affect the possibility of attaining mainstreaming of health care services? Taking resistance first, some Prison Service health care staff did not wish to become employed by the NHS. They utilised cultural symbols such as their Prison Service boot allowance as excuses, while other Prison Officers' attitude toward the health care centre was dismissive. It was not seen as part of the prison and as such had implications for the implementation of the decency in prisons and public health agendas. Also, some Prison Officers were also seen as having a culture of resentment towards treatment for prisoners as well as being less than cooperative in their attitude to prisoners[96].

The other effect the rigid prison culture and imposing physical environment has, as related by respondents, is with regard to the recruitment of health care staff. At the least and from my limited experience it is not an attractive working environment and with the exception of those who left the NHS to join the Prison Service was not the first choice of career for many health care professionals. That said a number related how it was the best job they had in their lives (R16, R27). Others, however, were not so sure.

The question this then raises is did the service attract certain 'types' of individuals who may or may not be best suited to providing broadly equivalent services in the custodial environment? (see Reiner for a similar debate on policing, 1997). Indeed, backing this up is the fact that part of the PCT's strategy for overcoming resistance was to get their own personnel into the prisons and manage them as soon as was possible. Clearly, at least some of the existing staff were seen as inappropriate for the mainstreaming goal.

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[96] That said, again it must be recorded than only one Prison Officer was interviewed and respondents also stated that, though there was some way to go, Prison Officers' attitudes were changing in a positive manner.

Generally speaking respondents viewed the NHS as relatively flexible with the Prison Service more static in its ways. Starting with decision making the importance of having the Governing Governor on board in driving the policy goal forward cannot be underestimated (see *Framework*, Appendix 4). The hierarchical structure outlined above dictates that no policy initiative or operational change will occur without the say so of the Governing Governor. That said, obviously the PCT must be onside as well. While there was no evidence of disengagement, or indeed attempts at disengagement in the research sites, anecdotal evidence provided by respondents suggests that, at least in some areas of England and Wales, PCTs did not wish to engage with the prison service in taking mainstreaming forward:

> 'I have heard stories from colleagues around the country where PCTs have tried very hard to see if there was any way they could disengage and even though there isn't they have been reluctant to engage and been very unhelpful' (RX).

While other PCTs/prisons are obviously outside the scope of my research it is nonetheless relevant in illustrating that both parties need to be on board or significantly different outcomes are likely for national policy in different areas.

## 9.7 Applying theory on organisational culture and managing change

Here I wish to return to the main points raised in that discussion for the purpose of examining their relevance to the research. Beginning with Prosser et al's (2006) claims that change is a continuous process which occurs within complex environments as we can see from the findings on, for example, receptive contexts and mainstreaming outcomes are indeed very uneven. That said, the internal context of change at Prison D produced outcomes which were very much in line with mainstreaming goals but had little to do with central policy drivers.

In addition, while Prosser et al (2006) point to change as a continuous process, this may not necessarily be the case as illustrated by implementation gaps with regard to infrastructure at Prison A. In this case change simply failed to occur. Furthermore, the

notion of change as a one-off event is challenged by evidence provided by R21 the Director of Public Health at PCT 2, which suggests that a change of key senior executive personnel such as Governing Governors may mean that the entire relationship building process needs to be revisited. Indeed, R13 also pointed to the frustrations associated with needing to re-establish relationships with both central government and the partner body due to changes in personnel. Change may therefore be more accurately described as an at times *recurring* process.

On the other hand, it is clearer that it may indeed take years before an impact may be identified. As R7 pointed out the health care in the Prison Service had nearly 60 years of developments in the NHS to catch up with. Also, the idea that different people may classify change and the quality of change differently is borne out by contradictory evaluations described earlier of care pathways for prisoners on release. Indeed, noting the claim that the 'productive function of many public services is unknown' (Prosser et al, 2006, p.24, op cit) thus rendering them problematic to measure may view the issues surrounding the penal justice system as an example of this *par excellence*. For example, if the purpose of the criminal justice system is to stop crime then it fails spectacularly. If one argues for its rehabilitative nature then recidivist rates illustrates similar problems. What does it do for victims? Again, this raises many questions.

In the interests of not beginning a broader discussion on the criminal justice system, for us there is a clearer question to be addressed: Is the introduction of the NHS into the prison estate resulting in people exiting the system (albeit often on a temporary basis) in a better state of health? The answer, of course, is that in the absence of a proper evaluation of prisoners at discharge we have no way of knowing. Indeed, this point also links well with Pollitt et al's (1999) notion that audits of public service policy tend towards a box-ticking exercise driven by professional considerations and compliance with procedure. Instead, what should be happening is an evaluation of whether or not prisoners' health inequalities are being addressed.

Moving on to issues surrounding winners and losers it is evident that this there was considerable resistance from both HCOs at Prison B and the nursing staff at Prison C to change. Each group felt they were losing out even though the approaches made to each party were very different. In the case of the HCOs PCT 1's attitude was one of

engagement through an open discussion of why the PCT was taking over commissioning, what it meant in terms of new opportunities for HCOs and when it would happen. The negative reaction chimes very well with Johnson's (1990) view that some actors who perceive themselves as losers will stubbornly resist change even though their position was demonstrably untenable. Interestingly the same culture of resistance also emerged in the case of the nursing staff at Prison C even though the PCT's approach was nowhere near as progressive as at PCT 1. In short, a seemingly accommodating approach may also encounter resistance.

Turning to external and internal factors which affected change, in the interests of brevity, I have summarised these in the following table:

Table 9.3

Situating change: introducing the public health agenda into prisons: external and internal influences from research findings.

| **External** | **Internal** |
|---|---|
| Socio-economic background of inmates: most come from poor backgrounds with associated health inequalities and economic deprivation | Overcrowding |
| Wider determinants of health (Dahlgren and Whitehead, 1991) | NHS/PCT policy and priorities |
| Immigration policy: housing asylum seekers in prison | Prison Service/Home Office policy and priorities |
| Government policy on the criminal justice system, for example on custodial sentences and resources. IT in prisons still behind NHS standards | Systemic barriers such as blockages in transferring prisoners due to divergent local policies on administering methadone |
| Labour market: unemployment | PS/NHS staff attitudes to inmates |
| Education: lack of emphasis on diet/exercise in schools notwithstanding recent developments | PS/NHS staff attitudes to public health agenda |
| Informal support systems: family, friends | Professional cultures |
| Perception of general public on spending on prisoners | Resources |

Following Dawson (see Table 9.1) on internal and external factors there appears to be a close fit with regard to what he identified as important variables. While the factors as stated above are more fragmented they may all be included under the broader typologies provided in Dawson's analysis *apart* from issues surrounding the socio-economic background of inmates, the importance of informal support systems such as family and friends and the attitudes of professional actors. This, I believe is an important point. Eliminating the particular difficulties associated with the background of client groups, informal support systems and the public service ethos of the respondents from an analysis of factors influencing organisational capacity for change represents a gap in Dawson's categories, at least as applied to the Prison Service/NHS environment.

Moving on to Prosser et al's (2006) argument that change occurs within external environments which are themselves subject to change, this seems to be an entirely reasonable one and is supported by the research. For example, a number of the HNAs recognised the difficulties which prisons face because of their dependence on what happens outside the prison walls such as government policy on custodial sentencing, which will have a direct impact on the prison population that will affect both the prison and the PCT directly.

Also, Rawlings' (2003) continuity and change model may also be employed when examining the data. This is not applied so much to types of resistance as recognising that certain elements, what I term 'organisational fundamentals' such as the prioritisation of security, remain constant. This view came through strongly from all respondents. Furthermore, in keeping with the model, change *is* occurring.

In addition, Christensen's (1997) argument that 'theories in use' may be strong enough to resist change highlights the difficulties raised by a significant number of respondents with regard to the attitude of some POA staff towards health care in general and the public health model in particular. While the paradox of non-health care staff articulating their concerns about issues such as housing and employment has been elaborated elsewhere their antipathy to aspects of the agenda such as smoking cessation is one which needs addressing.

Although not health care professionals in the more medicalised sense, Prison Officers nonetheless have an important role to play in broader aspects of well being. In that sense they have health care duties. Changing the perceived theories in use of Prison Officers on this issue and bringing them on board with the new public health paradigm therefore makes Christiansen's ideas an important tool which may be used for analysing resistance.

Turning to the internal context Lipsky's (1980) ideas on the importance of having senior executives supporting external policy goals may appear an obvious observation but this may be problematised by the argument that the methods employed to achieve goals such as mainstreaming or reducing health inequalities may differ across locales. The most obvious example here is the fact that different prisons have different policies on administering methadone. Thus the patient/prisoner will experience different treatment depending on which prison they are to serve their time. Therefore, achieving the mainstreaming goal may be approached in different ways.

With regard to 'muddling through' (Lindblom, 1959) instances where local actors sought to develop policy in the absence of much needed policy guidance and support from central government were not difficult to find. I will provide just two. Firstly, Prison B went through a long process of trying to establish best practice with regard to transferring HCOs to the NHS. After about a year a government directive finally clarified the situation. The time wasted and the resentments which built up as a result of the unclear nature of where such employees would stand with regard to their pension rights created difficulties which were easily avoidable through a proper consultative process between the POA and central government. Secondly, there was no guidance on how at a very basic level PCT staff would 'learn' how to work in a prison. This had to be acquired through experience and no courses on the previously mentioned 'jail craft' came to light. Indeed, PCT respondents even at the end of the fieldwork were still learning their way in the prison system.

In sum then there were a significant number of areas where the literature on organisational culture could be applied to the research findings. It appeared to be particularly useful when looking at resistance and identifying internal and external factors which affected an organisation's ability to put new policies in place. Most of

these could be applied to the research findings. On the other hand, the research would appear to have added the importance of more human elements of an organisation's effectiveness in producing change such as consumer expectations and needs, for example, the consumer as having input into the design of services as important variables which need to be included in studies of organisational culture and change.

Finally, culture *matters*: it can have detrimental outcomes for the implementation of mainstreaming. Chief among the cultural obstacles, apart from having senior PCT and Prison Service executives committed to mainstreaming, was getting Prison Officers onside and also addressing the concern that consumers who expect little will receive it. Thus, bringing together different organisational, professional and consumer cultures poses a significant challenge to both the mainstreaming agenda and decency in prisons. However, as R1 put it:

> 'I don't think they should be regarded as cultures which are fighting for dominance. They are necessary adjuncts to providing health care within a custodial setting. It is appropriate for those two forms of governance to be applied simultaneously and not for one to be ruled by the other.'

In short, managing cultural difference may well matter as much as the provision of reasons and resources in taking forward and achieving the mainstreaming goal. We may need to live with this ambiguity but, given the variation in approaches already identified, is there some kind of standard against which outcomes might be referenced? The next chapter, which as outlined in the introduction to the thesis stands somewhat to one side in reflecting my own thoughts as to how matters may be improved in practice, moves on to consider this by proposing a conception of prisons as neighborhoods.

Chapter 10

# Prisons as neighbourhoods

Prisons have been described as communities or towns in their own right (R12. Caragher, 2003). Notwithstanding their apparently self-contained nature here they are claimed to be, in effect, neighbourhoods. The question, in the context of mainstreaming services, then becomes: if a neighbourhood in the wider community displayed characteristics such as ill-health, problematic living conditions/environment, inadequate leisure facilities and poor employment prospects, what policy initiatives would be aimed at that locality to 'turn it around?'

Firstly, though, can we think of prisons as neighbourhoods? This will be examined through a discussion of what a 'neighbourhood' is in the first place. Here, I will outline a number of definitions before taking the essential elements of each and exploring them in the context of the prison environment. Next, I will question why neighbourhoods matter before moving on to focus on health care issues which are common to both deprived areas and prisons. Again, this will be seen to reinforce the comparison between a prison when conceptualised as a neighbourhood and what we think of as a community more generally.

I will then briefly outline the broader, structural attempts at regeneration in Britain over the past few decades before summarising non-medicalised NHS related initiatives which have been targeted at deprived areas in the wider community. In the conclusion the extent to which these programmes have been introduced into 'prison neighbourhoods' will be questioned within the context of the aim of providing broadly equivalent services for both communities.

Beginning with the question of whether we can reconceptualise how we think of prisons, it is clear that defining what we mean by 'neighbourhood' and 'community' is not straightforward. Indeed, Meegan & Mitchell note that the Social Exclusion Unit (SEU) does not provide a clear framework for their identification and definition (Meegan & Mitchell, 2001). Are they spatially bound or do they transcend borders with groups identifying more with similar population cohorts, sharing common values

and goals, but based in other areas? Alternatively, can they be divided into localities which act as 'the space within which the larger part of most citizens' daily working and consuming lives is lived': a perspective which allows for time as an important spatial boundary (Cooke, 1989, p.12).

This idea of spatial limit is also evident in definitions such as that offered by Glass (1948, p.126) who described a neighbourhood as a 'distinct territorial group, distinct by virtue of the specific physical characteristics of the area and the specific social characteristics of the inhabitants'. The importance of 'place' is, however, further refined by Wilkinson who proposes that;

> 'A community is not a place, but it is a place-orientated process. It is not the sum of social relationships in a population but it contributes to the wholeness of local social life. A community is a process of interrelated actions through which residents express their shared interest in the local society' (Wilkinson in Meegan & Mitchell, 2001, p.2173)

Meegan and Mitchell also make a distinction between a neighbourhood and a 'space-based community' proposing that the former refers to a more restricted spatial collective where, 'the majority of people know each other by sight' whereas the latter is more complex and relates to particular usage of facilities and planned space (Holman in Meegan & Mitchell, 2001, p.2172). Indeed, they go on to list seven definitions of community and neighbourhood, each of which emphasises different delineating characteristics such as boundaries, populations, common interests, local awareness, collective life, shared interest, physical character, local facility use, organisation, and area pride[97].

*Place*-orientation is therefore at the core of these definitions, again stressing links to a locally defined area. Alternatively, however, neighbourhoods have been described as 'open systems' exposed to and influenced by what happens elsewhere (Blackman, 2006, p.33). This perspective broadens the definition to recognise the inter-

[97] Whether inmates experience 'area pride' has not been a focus of the research. That said, prisoners are seen to take pride in winning awards for work such as HMP Camp Hill taking the national awards for gardening and maintaining common areas well (R23), (Royal Horticultural Society, 2005).

connected/inter-dependent nature of life in post-industrial societies and also raises the question as to whether or not it is possible to define a group of people as a community, spatially and characteristically separate from others in the first place. Indeed, further complicating the issue, as Byrne (1995) points out factors may affect different people within a community or neighbourhood differently. For example, a minority ethnic group which is being harassed in a 'bad' area may be expected to suffer disproportionate environmental deprivation compared to the dominant neighbourhood cohort, even though they also experience poor living conditions.

In addition, the nature of community associated with modernity, i.e. the 'traditional' family unit, homogenous ethnicity and identity is argued to have changed and is said to be far more fragmented, heterogeneous and contingent in 'late-modernity' (Lash & Urry, 1987, Giddens, 1990). The issue is therefore complex. However, taking factors which may reasonably be seen as being at least part of the *essence* of what constitutes a neighbourhood/community/locality, i.e. those listed by Meegan and Mitchell and the more 'open' definition offered by Blackman above, it is possible to make comparisons between the nature of prison life and a neighbourhood/community ideal type. It is to this comparison that I will now turn.

Firstly and most obviously, the spatial nature of the prison population is clearly defined as are some definitions of local areas, for example, wards. Furthermore, the inmate population have common interests, use what local facilities there are, share a collective life and organisation and form relationships based on their spatially defined boundaries[98]. There are differences, however, between what we may see as a community on the 'outside', for example, the nature of the coercive environment. However, it is worth noting that this may not be as exclusive to the prison setting as we may assume as research on domestic violence, for example, illustrates (Westmarland, 2006). In addition, the influence of other systems such as the criminal justice system (formal) or inter-personal relationships (informal) on the prison

[98] That these interests may be deviant or illegal, for example, drug taking, is not the point; of chief relevance here is the spatially defined and shared values displayed by the population (Becker, 1991).

community reinforces the view that prison neighbourhoods, like other neighbourhoods, are 'open systems'[99].

Relating the issue more specifically to health and the public health agenda what have communities characterised by low deprivation and prisons got in common? Focussing firstly on factors identified by the NRU as inhibiting even well-funded, evidence-based interventions in deprived areas, they are both characterised by poor quality housing stock, which can contribute to respiratory diseases, stress and other health problems. They also share other wider determinants of health (Department of Health & NRU, 2002 such as low standards of education/literacy, poor housing (cellular confinement in Victorian buildings)[100], an absence of a green environment which has been strongly linked with feelings of poor well-being and other symptoms of ill-health such as crime itself (Kuo & Sullivan, 2001a, 2001b)[101].

In addition, while some meaningful time in prisons is spent in workshops and training for work, in common with job prospects in deprived areas on the out, opportunities for employment are limited. Also, the average stay in prison is less than six months while socio-economically disadvantaged areas are known to accommodate transient populations (Blackman, 2006). Other parallels are also evident. For example, minority ethnic groups, who have significant health inequalities, are disproportionately represented both in prison and in deprived areas (Department of Health, 1999b, Smith, 1997). Lastly, the NRU recognises that people in prison, in common with those living in deprived areas are at a very high risk of mental illness (NRU, 2002). In short, there are a number of parallels which may be made between both prisons as neighbourhoods and health care issues which are common to both deprived environments and the prison estate.

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[99] This view lies at the heart of the thesis in the sense that prisons should not be seen as somehow 'separate' from the wider community; on the contrary they are located absolutely *within* broader social systems. Put starkly, the only inmates who will not return to the wider community at some stage are those who die in prison or, having been sectioned to mental health institutions, die there.

[100] Which may be likened to the 9% of English housing stock which was not considered fit for human habitation (Blackman, 2006).

[101] Indeed, here it should also be noted that offenders are also often the victims of crime themselves (Felson, 1998).

However, why does the issue of neighbourhood matter in the first place? Surely it is up to each individual to take responsibility for one's lifestyle? The answer lies in the fact that one's structural position in a society has a large influence on an individual's opportunity *for* and ability to engage *with* healthy lifestyle choices (see Caragher et al, 1998 on food deserts). Furthermore, there is a direct, proven link between poverty and ill-health, and part of this is a neighbourhood effect (Acheson, 1998). For example, in 1999/2001 the difference between areas with the highest (North Dorset) and lowest (Manchester) life expectancy at birth for boys was 9.5 years and 6.9 years for girls (Department of Health, 2003d). In short, where people live *matters*; it directly affects their quality of life, morbidity rates and mortality rates. As *Choosing Health: Making Healthy Choices Easier* puts it;

> 'differences in income and wealth mean that market systems – which are designed to promote choice – bring inequalities in terms of opportunities to make healthy choice in where we live, what food we eat and how we spend our leisure time' (Department of Health, 2004).

What though constitutes a decent neighbourhood? It has been pointed out that while a set of standards have been established for defining 'decent homes' (see Communities and Local Government, 2006a) no definition of what constitutes a decent neighbourhood exists in the UK (Blackman, 2006) [102]. In prisons, however, *Health Promoting Prisons: A Shared Approach* prioritises the concept of decency as fundamental to health promotion and places it at the centre of prison life. Here, the focus is on treatment within the law, delivering certain standards such as the provision of clean and properly equipped facilities, responding to prisoners' proper concerns, protecting them from harm, creating regimes that make 'imprisonment bearable' and fair and consistent treatment by staff (Department of Health, 2002a).

All very well. However, an individual's sense of control over their environment is also seen as important to their psychological well-being (Blackman, 2006). In this sense residents of deprived areas and prison inmates both experience oppressive and debilitating environments defined by either their status as incarcerated citizens or

[102] Which I would suggest may be used as a standard for auditing cellular confinement.

being structurally disadvantaged. In both cases these groups are seen as lacking the resources to take meaningful control over their lives (Smith, 2000, Sim, 2002). Lawton's concept of 'environmental press' generated by such environments is useful here in understanding how the lack of control and oppressive surroundings may affect both inmates' and marginalised communities' sense of self-worth and esteem (Blackman, 2006)[103].

## 10.1 Policies for deprived neighbourhoods

Having looked at similarities between prisons and locales in wider society I will now provide a brief outline of the main interventionist policies and funding opportunities for regions which were described as 'lagging behind' better areas in post-industrial Britain[104]. This section will begin by concentrating on structural programmes, aimed at regions and areas defined by city boundaries before moving on to schemes which target localities identified by high scores on the Index of Multiple Deprivation. In the conclusion, I will position these programmes within the mainstreaming goal and question the extent to which they have been introduced into prison neighbourhoods.

Beginning with large scale, regional/city level interventions City Challenge was introduced to provide business support, grants, one stop shops, local recruitment services, business parks and managed workspaces. Also, Regional Selective Assistance grants were available for creating viable business or supporting existing companies for the purpose of safeguarding jobs and contributing to the national economy (Jewson & MacGregor, 1997, Office of the Deputy Prime Minister (ODPM), 2006b). In addition, European Union money is available via Structural Funds such as the European Regional Development Fund which distributes monies to areas which are falling behind (European Commission, 2007).

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[103] It is important not to get carried away by structural barriers and also note the possibility for agency. Individuals can 'make space' or create opportunities in both environments; the argument is that meaningful, targeted interventions may increase opportunity in both.

[104] It is recognised that this term is also contested. The extent to which Britain is actually 'post-industrial' is the subject of on-going debate. However, what is not in dispute is the degree to which some communities have been adversely affected by the closure of heavy industry; shipbuilding, mining, and steel, for example, and the move to the 'new economy' (Hutton, 1996).

Turning to more locally targeted measures since 1997 there have been seventeen major developments in urban policy and governance (ODPM, 2006a). All focus on addressing inequalities, producing sustainable communities and regenerating deprived areas. They range from the establishment of the SEU in 1997, which was set up to 'tackle the problems of marginalised groups and areas' to *Sustainable Communities: People, Places and Prosperity*, the government's five year plan to give people, working with Local Authorities, more say in how places are run (ODPM, 2006a). Ruth Kelly, Minister of State at the Department for Communities and Local Government (DCLG), the latest incarnation of the ODPM, spells out their vision as follows:

> 'DCLG's work is at the heart of the Government's commitment to social justice - driving social mobility and promoting economic inclusion. My vision is of a Department on the side of people who want to make a difference, where everyone has the opportunity to fulfill their potential and to build a stake in society for them and their families. We want strong, cohesive communities in which people feel comfortable and proud to live, with a vibrant civic culture and strong local economy' (Kelly on Communities and Local Government, 2006b).

In between, notable programmes include the Neighbourhood Renewal Unit which 'prioritises health as a key focus of its work' (NRU, 2002). The Neighbourhood Renewal Unit was established in 2001 with a remit to 'narrow the gap between most deprived areas and the rest through realignment and reshaping of mainstream funding programmes' as part of the National Strategy for Neighbourhood Renewal (ODPM, 2006a)[105]. Importantly, this emphasis on 'narrowing the gap' mirrors the NRU health inequality target of improving the *relative* health of marginalised groups compared to more affluent areas as well as their *absolute* health status (NRU, 2002). More specifically, its aim is to ensure that 'no one should be seriously disadvantaged by

[105] The initiatives were originally aimed at the 88 most deprived local authorities in England.

where they live because of 'failing' local services or a poor environment' (Blackman on SEU, 2006)[106].

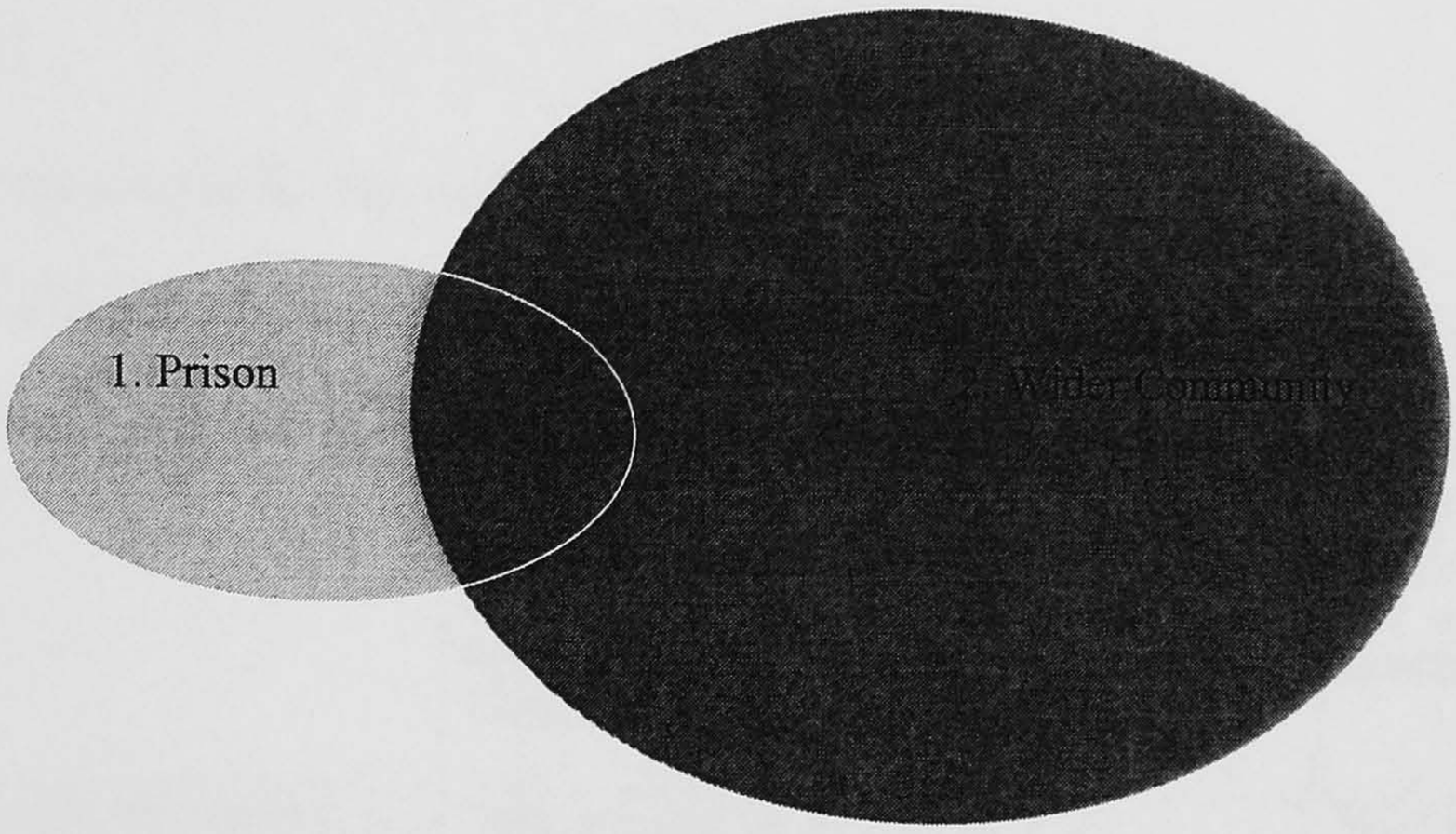
In large part, the National Strategy for Neighbourhood Renewal is being done through the involvement of local actors: 'a strategy that responds to local circumstances rather than directs everything from Whitehall' (Neighbourhood Renewal Unit, 2006) and is delivered by LSPs. These partnerships have responsibility for bringing key stakeholders such as the local authority, the NHS, community groups and businesses together, managing budgets and monitoring outcomes (Blackman, 2006). Other initiatives include the New Deal for Communities programme, the Safer Stronger Communities Fund and the Single Regeneration Budget which provides ring-fenced funding for a range of business support programmes within deprived areas (ODPM, 2006b).

These programmes therefore amount to a substantial package of national and supra-national policy aimed at disadvantaged/deprived communities and neighbourhoods. What specific services though have the NHS in place for targeting such communities? Here, I will begin by describing in diagram form the NHS' new domain of responsibility in the prison estate. I will then outline the main initiatives which have been developed by the NHS for tackling health inequalities in the wider community beginning with initiatives which emerged from *The NHS Plan* before concluding with a summary of the main text and a discussion which situates these programmes in the context of the mainstreaming goal.

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[106] As I am writing this chapter Official Figures have been published showing that both absolute and relative poverty has increased in Britain for the first time in a decade (Seager, 2007)

Fig. 10.1 New NHS service delivery environment[107]




The overlapping area represents deprived neighbourhoods from which, and into which, most prisoners flow.

Notes:

1. Prison environment prioritises security/restraint.
2. Wider community NHS strategy based on health/choice and addressing inequalities; medicalised and up-stream public health interventions.
3. Overlapping area; identifying new domain of NHS responsibility. Prison as deprived neighbourhood characterised by high morbidity and unhealthy environments.

Turning to specific NHS related programmes, in the foreword to *From Vision to Reality*, the NHS guidance for patients to *The NHS Plan* the Department of Health states:

> 'At the beginning of the twenty-first century, your chances of a healthy life still depend on what job you do, where you live, and how much your parents earn. That is unfair and unjust. [ ] That is why this government is committed to narrowing the health inequalities that scar our nation, and to improving health for *all*.' (Department of Health, 2001c, emphasis added, p.i).

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[107] I am grateful to my supervisor, Prof. Tim Blackman, for this observation and also for leading the discussion towards an examination of prisons as neighbourhoods.

The following table highlights the substantial set of programmes developed to address the 'unfair and unjust' situation just described.

Table 10.1

Government inequality interventions/programmes

| **White Paper/Report** | **Scheme/type of support** | **Link to prison estate** |
|---|---|---|
| Tackling Health Inequalities: 2002 cross cutting review (DH, 2002c) | Supporting People; The Supporting People programme provides essential housing related support services for over 1.2 million vulnerable people, including thousands of people with learning disabilities, across England | Prisons are a 'user group' in Supporting People programmes (i.e. as ex-offenders needing housing) |
| Tackling Health Inequalities: A programme for action (DH, 2003d) | Drug and alcohol action teams are (DAATs) partnerships combining representatives from local authorities (education, social services, housing) health, probation, the prison service and the voluntary sector (Drugs and Alcohol Action Team, 2006) | Works in partnership with the prison service |
| Neighbourhood Renewal Unit (DH & NRU, 2002) | Remit to narrow the gap between most deprived areas and the rest through realignment and reshaping of mainstream funding programmes. Health as a key focus of its work | Recognises prisons as 'disadvantaged communities' but not elaborated upon. |
| Sure Start (Sure Start, 2006) | Government programme with the aim to deliver the best start in life for every child. They bring together, early education, childcare, health and family support | Although not directly relevant to the prison service many inmates are also fathers and mothers. No evidence of a connection with Sure Start was evident during the fieldwork perhaps because of limited success when working with fathers. |
| Safer Stronger Communities Fund (Blackman, 2006) | Aimed at tackling antisocial behaviour, drugs, crime and improving the conditions of streets and public spaces | Includes some diversionary initiatives aimed at preventing offending |
| New Deal for Communities (NDC), (ODPM, 2006b) | Previous funding was often based on a bidding process, e.g. City Challenge, this initiative marked a move towards resource allocation based on need (ODPM, 2006b) | |
| Health Action Zones (HAZ), (ODPM, 2006b) | New partnership approach to addressing health inequalities, identifying needs and modernising services by integrating health, education, housing, employment and anti-poverty initiatives (ODPM, 2006b) | |

| | | |
|---|---|---|
| Education Action Zones (ODPM, 2006b) | Partnerships between schools, their LEA and local organisations to tackle problems of social exclusion in disadvantaged (mainly urban) areas (ODPM, 2006b) | |
| Healthy Living Centres (HLCs), (NHS Executive, 1999) | The aim here is to focus on health 'in its broadest sense', providing opportunities to improve quality of life and enable people fulfil their full potential (NHS Executive, 1999) | |
| Local Improvement Finance Trusts (LIFT), (DH, 2006c) | NHS LIFT aims to develop a new market for investment in primary care and community-based facilities and services. It allows PCTs to invest in new premises in new locations, not merely reproduce existing types of service (DH, 2006a) | Does not extent to prisons |
| Smoking Cessation Programmes | Government is pursuing smoke-free public places (*Choosing Health* White Paper, DH, 2004). See Chapter Eight for up to date position. | NRT available in prisons (Acquitted programme, DH, 2003). |
| Mental Health/CPA teams | 335 mental health teams were established under The NHS Plan. These were also introduced into the prison system (DH, 2000) | MHIR teams working in the prison estate |
| Health Trainers | Introduced under the *Choosing Health White* Paper, this initiative will provide a new resource for people to get individual advice and help in putting their ambitions to do more physical exercise into practice (DH, 2004) | Research identified one PCT initiative which plans to pilot a health trainer scheme in one of its prisons; no plans for nationwide roll-out |
| NHS Direct | Offers advice on self-care and is available 24 hours a day, 365 days a year, via telephone, internet or interactive TV (*Our Health, Our Care, Our Say*, DH, 2006a) | Not available in prisons |
| NHS Walk-in Centres | Providing a range of primary care services to all patients on demand (*Our Health, Our Care, Our Say*, DH, 2006a) | HMP Full Sutton has introduced a Walk-in Centre – only one in evidence |
| Housing Market Renewal (HMR) | Housing market renewal (HMR) is designed to tackle problems caused by failure in the private sector housing market in parts of the Midlands and Northern England such as houses in poor condition and abandoned properties (Blackburn Borough Council, 2005, Blackman, 2006) | Not specifically an NHS programme but included due to its relevance to the wider public health agenda |
| Neighbourhood Wardens Programme (ODPM, 2006b) | Neighbourhood level uniformed semi-official presence designed to reduce crime, anti-social behaviour, fear of crime, improve environmental quality and build communities (ODPM, 2006b) | Not specifically an NHS programme; included due to relevance to wider public health agenda |

Non-criminal justice specific community based interventions either initiated by the NHS or having string links to the NHS. The programmes outlined here are not medicalised health care interventions; they focus strongly on wider determinants of health and the public health agenda.

It is noted, however, that the list is not exhaustive, for example, some agencies such as the HDA which had a remit for focussing on vulnerable groups, have been disbanded or amalgamated. That said numerous initiatives are in evidence. It is also noticeable, however, that while some, such as MHIR engage with the prison estate most of the programmes are not tailored towards this marginalised section of society. These gaps could be addressed through, for example, the introduction of prison 'Sure Starts' and prison 'healthy living centres'.

In conclusion, as recognised in *The Future Organisation of Prison Health Care* prisons should be part of our communities, not separate from them (HM Prison Service & NHS Executive, 1999). However, for many years prisons were isolated from mainstream NHS services. Indeed, it does not seem far fetched to propose that the general view on prisons as seen by the general public is as institutions divorced from society. After all, that is part of the reason why they are there: to reinforce ideas of 'us' as the good and 'them' as evil, to isolate and to protect. Thinking of them as part of society includes us all as somehow culpable.

However, the vast majority of inmates will return to the wider community. Prisons in that sense are therefore no more isolated from society than hospitals or boarding schools. The argument here goes further though by proposing that prisons are neighbourhoods *in themselves*; open systems with their own spatial, cultural and community identities. In addition, even allowing for the contested nature of what constitutes a neighbourhood, as outlined above there are numerous parallels which may be drawn between deprived areas and prisons.

Furthermore, and returning to the policy agenda, The European Prison rules state that 'The [prison] medical services should be organised in close relation with the health administration of the community or nation' (HM Prison Service & NHS Executive, 1999, p.5). This obviously goes beyond just primary care to include the substantial package of care offered in the wider community and described above. However, prison neighbourhoods, despite housing some of the most deprived and unequal communities in health terms, have not received anything like the same focus of attention.

Reconceptualising prisons as neighbourhoods, and transitional neighbourhoods at that, is therefore extremely helpful in highlighting this gap in service provision[108]. It is not, however, enough to leave it at that. This paradigm shift also carries implications for the process of carrying out HNAs and producing PHDPs. While PHDPs are at present jointly produced by just two agencies, i.e. PCTs and the prisons, in order to take into account the arguments advanced in this chapter future plans should include contributions from other agencies such as the Environment Agency and the Department of Communities and Local Government in producing more holistic plans for improving prison environments. In short, in the context of the complex relationships between wider determinants of health and health inequalities, the public health agenda and mainstreaming NHS services there is no reason why the broad spectrum of programmes which would be targeted at deprived neighbourhoods in the wider community could not also be adapted for prison neighbourhoods.

[108] Somewhat ironically, however, this lack of targeted programmes mirrors what is happening in the wider community in the sense that communities in greatest need are also those least likely to receive the services they require *The NHS Plan: A Plan for Improvement, A Plan for Reform* (Department of Health, 2000).

Chapter 11

# Rethinking prison health

As the thesis moves towards a conclusion its modular nature has become more apparent. The central question which links the work together, however, is how implementation gaps are managed at ground level by 'coal-face' service providers, Lipsky's street-level bureaucrats (Lipsky, 1980). The purpose of this chapter is to focus on implementation gaps for the purpose of exploring what the findings say about the implementation of social policy more generally and how they provide the basis for my overall thesis. It also serves to emphasise the finding that while mainstreaming is a progressive and worthwhile goal it is flawed because the conditions in which health care services in the wider community are delivered cannot be compared to those in the prison environment. This point is argued to be particularly important for the public health agenda.

This discussion chapter is presented in two parts. Firstly, I look at the implications of the findings for the implementation of social policy generally and then for the specific area of criminal justice and health care in England and Wales. In the second section I return to the applied social research aspect of the work to outline a list of recommendations for health care policy makers which have been formulated to address gaps in implementation and opportunities for innovative forward planning as a result of the research. I then draw these findings and proposals together before reaching a conclusion as to where we stand at present.

## 11.1 Broad implications for social policy implementation

Beginning then with what the thesis has to say about the introduction of major social policy initiatives. While the studentship was established for the primary purpose of examining opportunities for the introduction of the NHS public health model into the prison estate it became apparent that, in a more general sense, the work could not be addressed without an approach which recognised the wider implications the findings may have for the implementation of social policy. Indeed, it was for this specific reason that the implementation gap concept was introduced into the methodology.

What then can it tell us? Well, firstly, outcomes are highly contingent, incremental and dependent on a multitude of variables not least externalities over which the delivery bodies have sometimes no control. In addition, the application of social policy which is designed to be universally applicable is mediated through unique local circumstances containing barriers and facilitating factors which affect how far policy may be fully implemented.

Furthermore, geographically defined 'localities' are not necessarily operating autonomously in spite of the devolution of decision making powers to local actors. Instead, they are set in relationships with other local bodies as well as central government which determine both policy outcomes and opportunities for pushing through agendas. For example, the research illustrates how important recognition of this 'interconnectedness' is in how inconsistent local policies on methadone treatment result in some prisoners not being able to avail of better training facilities at certain prisons.

In addition, while delegating power locally may well result in the empowerment of local actors in a positive sense it also includes the power not to make decisions: negative power. An example here is the failure of two PCTs to appoint a health promotion specialist for the prisons in their areas. As Lukes puts it:

> 'power is not an unambiguous term…it describes the nature of relationships and involves not only the overt exercise of power, but also what has been described as non-decision making, as well as the deeply embedded structures and cultures of organisations' (Rawlings, 2003 pp.25-26).

Importantly, as the findings on organisational culture and structure illustrate, national policy is really only national at the level of central government. As it is rolled out in the wider system through channels of local actors, each with their own organisational and professional imperatives, competing for scarce resources and striving to get their interests, for example public health, onto local agendas, national policy becomes

amorphous both in terms of how it is delivered (supply) and how it is consumed (demand).

Complicating the matter further and directly contributing to implementation gaps is the observation that freedom from central government directives may not necessarily be what local actors want. For example, failure to address issues such as pension rights for health care officials who were transferred from the Prison Service to the NHS at a national level resulted in resistance to changes in health care delivery locally. Local actors, in the absence of central government backing were then left to 'muddle through' as Lindblom (1959) suggests. Ironically then, at a time when government policy calls for power to be devolved locally, local actors encounter difficulties in effecting government policy *precisely because* they have been shorn of central government backing.

It is also apparent that the delivery of services is often uneven. Each local environment differs in a variety of ways with factors such as professional ethos, organisational priorities and historical legacies important. In the case of the prison estate it is a long term truism that each prison is different from all others. Here, as the research confirms, the role of Governing Governor is critical. It is therefore evident that implementing social policy via a third party in such circumstances cannot take place without the backing and commitment of key gatekeepers.

Also, it is no longer enough to establish the character of prisons through variables such as their physical environment, inmate demographic, ethnicities, gender and so on. Now, the nature of the local PCT's involvement, commitment and priorities will play an important role in determining prison life and culture. Indeed, the character of the PCT may also be similarly remoulded.

A number of points which emerged from the research are particularly important here. Firstly, the receptive context in which the policy initiative is managed locally may be very important for determining the future trajectory of policy goals and bridging implementation gaps. As we have seen PCT 1 provided a progressive, welcoming environment which, although it placed great strain on the PCT because of the disproportionate (in national terms) burden the changes made on them, nonetheless

this greatly assisted in bringing together a critical mass of senior personnel who had more than just a professional interest in taking the agenda forward.

In contrast, while progress towards the mainstreaming goal was going ahead at the other two PCTs, the receptive contexts were ones of recognisably lesser engagement. The resulting problems with resentment among staff in their prisons (notwithstanding problems encountered for different reasons by PCT 1 at Prison B) meant that relations were not as well developed. Indeed, as mentioned, PCT 2 was not included in the first wave of institutions of commissioning trusts[109]. This finding may have important lessons for policy makers in the future. Driving though policy is more effective if the groundwork on the reasons for its introduction are accepted in the first place. Furthermore, gains are also apparent if a consultative process is established before policy is rolled out locally.

The second point concerning the involvement and influence of local actors is where does the new policy fit into their existing agendas? Will it be highly prioritised or will it melt into the already difficult raft of tasks for which the body is responsible? Here, it was rather too easy for me having been in touch with professionals who solely dealt with health care in prisons to believe that that was all the PCT did. In fact, it was very enlightening to speak to professionals who worked outside prisons and for whom prison health care was just one among many issues they faced.

This again has important implications for policy makers. In this instance where a particular policy target fits into a delivering agency's broader responsibilities will, at least in part, determine what priority is given to that agenda. Here, it could refer to a PCT whose population is over 200,000 with prisoners on their patch accounting for just 3% of that total[110]. How much resources and what priority ought the PCT give to that 3%? The intuitive answer may be, well 3%, however, we know that the health care needs of that small population is far greater.

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[109] It is interesting that there does not appear to have been any scientific evaluation of the suitability of those institutions which moved to commissioning in the second wave suitability as commissioning bodies. They simply 'went on board'. That each had fulfilled the necessary criteria by which the first 18 were transferred having failed just 12 months later is therefore indeed impressive.

[110] Following restructuring each of the 152 PCTs is now responsible for around 300,000 people (Hawkes, 2007).

As Foucault, problematising what is means to be 'healthy' in the first instance, put it: '[t]he problem raised is, therefore, that of the relationship between an infinite demand and a finite system', an observation which may have particular resonance for the prison population in the sense that the more screening is done the more need is apparent (Foucault quoted by Osborne in Petersen & Bunton, 1997, p.180).

This then returns us to the importance of externalities for implementation gaps. It is clear that the delivery of health care is being impeded by overcrowding in prisons and this in turn is caused by the focus on incarceration by the criminal justice system. Externalities, however, I would argue ought to be further distinguished into those which are outside the control of the delivering body, for example, the socio-economic backgrounds of inmates and ones over which they may exert some influence, for example, funding from central government.

In addition, there is the question of the relationship between partner bodies. In Chapter Seven the issue of exactly how equal is the relationship between the prisons and PCTs was raised. Indeed, as pointed out, ultimate responsibility for health care in the prisons still rests with the Governing Governor. This internal issue may also determine how far a policy objective may be met. Also, it is critical to note that the tension between security and health care will not be eradicated in the prison system. To re-work Durkheim, prisons' purpose is the separation of the *profane* individual from *sacred* society before cleansing that individual through the denial of liberty (Durkheim, 1995). As long as that is the case the tension between security and health will necessarily remain. However, I would argue that this relationship need not be an absolute one.

Another important point is that it is not enough to deliver services, they must also be consumed. Inmates also need to have, in Pawson's (2006) terms, reasons and resources to avail of health care in the first place and failure to provide these may have particular implications for successfully introducing particular services, most especially the public health agenda. To elaborate, it is known that the rate for requesting appointments is significantly higher in prison than in the wider community. However, the same may not be the case for the public health agenda because many of its targets are the exact things that prisoners use as coping strategies, for example, smoking and

using illicit drugs. Indeed, there is a further irony here in that people were the target of regeneration funding for decades (and the public health agenda more recently) are now the very ones who are again being targeted in prison.

What though do the findings have to say about local actors, those who actually implement policy on the ground? While it is clear that those working on the NHS side of the partnership as well as those in senior positions within the prisons were committed to the mainstreaming principle it was less clear that bringing Prison Officers on board, the street-level bureaucrats, had been successful. The most obvious example of this was how Prison Officers saw their role as returning inmates to the wider community drug free and not dependent on methadone.

The policy of some prisons which, somewhat ironically is in line with what would happen in the community on methadone, is therefore in direct conflict with the role of a Prison Officer as they see it. As such public servants may be carrying through policy even though they have a fundamental philosophical disagreement with it. How this effects their engagement with the mainstreaming in general and public health in particular is therefore open to question.

Furthermore, I would suggest that uncertainty resulting from a lack of clear direction, (for example, on the transfer of HCOs to the NHS) offers the opportunity for street-level bureaucrats to address implementation gaps, not as a result of specific national directives, but rather as a result of the 'freeing-up' and suddenly contingent nature of previously hegemonic management and regulatory frameworks. These 'contexts of uncertainty', where official policy is either ambiguous or absent, the thesis suggests are different to the street-level bureaucrat scenario where policy outcomes are produced in the context of directives. Here implementation gaps are addressed and policy outcomes emerge precisely because of a *lack* of direction and whose version or interpretation of 'what happens next' holds sway in such circumstances brings us back to issues of power and resistance.

Lastly, it needs to be recognised that implementation gaps occur because each delivery site will have different 'recovery points' from which they must reach broad equivalence with NHS standards. However, it is interesting that although standards of

prison health care may be expected to correlate with category of institution, for example, the possibilities for more engagement with the public health agenda in a resettlement prison, what actually happens may be the opposite. In this case, respondents indicated that the particular needs and concerns of resettlement prisoners such as anxiety about returning to the wider community meant those perceived opportunities may be lost. Indeed, it was also argued that there may be *more* potential for the public health agenda in a secure facility where the average stretch was four years.

In short, generalising on the outcome of policy initiatives is therefore difficult. It involves numerous variables including the externalities already mentioned plus internal issues such as Pawson's (2006) ideas on disseminating acceptable reasons for local actors to take on board broad policy initiatives as well as providing adequate resources to see policy through.

Moving on from this the research also illustrates many of Gunn's (1978, p.169-176) reasons why implementation is difficult. For example, 'the circumstances external to the implementing agency impose crippling constraints' (overcrowding), 'adequate time and sufficient resources are not made available to the programme or policy' (public health agenda) or 'dependency relationships are multiple' (poor communication between departments known as silos) are all evident.

Also, and with critical importance for the central thread of the research, i.e. the implementation gap, Gunn argues that 'the policy to be implemented is not based on a valid theory of cause and effect' (Gunn, 1978, pp.169-176). Here, the finding that the particular nature of the prison environment means that the provision of prison health care needs more consideration than simply applying methods used in the wider community is particularly relevant. In short, policy implementation is complex, uneven and difficult. In addition, I would argue that this is further complicated by the use of the NHS model as a panacea for prison health care in a situation where health care necessarily takes a back seat to security.

How to address this? I suggest that there are appear to be three possibilities. Firstly, either the NHS model is revisited, alongside comprehensive, accurate HNAs and

significantly amended to take into account the special nature of the prison estate or the prison estate is reconceptualised as a neighbourhood in its own right with entitlement to regeneration initiatives in the same way disadvantaged locales in the wider community are targeted with measures specific to those contexts and clear outcomes expected from those responsible for delivery. The third option is a combination of both. However, this cannot happen in isolation from wider developments in what I see more generally as the management of marginalised groups.

Here, care for the mentally ill is critical as is the issue of overcrowding. Taking mental illness first, it is clear from the respondents that they place it at the very top of their concerns regarding health care on prisons (see *Framework*, Appendix 4). In the past the building of large scale asylums for those ascribed to be mentally ill took place separate from the development of institutions of incarceration for the criminalised meaning, at least in theory, that the criminal and the insane would be separate (Goffman, 1968, Foucault, 1977). However, the necessary dismantling of mental health care institutions in Britain which were found to be both wholly inadequate as well as dangerous for patients without the creation of proper replacement facilities has occurred alongside increasing numbers of inmates with mental health problems in prison (R7, R12)[111].

While it has been acknowledged previously that establishing a link between sentencing policy and the incarceration of individuals with mental illnesses would require further research it should also be acknowledged that there is a further need for research on a link between mental illness and behaviour which subsequently brings individuals before sentencing judges in the first place. In the absence of such material I am left to pose two questions.

Firstly, is the lack of adequate mental health facilities in the wider community leading to the incarceration of individuals who would otherwise be cared for very differently? Secondly, what does this conflation of the criminalised and the insane say about how

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[111] Backing this up are Home Office statistics for 2005 which were the highest seen in the previous decade (Home Office, 2007b).

marginalised populations are being managed in 'late-modernity' more generally (Giddens, 1991)?

Indeed, relevant here is research conducted by the Institute for Public Policy Research which suggests that 12,000 inmates would be better dealt with outside prisons (Pearce, 2007). These include 2,000 female prisoners serving less than six month sentences who would be more appropriately serving community sentences, 5,000 who should be in mental health accommodation and a further 5,000 who ought to be in drug rehabilitation programmes. In addition, referring to the process as 'warehousing social problems' the work will go on to contradict the figures I quoted earlier on recidivism stating that actually 67% of ex-prisoners are caught re-offending within two years of release.

The second difficulty raised here is that of overcrowding. As HMCIP Anne Owers states the mentally ill are 'languishing in overcrowded jails' (Batty, 2005). This obviously raises the possibility, already under way, for the building of more prisons. However, Britain already has the highest rate of incarceration per capita in the western European Union apart from Luxembourg. Also, recidivism figures illustrate that, for many, prison is simply a revolving door in a cycle of offending, incarceration, re-offending and return to prison (Johnston & Wilson, 2007) [112]. Indeed, it further raises the possibility of more custodial sentences simply because more places may be available. The issue of exacerbating the problem rather than addressing what is wrong with the existing penal process is therefore a very real possibility.

Returning then to the three potential ways forward given the problem that we simply do not know how the extent of need in prisons fully, fresh, comprehensive needs assessments are required. In addition, the NHS model needs to be revisited in the context not only of how services are delivered but consumed in prisons. This, however, is largely what has already been tried and, though significant progress is being made as highlighted in the positive outcomes which emerged from the research, problems remain.

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[112] Figures published in January 2007 show that the rate of incarceration per capita in England and Wales is 148 per 100,000, up from 120 per 100,000 in 1997 (Johnston & Wilson, 2007)

While the goal of mainstreaming is indeed as progressive one, in order for it to have a chance of being successful the environments in which individuals are incarcerated must be reconceptualised as neighbourhoods in their own right. Mainstreaming is therefore not about equivalence with health interventions in 'ordinary' society but with interventions in the most deprived neighbourhoods. Addressing the issue primarily from the perspective of a medicalised, reactive health care model, particularly in the light of the public health agenda is insufficient. In short, the irony may be that public health is indeed mainstreamed within prisons already in the sense that it takes a back seat to the medical model just as is argued to be the case in the wider community in an example of what I term 'negative equivalence'.

To sum up then moving the research findings away from the specific prison estate there may be important lessons for policy makers as a whole. The local environments and actors need multiple support before national policy directives may be achieved. They are each unique environments, with different operational philosophies and competing agendas. In the context of scare resources addressing issues in a reactive manner will most likely only stem the tide rather than achieve long-term change.

That said, it would be incorrect to write off the progress made and professional commitment of the host institutions and professional respondents who took part. On the contrary it is clear that positive outcomes are being achieved. The problem, however, is that many of the consumers of services are not in the correct environments in which to benefit from them.

## 11.2 Recommendations for addressing implementation gaps

As mentioned in the introduction to the *Framework* analysis tool I view this Ph.D thesis as a piece of applied social research. As such I believe that it is insufficient to take a set of research questions, apply them to a particular area and come to a conclusion. Instead the outcome should also include a set of recommendations for consideration by key stakeholders, in this case the Home Office and PCT bodies.

Obviously, these have been put together from the relative safety of a university department free from the budgetary constraints, the influence of competing bodies

with disparate agendas and so on. Nonetheless, the fact that issues these with would no doubt come to the fore in the 'real world', should not be seen as a sufficient deterrent for the publication of issues which I strongly believe ought to be placed on the prison health care agenda.

No doubt the list is not exhaustive and some may be at best difficult to achieve, however, the following pages contain a number of recommendations which emerged as a result of gaps in current policy implementation and during the research.

- Firstly, mindful of the flaws in the original HNAs an up to date, comprehensive audit of all health care needs with particular attention given to mental health, should be undertaken as soon as the ongoing process of introducing an up and running IT system for IMRs into the prisons is complete. In addition, as suggested in Chapter Ten, this should be done in consultation with agencies such as the Environment Agency and the Department of Communities and Local Government.

- Mental health needs should be considered as a broad continuum from low level and preventative care to serious mental health disorders. The present remit for Mental Health In-Reach teams, though seen as valuable, is narrow and is believed by respondents to allow too many to remain untreated because they are, ironically, not sick enough. In the interim, Mental Health In-Reach teams should be expanded.

- All decisions on patient/prisoners who are being considered for transfer out of the prison estate to secure facilities in the wider community need to be fast-tracked. This will obviously have implications for non-criminalised mental health patients; however, this may be addressed by extending existing facilities as a matter of urgency. In short, the need for adequate mental health care facilities in the wider community must be seen as an important part of the mainstreaming goal[113].

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[113] See also the opportunities for further research section in the conclusion chapter which deals with claims that prisons are being used as storage depots for the incarceration of offenders with mental health problems.

- These assessments and the programmes which are subsequently established may be audited through the use of Health Impact Assessments (HIA). This tool has been identified by the NRU as of use in evaluating how 'a combination of procedures or methods by which a policy, program or project may be judged as to the effects it may have on the health of a population' (WHO quoted in Neighbourhood Renewal Unit, 2002, p.31) and would provide evidence of returns on capital invested which will be critical in obtaining funding for future projects.

- In keeping with Chapter Ten on seeing prisons as neighbourhoods each prison needs to be assessed as any deprived locale in the wider community would be. For example, through the use of indices of deprivation, adapting the Housing Health and Safety Rating System (HHSRS) for prisons and the granting of 'healthy prison' status to appropriately performing institutions. The regeneration initiatives which would be made available to such areas would then be applied to each particular prison environment and tailored in consultation with the prison security regimes.

- Full consultation on the introduction of needle exchange programmes for intravenous drug users needs to be initiated. These have been implemented in a number of countries, for example, Spain, Canada, Switzerland, Germany, Moldova and Belarus and research on their worth is very positive (Autores et al, 2002, Lines et al, 2006). The difficult political waters such a proposal would have to cross ought not to be an impediment to saving people's lives. The case for their introduction must also be sold to the general public using the public health agenda. It must be also acknowledged that the position of the POA is therefore critical in taking this proposal forward. Full consultation with this body is therefore crucial.

- The issue of synchronising policy on methadone treatment needs to be addressed nationally. While varying standards of health care and type of treatment may somewhat ironically represent the achievement of

mainstreaming, it is leading to systemic blockages in the transfer system as detailed in the research findings.

- In order for this to be achieved it is important that POs are brought on board in a more proactive and positive manner. This may be achieved by providing training for POs on the public health agenda and emphasising that the whole prison approach is designed to make life better for everyone in prisons, not just inmates. Here, it is noteworthy that respondents did not feel that prison officers understood or wanted to engage with this principle.

Evidence suggests that resentment at improving conditions and providing better health care for inmates exists. However, breaking down this mindset may not be as difficult as its supposed embeddedness suggests. As noted it was the non-medicalised respondents who used the wider determinants of health most in their discourse. Furthermore, better prison environments mean better working conditions.

- Staying with the public health agenda care should be taken that the participation of inmates in public health initiatives such as smoking cessation programmes takes place *in addition to* other activities such as work or going to the gym, not *instead* of it. This has been covered in the research findings and may be implemented through the introduction of an appropriate PSO.

- In the context of *Choosing Health: Making Healthy Choices Easier* the fact that only one PCT had the resources to appoint a specialised health promotion official (who actually had responsibility for three prisons) is appalling (NHS, 2004). At each prison at least one health promotion professional, responsible for developing and co-ordinating the public health agenda in the prisons and answerable to the PCTs, should be appointed immediately.

- During the research it became obvious that having a dedicated, full-time PHLM made a significant difference to relations between the PCTs and their prisons. Each PCT with responsibility for a prison should appoint a PHLM

with responsibility for liaising between the prison estate and the local PCT immediately.

- Turning to overcrowding this brings with it the issue of externalities. It is well beyond the remit of this research to overhaul the criminal justice system but great care should be taken before the building of more prisons is adopted as a long term solution. There is sufficient feedback from respondents voicing their concern on this subject to suggest that putting more people in prison exacerbates the difficulties in offering reactive care and puts upstream initiatives further down the agenda.

- From the research it became increasingly unclear as to what targets prison health care teams were being measured against[114]. Each prison is assessed against their health audit baselines as set out in Home Office directives but whether or not they are expected to be working to NHS targets appeared unresolved. One PCT was in consultation with its SHA during the fieldwork with a view to introducing a targeting system. However, this was a local initiative and had not been completed by the time the research came to be written up.

  Although targets are controversial and the prison system has its unique set of difficulties in assessing performance, for example, with regard to factoring in lock-downs some national standards need to be established if there is to be a way of judging whether or not mainstreaming is being achieved.

- A major concern among respondents was the possibility that prison health care budgets would disappear within the overall PCT pot and that standards may actually regress as PCTs sought to allocate scarce resources among the 'general public'. This was also a concern for public health initiatives *within* prison health care budgets. In order to ensure resources continue to be designated for the prisons such funding should be ring-fenced indefinitely.

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[114] Key audit baselines for the prisons are set down in the various PSIs and PSOs related to health care in Home Office guidelines.

Furthermore, funding for public health initiatives within those budgets must be further protected.

- Finally, a second Joint Working Group comprised of officials at an executive level from the NHS and similarly ranking officials from the Prison Service should be reformed along the lines of the original committee for the purpose of, firstly, examining the current state of prison health care and, secondly, placing greater emphasis on how far the public health agenda is being promoted in the prison system (HM Prison Service and NHS Executive, 1999).

Obvious items such as staffing and the provision of better training and infrastructure are covered in the findings chapters and have been omitted here for the purposes of minimising duplication. In short there is much to be done. However, no recommendation appears unachievable given sufficient will.

## 11.3 Conclusion

As the research draws to a close there are currently 81,040 people in prison in England and Wales (Howard League, 2007). Indeed, it has been predicted that these numbers will rise in the course of the coming years with worst case scenario figures indicating that by 2011 there will be almost 88,000 people held in custody (de Silva, 2005). Providing for their needs at a level of which constitutes at least broad equivalence with service delivery in the wider community will require even greater resources than those already applied.

There are therefore likely to be substantial challenges ahead. However, as this research illustrates the criminal justice system and the role of health care within it has come a long way from the principle of less eligibility to the active pursuit of the mainstreaming goal. This paradigmatic shift is a hugely progressive step in penal philosophy and whatever the difficulties still encountered represents a fundamentally different way of thinking about how incarcerated individuals are treated[115].

[115] It is noted that such developments are far from being acknowledged as progressive in all quarters. Indeed, it is interesting that the media does not appear to have picked up on the mainstreaming goal given out cry over 'soft regimes'.

What this thesis argues though is that it does not go far enough. The mainstreaming principle does not sufficiently take into account the particular circumstances of delivering and consuming health care services in the prison estate. Essentially it seeks to introduce a model (which is acknowledged as not being without its own difficulties) into environments in which security will always take precedence over health care. I am therefore proposing that health care delivery within the prison estate needs to be adapted to the needs of unique environments not just transplanted from another model.

Also, the public health agenda which is being promoted by PCTs in the wider community is severely hampered in prisons due to the oppressive nature of the prison estate. As Smith (2000) argues, prisons themselves, almost by definition, have an impact on health and well being. However, it is also evident that no prison is precluded from advancing this agenda because of its category and opportunities certainly arise for health promotion.

What I am further proposing therefore is another paradigm shift; a move away from conceptualising prisons in social policy terms as communities separate from wider society. Virtually every inmate will be released and have an impact on the wider community. This is where the original research question concerning the impact of taking a public health perspective of criminal justice is particularly pertinent. Looked at from this position prisons are neighbourhoods in themselves and there remains no reason why they should not be included in the same regeneration initiatives as deprived socio-economic neighbourhoods in the wider community. The prison sentence (or time spent on remand) is only directed at the loss of liberty for a period of time, not the loss of liberty in a poor environment which may damage the health of a citizen.

Also, what the thesis is seeking to emphasise is that concentrating on the delivery of services is not balanced by consideration of the differential *experience* of consuming them for inmates. In order for broad equivalence to be achieved the manner in which patient/prisoners engage with services must also be addressed. As I hope the research shows the prison estate provides a very different setting for obtaining both proactive and reactive health care to what happens in the wider community.

In addition, there is the question of the criminal justice system being criminogenic in itself. The suggestion usually advanced here is that prisons are 'universities for crime'; conference venues where delegates forge '(bad) business' partnerships, with presentations given on the latest underworld technology and papers on the best methods of consuming illicit drugs disseminated (Hobbs, 1995). Indeed, though showing a decrease, latest figures indicate that approximately 55% of inmates return to prison within two years of release having been caught, convicted and sentenced of other crimes, a figure which obviously omits those who are not apprehended (Cunliffe & Shepherd, 2007).

To this I would add the criminogenic nature of poor health care. In short, if medical conditions such as mental illness and/or addiction have contributed to a person committing crime in the first place then returning them to the wider community in a worse condition makes the prison 'an accessory before a resulting future offence' (Ramsbotham, 2002).

This, of course, is easy to argue from a university office. Policy implementation on the ground, as the research illustrates, is a hugely complex and contingent matter. However, I do hope that at least some of what has emerged may be useful for both academics and professionals working in both the prison estate and social policy more generally. It was obvious, however, that during the research there were a number of avenues which merit greater exploration than the boundaries, idiosyncrasies and flaws which accompany this work. Here I will outline just three.

Firstly, as pointed out in the introductory chapter the costs of crime to victims, the criminal justice system, the NHS and society more generally are immense. Indeed, it could be further argued that they are immensely costly to criminals themselves. It would therefore appear worthwhile to investigate further the possibility for connections between ill-health and crime. For example, this research could look at issues such as whether or not better rated prisons have lower rates of recidivism i.e., is there *in reality* some pay off besides a moral one in terms of reduced criminal behaviour and its negative impact on communities and costs?

Secondly, as mentioned earlier, there is an obvious gap in the work in that the views of prisoners have not been taken into account. While independent research has been undertaken on prisoners' views in the past this work was undertaken when prisons had sole responsibility for the provision of care (Howard League, 2005). Given the involvement of the NHS and the current emphasis on treating patients as customers now appears to be an appropriate time to revisit what inmates consider to be their health care needs (Department of Health, 2005e).

Thirdly, returning to my comments earlier on the apparent conflation of incarceration for the mentally ill and the criminalised I feel the need exists to investigate this properly. While I do not underestimate the potential ethical and access issues involved, the strength of the views of respondents with many years experience of working in prisons suggests that ignoring the possibility would be a serious omission. As with much academic work then the research seems to have produced more questions than answers.

In conclusion, I would argue that utilising the central thread which runs through the thesis, i.e. addressing implementation gaps, as a key explanatory framework for delivering social policy initiatives is critical for taking forward the mainstreaming principle. If indeed Churchill was right in saying that 'the symbols which in the treatment of crime and criminals mark and measure the stored up strength of a nation, and are the sign and proof of the living virtue in it' then the present situation is problematic to say the least (Hansard, 1910). While I would not be so presumptuous as to claim to have come anywhere near the level of engagement with health care in prisons as the original Ramsbotham report, I believe the thesis illustrates the importance of developing health care in general and the public health model in particular for the betterment of society as a whole. To this end I believe that the work reinforces the view that seeing prisoners as either a patient *or* a prisoner is incomplete. Rather, I believe the research has shown that they are better conceptualised as both: Patient *and* prisoner.

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Appendix 1

Respondent codes and professional roles

| **Identifier Code** | **Professional Role** | **Primary Employer** | **Most Active in Host Institution/s** |
|---|---|---|---|
| R1 | Non-Executive Director | NHS | PCT 1 |
| R2 | Health Promotion Specialist | NHS | Prisons A/B |
| R3 | Executive Director | NHS | PCT 1 |
| R4 | Director of Public Health | NHS | PCT 1/Prisons A/B |
| R5 | Prison Health Liaison Manager | NHS | Prisons A/B |
| R6 | Head of Nursing | NHS (ex-Prison Service) | Prison A |
| R7 | GP | NHS (ex-Prison Service) | Prison A |
| R8 | Governing Governor | Prison Service | Prison A |
| R9 | POA Shop Stewart | Prison Service | Prison A |
| R10 | Detoxification Team | Prison Service | Prison A |
| R11 | Independent Monitoring Board | Independent Voluntary Organisation | Prison A |
| R12 | Ex-Governing Governor | Prison Service | Prison A |
| R13 | Governing Governor | Prison Service | Prison B |
| R14 | Health Care Centre Manager | NHS (ex-Prison Service) | Prison B |
| R15 | Independent Monitoring Board | Independent Voluntary Organisation | Prison B |
| R16 | Health Care Officer | NHS | Prison B |
| R17 | Head of Clinical Governance | NHS | PCT 2 |
| R18 | Clinical Governance Manager | NHS | PCT 2 |
| R19 | Drug Strategy Lead | NHS | PCT 2 |
| R20 | Prison Health Liaison Manager | NHS | PCT 3/Prison D |
| R21 | Director of Public Health | NHS | PCT 3/Prison C |
| R22 | GP | NHS | PCT 2/Prison C |

| | | | |
|---|---|---|---|
| R23 | Health Care Centre Manager | Prison Service/NHS (role under review) | Prison C |
| R24 | Nurse (RGN) | NHS (ex-Prison Service) | Prison C |
| R25 | Prison Health Development Manager (temporary position) | NHS | PCT 2/Prison C |
| R26 | Director of Public Health | NHS | PCT 3 |
| R27 | Health Care Centre Manager | NHS (ex-Prison Service) | Prison D |

Host institution codes and areas of responsibility

| **Prison's coded title** | **Prison category** | **PCT Responsible** |
|---|---|---|
| Prison A | B Local | PCT 1 |
| Prison B | High Secure | PCT 1 |
| Prison C | D Resettlement | PCT 2 |
| Prison D | YOI | PCT 3 |

Appendix 2

Prison security categories for men

All male prisoners are given a security categorisation when they enter prison. These categories are based on the likelihood that they'll try to escape, and the danger to the public if they did escape. The four categories are:

1. Category A - prisoners whose escape would be highly dangerous to the public or national security

2. Category B - prisoners who don't require maximum security, but for whom escape needs to be made very difficult

3. Category C - prisoners who can't be trusted in open conditions but who are unlikely to try to escape

4. Category D - prisoners who are trusted enough to wander freely but must show up for daily roll calls

Young Offender – Aged between 18-20

(HM Prison Service, 2000)

Appendix 3

Research Ethics Committee supporting documentation and interview questionnaires

1. Participant Information Sheet

1. Research Title

**'Organisational Adaptability and the Transfer of Funding for Health Care responsibility in Prisons in England and Wales'**

2. The researcher is currently studying for a PhD. in the School of Applied Social Sciences at the University of Durham. Participants should note that the research is part of an educational qualification.

3. Background

A collaborative research project between Durham University's Department of Sociology and Social Policy and the Health Development Agency (HDA) (North East), funded by the Economic and Social Research Council and the HDA, is investigating the implications of the transfer of responsibility for prison health from the Home Office to NHS Primary Care Trusts (PCTs).

This transfer of responsibility for prison health care to PCTs is part of the government's strategy for 'mainstreaming' prison health care in the NHS. By April 2006, PCTs will become responsible for the commissioning and provision of health services to prisoners in their areas. This transfer offers substantial opportunities to improve prison health services and the health of prisoners, for example, by improving the links between primary care inside and outside prisons and ensuring that prisoners benefit from health care improvements and initiatives in the wider NHS.

4. Aims

The research aims to explore the community health implications of prisoner health and to consider the factors that are likely to influence the success or otherwise of making PCTs responsible for prison health services. It will tackle a number of questions. For example:

- From what is known about the nature and range of health issues among the prison/ex-prison population, what are the public health consequences of these health issues and how might they be tackled?
- How, if at all, do PCTs and their communities understand the community health implications of prison health issues? What might help these links to be made?

- What information, collaboration and support do PCTs need to carry out their funding, commissioning and providing responsibilities in relation to prison health?

It is also planned that the research will provide the participating prisons with an understanding of the difficulties experienced by PCTs in aiming to eliminate inequalities between the provision of health care within prisons and that offered by the NHS in the wider community as well as bring to the attention of PCTs issues which are of concern to the prison estate.

In addition, it is hoped that the research will identify 'best practices' across the respondent institutions and professions which will be disseminated to the participating respondents/institutions locally as well as to policy makers at a national level, e.g. Prison Health within the Department of Health.

5. Participation is entirely voluntary and confidential.

No personal details apart from occupation will be included. In addition, the identity of the host organisation, i.e. the prison or PCT, will be coded rather than named thus reinforcing the anonymity of participants.

Also, each participant will be provided with feedback and the opportunity to comment on my draft analysis. Each interviewee will be asked to sign an informed consent form confirming their agreement to voluntarily participate in the study and will be provided with a letter outlining their guarantee of confidentiality.

Turning to the actual interviews each participant will be provided with a copy of the interview questions. The interview will be recorded using an audio recording device for the purpose of transcription. It is anticipated that each interview will last for no more than one and a half hours.

Finally, each participant will be provided with a copy of the 'best practice' procedures which have been identified during the study. These will be made available during the final stage of the research in September 2006.

2. Letter Guaranteeing Confidentiality

To whom it may concern

Dear Sir/Madam

**Re: Research on Health Care in Prisons – Guarantee of Confidentiality**

Firstly, thank you for agreeing to participate in this research. This letter is your guarantee that no personal or place of employment details apart from occupation will be available in the researcher's draft or final thesis, reports or articles.

This commitment is re-stated below;

Participation is entirely voluntary and confidential. No personal details apart from occupation will be included. In addition, the identity of the host organisation, i.e. the prison or PCT, will be coded rather than named thus reinforcing the anonymity of participants.

Also, each participant will be provided with feedback and the opportunity to comment on my draft analysis. Each interviewee will be asked to sign an informed consent form confirming their agreement to voluntarily participate in the study and will be provided with a letter outlining their guarantee of confidentiality.

Should you have any queries or concerns regarding this then please do not hesitate to contact me.

Yours sincerely

---

John Quinn
Prison Health Care Researcher

3. Research on Health Care in Prisons – Front Sheet

Background Information on Participant[116]

1. Professional Title

_____

2. Length of Service

(a) Current Position

_____

(b) Previous Position(s)

_____

3. Institution

(a) Current Employer

_____

(b) Previous Employer(s)

_____

4. Gender

_____

5. Age

_____

[116] Each category, apart from occupation, will be allocated a code for the purposes on anonymising both respondents and institutions.

4. Letters of invitation to Participants (on headed paper)

Dear Sir/Madam/Title

Research Title:

**Organisational Adaptability and the Transfer of Responsibility for Health Care Provision in Prisons in England and Wales**

You are being invited to take part in a research study. Before you decide it is important for you to understand why the research is being done and what it will involve. Please take time to read the following research participant information sheet carefully and discuss it with others if you wish. Ask if there is anything that is not clear or if you would like more information.

I would be grateful if you could advise me of your decision by xx/xx/xxxx. Should you decide to become involved then I will contact you again to arrange a convenient time, date and location for the interview to take place.

Thank you for your time. I look forward to hearing from you.

Yours sincerely

---

John Quinn
Prison Health Care Researcher

5. Research Participant Consent Form

**CONSENT FORM**

Title of Project:

Organisational Adaptability and the Transfer of Responsibility for Health Care in Prisons in England and Wales

Name of Researcher:

1. I confirm that I have read and understood the information sheet dated ..... for the above study and have had the opportunity to ask questions.

2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason, without my legal rights being affected.

3. It is a condition of my participation that my identity will remain anonymous.

4. I agree to take part in the above study.

| | | |
|---|---|---|
| ---------- | ---------- | ---------- |
| Name of participant | Date | Signature |
| ---------- | ---------- | ---------- |
| Name of Person taking consent (if different from researcher) | Date | Signature |
| ---------- | ---------- | ---------- |
| Researcher | Date | Signature |

**Interview Schedules** Date: 21st June 2006 Final Version 2

## Core Questions

1. Have you encountered any 'cultural differences' between in the way the NHS approaches health care and how services for prisoners/patients now operate?

2. Have there been any difficulties implementing national policy at local level?

3. The public health agenda places a strong emphasis on health promotion in prisons. Do you feel that the balance between prevention and education on the one hand, and re-active treatment on the other, is right?

4. What improvements have you see in infrastructure? How are the new IT systems settling in?

5. What have been the main difficulties in taking on the commissioning of primary health care in prisons?

6. What additional support do PCTs need in order to carry out their new responsibilities?

7. Has the transfer of commissioning to the PCTs had any outcomes for throughcare?

8. To what extent is it possible to provide health care services within prisons which offer a 'broad equivalence' with those available in the wider community?

9. Taking a broad definition of health to include well-being and prevention of ill-health as well as treating illness, what do you see as the main health issues in prison?

10. How can these issues best be tackled?

11. Moving on to evaluating progress to date, although it is early days, are there any positive outcomes that have been identified?

12. Are there any factors which have smoothed through the transition?

13. Has there been any resistance to change, if so how was/is it being managed?

14. Have you any concerns about priorities or resources regarding prison health care in the future?

15. How do you see the relationship between prison health and community health and what is the role of the PCT in managing this relationship?

Also used for IMB respondents.

**PCT Chief Executive/Director of Public Health/PCT Non-Executive Director**

Core Questions Plus;

1. How do you feel about PCTs taking on responsibility for primary care in prisons?

2. Why should PCTs take on responsibility for primary care in prisons?

3. And, if so, how have these been overcome?

4. Can we move on to the partnership building process with the prison/s? How has the process evolved from the PCT's perspective?

5. Another aspect of the transfer is PCTs taking on responsibility for clinical governance in prisons. Has this resulted in increased scrutiny and accountability for their work?

6. Can we move on to staff issues? How have the changes affected the professional lives of existing health care centre staff in the prisons?

7. How effective is inter-agency working *within* the prison?

8. How will targets be affected by these new responsibilities?

**General Practitioner**

Core Questions Plus;

1. One of the main goals of transferring commissioning responsibility for primary care in prisons to PCT is to work towards 'mainstreaming' the service provided in prison with that seen in the wider community. What progress towards 'broad equivalence' have you observed to date?

2. Can I turn to your own professional career? Have you also practised in the community? If so, what are the main differences?

3. What differences has transferring the commissioning of primary care in prisons made to how primary care is provided in the prison setting?

4. How have the changes affected your role as a health care professional?

5. Has the transfer of commissioning changed your relationship with other health care professionals such as nurses?

6. What additional support have you had from the PCT which was unavailable under the old system?

7. What impact does using escorts to bring prisoners to the health care centre have on providing primary care services?

8. Have the prisoners' views been included in planning health care services?

**Prison Health Liaison Officer**

Core Questions plus;

1. How has your relationship with security staff in the prison developed?

2. What have the main issues been when establishing a working relationship with the prison?

3. What changes have the PCTs introduced since taking over?

4. Moving on to staffing issues, how have the changes affected the professional identities of what are now new NHS staff?

5. Have prisoners' views been taken into account? In what ways?

6. What additional support does the PCT need in order to move towards the goal of 'mainstreaming' services in prison with those in the wider NHS?

**Prison Health Centre Staff**

Core questions plus;

1. Can we start with your own professional career? How has the transfer of commissioning of primary care services affected your role as a health care professional?

2. What about training opportunities or opportunities to work for a time outside the prison?

3. Have your relationships with others working in health care such as the CARATs team, the Mental Health In-Reach team, and the GPs changed since the transferring of commissioning of primary health care to the PCT?

4. Have you always been NHS staff or have you transferred over from the prison service? If you have moved across from the prison service how have you found moving to a new employer?

5. What additional support have you had from the PCT which was unavailable under the old system?

6. How do you view your relationship with prison security staff?

7. One of the stated aims of transferring the commissioning of primary care in prisons to PCTs is that health care services which are provided in prisons are 'broadly equivalent' to service provision in the wider community? How do you feel about this goal?

8. Do you have any difficulties in carrying out your duties because of directives which are established at a national level which do not easily fit with the particular environment in which you work?

9. What feedback you have been getting from prisoners about how health care is changing?

10. What are the biggest difficulties you experience in the day to day provision of health care?

11. How do you feel about the Prison Health Delivery Plan?

12. Are condoms available for inmates in the prison? If not, why not?

13. Although it is early days, how would you evaluate progress to date? For example, what positive outcomes have you seen?

14. Turning to patient's records is the new IT system now in place? What difference has it made?

15. What health education do prisoners receive? Has this changed in any way since the PCT took over primary care?

16. Would you recommend working in prisons to other health care professionals?

Appendix 4

*Framework* analysis

pp.292-308

Area A Mainstreaming (M)

| | Attitude to (M) | Progress towards (M) | Prison health services > NHS | NB of NHS | Attitude of senior prison staff to (M) | Attitude of general PS staff to (M) | NB of prison culture | Ethical/ Profess-ional com-promises necessary | Influence of CJS policy on healthcare outcomes | Effect of change on career | Improve-ments under way anyway - evidence | Poss of (M) in long run | Diverge from (M)? | Non-medical /medical model in discourse | Whole prisons model in discourse | Influence of prison environ-ment on health |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| R1 | 1 | .7 | .5 | .8 | 1 | | .7 | 1 | .9 | 1 | | .8 | 1 | 5/5 | 1 | |
| R2 | 1 | .6 | .5 | .6 | | .4 | .7 | 1 | .7 | 1 | | .8 | 1 | 8/2 | 1 | 0 |
| R3 | 1 | .6 | .5 | .8 | 1 | | .8 | 1 | .8 | | | .9 | 1 | 4/6 | 1 | |
| R4 | 1 | .7 | .3 | .7 | 1 | .3 | .7 | 1 | .8 | | | .7 | 1 | 3/7 | 1 | 0 |
| R5 | 1 | .7 | .3 | .7 | 1 | .4 | .8 | 1 | .8 | 1 | | .8 | 1 | 2/8 | 1 | 0 |
| R6 | 1 | .7 | .4 | .7 | 1 | .4 | .8 | 1 | .7 | 1 | .6 | .8 | 1 | 2/8 | 1 | 0 |
| R7 | 1 | .7 | .3 | .8 | 1 | .3 | .7 | 1 | .8 | 1 | .7 | .8 | 1 | 3/7 | 1 | 0 |
| R8 | 1 | | | .5 | 1 | .5 | .8 | 0 | .9 | | 1 | .6 | 1 | 5/5 | 1 | |
| R9 | 1 | .5 | .5 | .5 | | .6 | .8 | 1 | .9 | | .8 | | 1 | 5/5 | 1 | .5 |
| R10 | 1 | | | .6 | | | .8 | 0 | .8 | | | | 1 | 2/8 | 1 | 0 |
| R11 | 1 | .5 | | .3 | | .6 | .8 | 0 | .8 | | .5 | | 1 | 2/8 | 1 | 0 |
| R12 | 1 | .5 | | .7 | 1 | .5 | .8 | 1 | .9 | | 1 | .6 | 1 | 5/5 | 1 | 0 |
| R13 | 1 | .6 | .5 | .8 | 1 | .7 | .7 | 0 | .8 | .5 | .7 | .8 | | 5/5 | 1 | 0 |
| R14 | 1 | .6 | .6 | .5 | | | .8 | 1 | .7 | .5 | .5 | .6 | 1 | 4/6 | 1 | 0 |
| R15 | 1 | | | .7 | 1 | | .7 | 0 | .8 | | | | | | 1 | |
| R16 | 1 | .8 | .6 | .6 | 1 | .4 | .7 | 1 | .7 | | .8 | | | 5/5 | 1 | |

Key 1 = positive, 0 = negative
1 = yes, 0 = no

PCT Primary Care Trust
PS Prison Service
CJS Criminal Justice System
IMB Independent Monitoring Board

Area B Mainstreaming (M)

| | Attitude to (M) | Progress towards (M) | Prison health services > NHS | NB of NHS | Attitude of senior prison staff to (M) | Attitude of general PS staff to (M) | NB of prison culture | Ethical/ Profess-ional com-promises necessary | Influence of CJS policy on healthcare outcomes | Effect of change on career | Improve-ments under way anyway - evidence | Poss of (M) in long run | Diverge from (M)? | Non-medical /medical model in discourse | Whole prisons model in discourse | Influence of prison environment on health |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| R17 | 1 | .6 | | .7 | | | | 1 | | 1 | | .7 | | 4/6 | 1 | 0 |
| R18 | 1 | | | | 1 | | .8 | 1 | .6 | 1 | | .8 | 1 | 5/5 | 1 | 0 |
| R19 | 1 | .7 | .5 | .8 | 1 | | | 1 | | .5 | | .7 | 1 | 4/6 | 1 | |
| R20 | 1 | .7 | .5 | .7 | 1 | .5 | .7 | 1 | | .7 | | .7 | 1 | 4/6 | 1 | 0 |
| R21 | 1 | | .5 | .6 | | | .8 | 1 | .8 | | | .7 | 1 | 8/2 | 1 | .5 |
| R22 | 1 | .9 | .6 | .7 | | | .7 | 1 | | | 0 | .9 | 1 | 3/7 | 1 | 0 |
| R23 | 1 | | | | | | | | | 0 | .8 | .7 | | | 1 | 1 |
| R24 | 1 | .8 | | .6 | | | .7 | 1 | | 0 | .7 | .7 | 1 | 5/5 | 1 | .5 |

Area C Mainstreaming (M)

| | Attitude to (M) | Progress towards (M) | Prison health services > NHS | NB of NHS | Attitude of senior prison staff to (M) | Attitude of general PS staff to (M) | NB of prison culture | Ethical/ Profess-ional com-promises necessary | Influence of CJS policy on healthcare outcomes | Effect of change on career | Improve-ments under way anyway - evidence | Poss of (M) in long run | Diverge from (M)? | Non-medical /medical model in discourse | Whole prisons model in discourse | Influence of prison environment on health |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| R25 | 1 | .6 | .5 | .7 | | | .7 | | .7 | 0 | .5 | .6 | 1 | 4/6 | 1 | .5 |
| R26 | 1 | .5 | .5 | .7 | 1 | .5 | .8 | 1 | | | | | 0 | 5/5 | 0 | |
| R27 | 1 | .9 | .7 | .1 | 1 | .5 | .8 | 1 | .5 | | 1 | | | 4/6 | | 1 |

Area A Public Health Agenda (PHA)

| | Attitude of NHS staff to PHA | Attitude of PS to PHA | Implementation of PHA medicalised model (A) | Implementation of PHA non-Medicalised (B) | Barriers to (A) | Barriers To (B) | Priority to med/non-med (based on work done) | Specific Health Promotion Staff in place | Importance of PHA Agenda for wider Community nonmed/ med | Embeddedness of PHA in discourse as an aspiration | Medical PHA in actual work | Non-medical PHA in actual work |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| R1 | | | 1 | 1 | .3 | .5 | 8/2 | 1 | .8 | .8 | .8 | .2 |
| R2 | .5 | .4 | n/a | 1 | n/a | .6 | 0/10 | 1 | .9 | 1 | n/a | 1 |
| R3 | 1 | | 1 | 0 | .3 | .8 | 8/2 | 1 | .9 | .9 | .8 | .4 |
| R4 | 1 | | 1 | .5 | .3 | .8 | 9/1 | 1 | .9 | .9 | .8 | .2 |
| R5 | 1 | | 1 | 0 | .5 | .8 | 8/2 | 1 | .9 | .9 | .7 | .1 |
| R6 | 1 | | 1 | 0 | .3 | .8 | 8/2 | 1 | .9 | .8 | .8 | .2 |
| R7 | 1 | | 1 | 0 | .4 | .8 | 8/2 | 1 | .9 | .8 | .6 | .2 |
| R8 | | | 1 | 1 | .4 | .4 | 7/3 | 1 | .8 | .8 | .7 | .6 |
| R9 | | 1 | | 0 | .7 | | | | .9 | .9 | .6 | .6 |
| R10 | | | 1 | 0 | .7 | .8 | 9/1 | 1 | .9 | .8 | .8 | .2 |
| R11 | | 1 | 1 | 0 | .8 | .8 | n/a | n/a | .9 | .8 | .8 | .1 |
| R12 | 1 | | 1 | 1 | .6 | .6 | 7/3 | 0 | .9 | .9 | .7 | .7 |
| R13 | 1 | 1 | 1 | 1 | .3 | .3 | 6/4 | | .9 | 1 | .8 | .6 |
| R14 | 1 | | 1 | 0 | .4 | .6 | 8/2 | 1 | .8 | .7 | .7 | .2 |
| R15 | | | | | | | | | .8 | 0 | | .3 |
| R16 | 1 | .5 | 1 | 1 | .3 | .3 | 8/2 | 1 | .8 | .7 | .6 | .4 |

Area B Public Health Agenda (PHA)

| | Attitude of NHS staff to PHA | Attitude of PS to PHA | Implementation of PHA medicalised model (A) | Implementation of PHA non-Medicalised (B) | Barriers to (A) | Barriers To (B) | Priority to med/non-med (based on work done) | Specific Health Promotion Staff in place | Importance of PHA Agenda for wider Community nonmed/ med | Embeddedness of PHA in discourse as an aspiration | Medical PHA in actual work | Non-medical PHA in actual work |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| R17 | 1 | n/k | n/k | .n/k | .4 | .3 | | | .9 | .8 | .8 | .5 |
| R18 | 1 | | 1 | 0 | .2 | .7 | 6/4 | 0 | .8 | .8 | .7 | .2 |
| R19 | 1 | | 1 | .5 | .4 | .4 | 7/3 | 0 | .8 | .8 | .8 | .6 |
| R20 | .5 | | .5 | 0 | .4 | .4 | 8/2 | 0 | | .9 | .8 | .3 |
| R21 | 1 | .5 | 1 | 1 | .4 | .8 | 8/2 | 0 | .8 | .9 | .5 | .3 |
| R22 | 1 | | .5 | 0 | .7 | .8 | 8/2 | 0 | .8 | .8 | .8 | .2 |
| R23 | 1 | 1 | | 1 | | | | 0 | .8 | .8 | .5 | .6 |
| R24 | 1 | 1 | 1 | 1 | .2 | .2 | | 0 | .8 | .8 | .8 | .4 |

Area C Public Health Agenda (PHA)

| | Attitude of NHS staff to PHA | Attitude of PS to PHA | Implementation of PHA medicalised model (A) | Implementation of PHA non-Medicalised (B) | Barriers to (A) | Barriers To (B) | Priority to med/non-med (based on work done) | Specific Health Promotion Staff in place | Importance of PHA Agenda for wider Community nonmed/ med | Embeddedness of PHA in discourse as an aspiration | Medical PHA in actual work | Non-medical PHA in actual work |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| R25 | 1 | | 1 | 0 | .2 | .4 | | 0 | .8 | .7 | .6 | .1 |
| R26 | 1 | | | | .5 | .5 | | | .9 | .7 | .4 | .3 |
| R27 | .5 | 0 | 1 | 1 | .1 | .4 | | 0 | .8 | .7 | .7 | .2 |

Area A Implementation Gaps

| | Broad compliance with policy | Diversion from other NHS goals | Alignment with community health promotion | Gaps due to funding shortages | Gaps due to prison environment /local issues | Lack of educational support for PCTs by government | Difficulties due to security | Poor direction from central government | Gaps due to unresolved staffing issues | Inefficiencies caused by changes | Spending on general pop vs. prison pop | Local initiatives | Disengage-ment from health care |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| R1 | 1 | 1 | | 1 | 1 | | | 0 | 1 | | 1 | 1 | |
| R2 | 1 | | | 1 | 1 | 1 | .7 | 1 | | | | 1 | |
| R3 | 1 | 1 | | 0 | 1 | 1 | 1 | 1 | 1 | | 1 | 1 | |
| R4 | 1 | 1 | 0 | 1 | 1 | | 1 | 1 | 1 | 1 | 1 | 1 | |
| R5 | 1 | 1 | 1 | 0 | 1 | 1 | 1 | 1 | 1 | | | 1 | |
| R6 | 1 | 1 | 1 | 0 | .5 | 1 | | 1 | | 1 | 1 | 1 | |
| R7 | 1 | 1 | 0 | 1 | 1 | | 1 | 1 | 1 | | | 1 | |
| R8 | 1 | | | 1 | 1 | | | 1 | 1 | | 1 | | |
| R9 | 1 | 1 | 0 | 1 | 1 | | | 1 | 1 | | | | 1 |
| R10 | 1 | | | 1 | 1 | | | .5 | 0 | 1 | | | |
| R11 | 1 | | 0 | 1 | 1 | | | 1 | | | | | |
| R12 | 1 | | | 1 | 1 | 1 | | 1 | 1 | | 1 | 1 | |
| R13 | 1 | | | 1 | 1 | 1 | .5 | 1 | 1 | | 1 | 1 | |
| R14 | 1 | 1 | | 1 | | | | 1 | 1 | 1 | | 1 | |
| R15 | 1 | | | | | | | | 1 | | | | |
| R16 | 1 | | 1 | 1 | 1 | | .2 | | | | | | |

Area B Implementation Gaps

| | Broad compliance with policy | Diversion from other NHS goals | Alignment with community health promotion | Gaps due to funding shortages | Gaps due to prison environment /local issues | Lack of educational support for PCTs by government | Difficulties due to security | Poor direction from central government | Gaps due to unresolved staffing issues | Inefficiencies caused by changes | Spending on general pop vs. prison pop | Local initiatives | Disengage-ment from health care |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| R17 | 1 | 1 | | 1 | 1 | 1 | | 1 | | | | 1 | |
| R18 | 1 | | 0 | 1 | | 1 | | 1 | | | 1 | | |
| R19 | 1 | 1 | | 1 | 1 | 1 | | 1 | 1 | | 1 | 1 | |
| R20 | 1 | 1 | | 1 | 1 | 1 | .1 | 1 | 1 | | | 1 | |
| R21 | 1 | | | 1 | 1 | 1 | | 1 | 1 | | 1 | 1 | |
| R22 | 1 | | 0 | 1 | 1 | 1 | 1 | 1 | 1 | | | | |
| R23 | 1 | | | 1 | 1 | | | 1 | | | | | |
| R24 | 1 | 1 | | | 1 | | 1 | | 1 | 1 | | | |

Area C Implementation Gaps

| | Broad compliance with policy | Diversion from other NHS goals | Alignment with community health promotion | Gaps due to funding shortages | Gaps due to prison environment /local issues | Lack of educational support for PCTs by government | Difficulties due to security | Poor direction from central government | Gaps due to unresolved staffing issues | Inefficiencies caused by changes | Spending on general pop vs. prison pop | Local initiatives | Disengage-ment from health care |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| R25 | 1 | | | 1 | | 1 | | | 1 | | | | |
| R26 | 1 | | | 1 | | | | | n/k | | | | |
| R27 | 1 | 1 | | 1 | | | | 1 | 1 | 1 | | 1 | |

Area A Street-level bureaucracy

| | Opportunities for agency in prison | Opportunities for flexibility in community | Increased inefficiencies due to bureaucracy | Frustration as a public servant | Specific local initiatives employed |
|---|---|---|---|---|---|
| R1 | | | | | 1 |
| R2 | 0 | | | | 1 |
| R3 | 0 | 1 | | | 1 |
| R4 | .5 | | | | 1 |
| R5 | .5 | | | | 1 |
| R6 | .5 | | 1 | | 1 |
| R7 | 0 | 1 | | | 1 |
| R8 | 0 | | | | 1 |
| R9 | 0 | | | 1 | |
| R10 | 0 | | 1 | | |
| R11 | n/a | | | | |
| R12 | .1 | | | | 1 |
| R13 | .1 | | | | 1 |
| R14 | 1 | | | | |
| R15 | n/a | | | | |
| R16 | .2 | | | | 1 |

Area B Street-level bureaucracy

| | Opportunities for agency in prison | Opportunities for flexibility in community | Increased inefficiencies due to bureaucracy | Frustration as a public servant | Specific local initiatives employed |
|---|---|---|---|---|---|
| R17 | 0 | 1 | | | |
| R18 | | 1 | | | |
| R19 | 0 | 1 | | | |
| R20 | .1 | | | 1 | 1 |
| R21 | 0 | 1 | 1 | 1 | 1 |
| R22 | 0 | 1 | | | 1 |
| R23 | 0 | | | | |
| R24 | | | | 1 | 1 |

Area C Street-level bureaucracy

| | Opportunities for agency in prison | Opportunities for flexibility in community | Increased inefficiencies due to bureaucracy | Frustration as a public servant | Specific local initiatives employed |
|---|---|---|---|---|---|
| R25 | 0 | | | | 1 |
| R26 | | | | | |
| R27 | 1 | | 1 | | 1 |

Area A Partnerships

| | Evidence of partnership building; senior level PCT/PS | Evidence of partnership building at ground level in prison PS/PCT | Resistance at senior level PS | Resistance at junior level PS | Importance of Governing Governor | Effect of change on internal agency working | Internal agency working effectiveness | Resistance at junior level NHS |
|---|---|---|---|---|---|---|---|---|
| R1 | 1 | | 0 | 1 | 1 | | | |
| R2 | | 1 | 0 | 1 | | 1 | .6 | |
| R3 | 1 | 1 | 0 | 1 | 1 | | | 1 |
| R4 | .8 | .4 | 0 | 1 | 1 | 1 | Was .2 Now .8 | |
| R5 | .7 | .2 | 0 | 1 | 1 | 0 | .1 | |
| R6 | .8 | .3 | 0 | 1 | 1 | 1 | .6 | .3 |
| R7 | .9 | .5 | 0 | 1 | 1 | | | .2 |
| R8 | 1 | .5 | 0 | 1 | 1 | | | 1 |
| R9 | | .4 | | 1 | 1 | | | |
| R10 | | .7 | | | | | | |
| R11 | | .6 | | | | | | |
| R12 | 1 | | | .3 | 1 | | | |
| R13 | 1 | .5 | 0 | .2 | 1 | 1 | .6 | |
| R14 | .8 | .5 | 0 | 1 | | 1 | .6 | .6 |
| R15 | | .6 | | | | | | |
| R16 | | .7 | | .2 | | | | |

Area B Partnerships

| | Evidence of partnership building; senior level PCT/PS | Evidence of partnership building at ground level in prison PS/PCT | Resistance at senior level PS | Resistance at junior level PS | Importance of Governing Governor | Effect of change on internal agency working | Internal agency working effectiveness | Resistance at junior level NHS |
|---|---|---|---|---|---|---|---|---|
| R17 | n/k | n/k | | | | | | |
| R18 | .7 | | 0 | | | | .2 | |
| R19 | 1 | | 0 | 1 | 1 | 1 | .5 | |
| R20 | 1 | .5 | 0 | 1 | .8 | .1 | .1 | |
| R21 | .5 | .5 | | 1 | .8 | | | |
| R22 | 1 | | | 1 | | | | |
| R23 | | | | 1 | | | | .7 |
| R24 | .4 | 0 | | | | | .4 | 1 |

Area C Partnerships

| | Evidence of partnership building; senior level PCT/PS | Evidence of partnership building at ground level in prison PS/PCT | Resistance at senior level PS | Resistance at junior level PS | Importance of Governing Governor | Effect of change on internal agency working | Internal agency working effectiveness | Resistance at junior level NHS |
|---|---|---|---|---|---|---|---|---|
| R25 | .6 | .1 | 0 | | | | .2 | .5 |
| R26 | .7 | .3 | 0 | 1 | | | | |
| R27 | .4 | .2 | 0 | 1 | 1 | 0 | .8 | .6 |

Area A Outcomes

| | Positive outcomes due to NHS | Negative outcomes due to NHS | Unresolved issues NHS | Positive outcomes due to PS/CJS | Negative outcomes due to PS | Unresolved issues PS | Unresolved outcomes due to central government | Attitude to care pathways | Care pathways in situ |
|---|---|---|---|---|---|---|---|---|---|
| R1 | .8 | | .5 | .6 | | .5 | .1 | 1 | 1 |
| R2 | .7 | | .4 | .2 | .5 | .5 | | 1 | 1 |
| R3 | .8 | | .6 | | | .4 | .8 | 1 | .5 |
| R4 | .8 | | | .2 | .5 | .5 | | 1 | .5 |
| R5 | .8 | | .2 | .3 | .5 | .5 | | 1 | 1 |
| R6 | .8 | | | .6 | .2 | | | 1 | 1 |
| R7 | .5 | .1 | .3 | .5 | .6 | | | 1 | 1 |
| R8 | .6 | | .7 | .7 | .2 | .7 | .7 | 1 | 1 |
| R9 | | .3 | .1 | | | | | 1 | |
| R10 | | | | | | .9 | | 1 | 1 |
| R11 | .5 | .9 | | | | .8 | | 1 | |
| R12 | .8 | | .5 | | | .5 | .7 | 1 | .5 |
| R13 | .8 | | .3 | .7 | | .5 | .8 | 1 | .5 |
| R14 | .7 | .6 | .2 | .4 | .2 | | | 1 | .5 |
| R15 | | | | | | | | 1 | .5 |
| R16 | .3 | | | .6 | .1 | | | 1 | 1 |

Area B Outcomes

| | Positive outcomes due to NHS | Negative outcomes due to NHS | Unresolved issues NHS | Positive outcomes due to PS/CJS | Negative outcomes due to PS | Unresolved issues PS | Unresolved outcomes due to central government | Attitude to care pathways | Care pathways in situ |
|---|---|---|---|---|---|---|---|---|---|
| R17 | .7 | | | | | | | 1 | .5 |
| R18 | | | .5 | | | .5 | | 1 | .5 |
| R19 | .7 | | .6 | .3 | | .6 | .8 | 1 | 1 |
| R20 | .6 | | .4 | .4 | .6 | .5 | .8 | 1 | .5 |
| R21 | .4 | | .7 | | | .6 | .8 | 1 | .5 |
| R22 | .8 | | .4 | | .6 | .5 | .6 | 1 | .2 |
| R23 | | .6 | .7 | | | .7 | | 1 | 1 |
| R24 | .3 | .9 | .9 | .7 | .2 | .2 | | 1 | 1 |

Area C Outcomes

| | Positive outcomes due to NHS | Negative outcomes due to NHS | Unresolved issues NHS | Positive outcomes due to PS/CJS | Negative outcomes due to PS | Unresolved issues PS | Unresolved outcomes due to central government | Attitude to care pathways | Care pathways in situ |
|---|---|---|---|---|---|---|---|---|---|
| R25 | .2 | | | .6 | .2 | | | 1 | 1 |
| R26 | .8 | | | | | | | 1 | |
| R27 | .1 | .4 | | .9 | | .1 | | 1 | 1 |

Area A Main Health Issues

| | In general | Medicalised public health agenda (PHA) | Non-medicalised PHA (upstream) |
|---|---|---|---|
| R1 | Hep C, Mental Health | Hep C | Health education |
| R2 | Chronic diseases | Sexually transmitted diseases (STDs), Blood borne viruses (BBVs) | Health promotion; literacy, sexual health education |
| R3 | Mental health | Substance misuse | Employment skills, education, health promotion |
| R4 | Mental health | STDs, BBVs | Health promotion |
| R5 | Mental health, self-harm | STDs, BBVs, Substance misuse | Health promotion |
| R6 | Mental health, chronic diseases | Substance misuse, BBVs | Health promotion |
| R7 | Mental health | BBVs | Contact with families |
| R8 | Mental health | Substance misuse | Employment, job skills, education |
| R9 | Drug misuse | Drug misuse | Housing, employment |
| R10 | Drugs, Hepatitis (type/s unspecified) | Substance misuse, the Criminal Justice System (CJS) itself | CJS |
| R11 | Mental health | Mental health | Mental health |
| R12 | Mental health, drugs | Mental health, drugs | Mental health, drugs, self-harm |
| R13 | Mental health, chronic diseases | Hep B, Hep C | Smoking cessation, health promotion |
| R14 | Mental health | | Mental health |
| R15 | Mental health | Mental health | Mental health |
| R16 | Mental health, need for more specialists in prisons | Mental health | Upstream mental health |

Area B Main Health Issues

| | In general | Medicalised public health agenda (PHA) | Non-medicalised PHA (upstream) |
|---|---|---|---|
| R17 | Mental health, Chronic heart disease (CHD), Diabetes | | Exercise |
| R18 | Chronic asthma | STDs, BBVs | Sexual health, drugs, education |
| R19 | Chronic disease management, drugs | Drug misuse | Healthier life styles |
| R20 | Teeth, oral hygiene | | Health promotion, education on access to services outside on release, smoking cessation |
| R21 | Mental health | Smoking, alcohol, oral health | Whole public health agenda |
| R22 | Prisoners seen as an 'ill population' in general | | Health education |
| R23 | Asthma, some chronic diseases | | Education, employment |
| R24 | Limited chronic health diseases | | Health education |

Area C Main Health Issues

| | In general | Medicalised public health agenda (PHA) | Non-medicalised PHA (upstream) |
|---|---|---|---|
| R25 | Drugs, teeth, dental hygiene, sexual health | Drugs, dental health | Sexual health, oral hygiene |
| R26 | Mental health, dentistry | Mental health, dentistry | Education on lifestyles |
| R27 | Drug addiction | Teeth, oral health, STDs | Sexual health education, dental health care (upstream), bullying |

Area A Miscellaneous

| | IT system progress | Effect of changes on staff moral; ground level | Systemic barriers to PHA | PCT 'knows best' | PS 'knows best' | Clarity on targets | Concern for future of health care in PS | Polar opposite opinions | Gaps in PCT knowledge of prison environments | Requests for prisoner input in health care | Discourse of responsibility; Back to the individual | Independent Monitoring Board view | Cross manipulation of other system | Dual ownership of the environment |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| R1 | .3 | .5 | | .5 | .5 | | 1 | | | | | | | 1 |
| R2 | .7 | | 1 | | | .5 | | | 1 | 1 | 1 | | | |
| R3 | .5 | .5 | 1 | .5 | .5 | .4 | 1 | 1 | 1 | | | | | |
| R4 | | | 1 | .8 | .2 | | 1 | 1 | | 0 | 1 | | | 1 |
| R5 | | .5 | 1 | .7 | .3 | | 1 | | 1 | | | | 1 | |
| R6 | .3 | .5 | 1 | .8 | | | | | 1 | 0 | | | 1 | |
| R7 | .2 | .2 | | .6 | .4 | .5 | 1 | | | 0 | | | | |
| R8 | | .2 | 1 | | | .9 | 1 | | 1 | | | | | 1 |
| R9 | | .3 | 1 | .5 | .5 | .5 | 1 | 1 | 1 | | 1 | | | 1 |
| R10 | | .2 | | | | | | | | 0 | 1 | | | |
| R11 | | | 1 | | | .5 | 1 | | | 1 | | 0 | | |
| R12 | | | 1 | .5 | .5 | | 1 | | 1 | | | | | |
| R13 | | .3 | | .5 | .5 | .5 | 1 | | 1 | | 1 | | 1 | 1 |
| R14 | .2 | .3 | | | | .5 | | | | 0 | | | | |
| R15 | | | | | | | 1 | | | 1 | | | | |
| R16 | | | 1 | .5 | .5 | .9 | 1 | | | 0 | | | | 1 |

Area B Miscellaneous

| | IT system progress | Effect of changes on staff moral; ground level | Systemic barriers to PHA | PCT 'knows best' | PS 'knows best' | Clarity on targets | Concern for future of health care in PS | Polar opposite opinions | Gaps in PCT knowledge of prison environments | Requests for prisoner input in health care | Discourse of responsibility; Back to the individual | Independent Monitoring Board view | Cross manipulation of other system | Dual ownership of the environment |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| R17 | | | | | | .5 | | 1 | 1 | 0 | | | | |
| R18 | .5 | | | | | .5 | 1 | | 1 | | | | | |
| R19 | .4 | | 1 | .8 | | .5 | 1 | | 1 | | 1 | | | 1 |
| R20 | .4 | .5 | 1 | .7 | .5 | .5 | | 1 | 1 | 1 | | | | 1 |
| R21 | | | 1 | .8 | | 0 | | | 1 | | | | | |
| R22 | .3 | | 1 | .8 | .2 | .8 | 1 | 1 | | 0 | 1 | | 1 | 1 |
| R23 | | | | | | | | | | 1 | | | | |
| R24 | .5 | 0 | 1 | .5 (1) | .5 | | 1 | | 1 | 0 | 1 | | | |

Area C Miscellaneous

| | IT system progress | Effect of changes on staff moral; ground level | Systemic barriers to PHA | PCT 'knows best' | PS 'knows best' | Clarity on targets | Concern for future of health care in PS | Polar opposite opinions | Gaps in PCT knowledge of prison environments | Requests for prisoner input in health care | Discourse of responsibility; Back to the individual | Independent Monitoring Board view | Cross manipulation of other system | Dual ownership of the environment |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| R25 | | | | .6 | .4 | .5 | 1 | 1 | | 0 | | | | |
| R26 | .2 | | | .7 | .3 | 0 | 1 | | 1 | 0 | | | | |
| R27 | .1 | .5 | | 0 | .9 | | | 1 | | 0 | | | | 1 |

Appendix 5

Research Management and Governance Unit application

Research Management and Governance Unit
Address anonymised

Your Ref: AD-MM 101

Date: 21st June 2005

Dear XXXX

**Re: Organisational Adaptability and the Transfer of Funding Responsibility for Health Care Provision in Prisons in England and Wales**

Firstly, thank you for your letter dated 31st May 2006 and also to the Scientific Committee for reviewing on project dated 26th May 2006. The advice offered has been very helpful.

Taking the Committee's recommendations in turn I have made the following essential amendments;

- A new Participant Information Sheet (PIS) has been compiled (please see Section 4 enclosed).
- A 'Research on Health Care in prisons' front sheet has been added which is designed to collect details on respondent's age/gender/length of service as recommended (Section 1 enclosed).
- The letter of information has been amended (Section 3) and will be presented to potential respondents together with the PIS (Section 4) and Research Participant Consent Form (Section 5).
- The interview schedule has proved difficult to amend. Each questionnaire is different due to the diverse roles each participant plays in the new system and it is felt that withdrawing questions would leave significant gaps in the research.

  Core questions have however now been identified separately and a supplementary page has been added which outlines 'profession specific' issues. I am, of course, open to further amending the schedules should the Scientific Committee feel this is necessary.

- The Research Ethics Committee approval will be submitted through COREC as advised.

Turning to the suggested amendments on the second page;

- The timescale for the fieldwork has been has been amended to three months rather than two (please see amended R&D application and Section 2).
- In addition, a further period of time has been allocated for transcription and analysis of the data (Section 2).
- The time each interview is expected to take has been amended to one and a half hours. The R&D application and respondents information sections have been amended accordingly.
- The question of there being a differential 'prison culture' is being addressed through reference to 'cultural differences' in the core questions schedule and 'resistance to change' in profession specific schedules.
- Section 2 has been amended to make clear that the HNAs and Prison Health Delivery Plans under analysis refer to those produced within the local SHA.
- 'Best Practice' procedures are to be disseminated to participants at the end of the project, i.e. scheduled for September 2006. The PIS has been amended accordingly.

Again, thank you for your time. I will look forward to hearing from you.

Yours sincerely

---
John Quinn

**Amended Documentation**

Organisational Adaptability and the Transfer of Funding responsibility for Health Care Provision in Prisons in England and Wales

Contents


Section 1 Research on Health Care in Prisons – Front Sheet

Section 2 Study Plan (as per COREC Application guidelines)

Section 3 Letters of Invitation to Participants

Section 4 Participant Information Sheet

Section 5 Research Participant Consent Form

Section 6 Confidentiality Letter


Supplementary Amended Documentation

1. NHS Research and Development Application Form

2. Interview Schedules

Date: 21st June 2005 Version 2

## 1. Project Proposal

Over the last decade, a number of reports have expressed concern about prisoner health and prison health care (Singleton et al, 1998; Joint Prison Service and NHS Executive Working Group, 1999; Marshall et al, 2000; Prison Health, 2002). There is plenty of evidence that the health status of prisoners is relatively poor, notably in relation to mental health problems. There is a high incidence of smoking, histories of excess alcohol consumption and other drug misuse. There have also been reported problems with the nature and standards of prison health care, historically the responsibility of prison governors rather than part of the NHS. Failure to tackle the health problems of prisoners can have far-reaching implications, not only for prisoners themselves and their families, but also for the (often disadvantaged) communities into which they are released. Crime has considerable and wide-ranging costs for health, in terms of the impact on victims and health services. Improving the health of prisoners could reduce re-offending, most evidently in relation to drug and alcohol related offences.

PCTs are operating in a context which stresses the need to meet targets and deliver on improving services for acute health care (Hunter, 2002). Noting these operational pressures it is relevant to explore whether service providers will actually be in a position to prioritise prison health or will it be considered to be less important than meeting expectations in respect of other priorities, for example, acute care waiting list targets?

Funding responsibility for prison health services is being transferred from the Home Office to the Department of Health. This is the first step in a process that over the coming years will see PCTs becoming responsible for the commissioning and provision of health services to prisoners and ex-prisoners in their areas. This represents a major shift and raises important research issues. Prison health care, although sometimes staffed by local GPs, has been planned and commissioned separately from other health services, shaped by and in tension with the security and correctional aspects of prison life, and concerned primarily with the treatment of illnesses and reducing health damaging behaviours within the prison walls. PCT responsibility will bring new challenges to both the prison service and primary care. These two lead organisations and those who work in them may have conflicting approaches and priorities. Decisions on the amount and nature of resources to be allocated to prison health care relative to other areas will be more transparent and are likely to be contentious. The links between health in prisons and wider, public health issues in the community could become more evident from a health care perspective. PCTs are responsible authorities together with the police and local authorities. The Crime and Disorder Act (1998) places a clear obligation on the responsible authorities to develop and implement jointly a strategy for tackling crime and disorder. In this context it is worth exploring the investment potential of a public health approach to prison health.

Date: 18th May 2005 Version 1

## 2. Study Plan (as per COREC application)

It is proposed to conduct a maximum of 40 in-depth, semi-structured interviews with:

- Key postholders in a varied sub-sample of three PCTs with prisons in their area (Chief Executive, Non-Executive Director, Prison Health Liaison Manager).

- Key postholders in a varied sub-sample of four prisons (The Governing Governor, Prison GP, Prison Medical Centre Staff - Nurse, a member of the Detoxification team, a member of the CARATs team, a member of the Mental Health In-Reach Team, Prison Officer - Prison Officer's Association (POA) representative, a member of the Health Care centre administrative staff, and a member of the Independent Monitoring Board (IMB)).

The aim would be to explore their perceptions of current issues in prison health, of the priorities for action and of the barriers and facilitating factors in the developing leadership role of PCTs. The interview questions would be guided by the research questions as identified in A7.

A qualitative methodology has been chosen as it provides respondents with the necessary flexibility to express their attitudes, opinions, and experiences on the research topic. In preparing the design the CI has visited HMP Durham and HMP Frankland and has also attended regular meetings of the Durham and Chester-le-Street PCT/Prison Health Group in a purely observational role. Informal meetings have also taken place between the CI and members of the local PCT as well as with Prison Health Care staff.

The interview transcripts will be analysed for the purpose of identifying common and divergent themes which emerge across prisons, PCTs and professional roles.

The CI has also consulted on the research topic with a senior official in the Justice Health Department of the Centre for Health Research in Criminal Justice, New South Wales, Australia, Prof. Michael Levy, and well as with Prof. David Hunter, Professor of Public Policy and Health at the University of Durham, who has wide experience of Public Health issues and Dr. Alyson Learmonth, Chief Executive of Sedgefield PCT who are members of the PhD. Research Steering Group.

It is believed that these preliminary engagements alongside the ongoing literature review and attendance at relevant conferences on Prison Health Care, e.g., the Durham Forum on Prison Health (2003), Howard League Conference on Prison Health (2003), and the Sharing Good Practice in Prison Healthcare conference which was jointly hosted by the Dept. of Health and HM Prison Service in 2004, will provide the CI with a sound grounding when preparing the research design.

Given the research methods outlined here it is not considered that they would present any risk to research participants.

Turning to the proposed timescale, the interviews are scheduled to take place between June 2005 and October 2005. It is anticipated that the interviews will take place at the place of work of the research participants, i.e. at the particular prisons and PCTs. However, the School of Applied Social Sciences would be willing to make an office available for conducting interviews should the need arise.

Respondents would be provided with a copy of my draft analysis and invited to make any comments. In addition, feedback would be given through the dissemination process.

With regard to the literature review and the use of secondary data, the literature relating to prison and prisoner health and to the impacts of crime on health will be reviewed from the two perspectives of public health and criminal justice. In addition, it is proposed to include a comparative analysis in the work which will situate health care in prisons in England and Wales in a broader global context through a review of literature based on research in other countries such as Australia and Russia, inter alia.

The proposed timescale is as follows; October 2003 - May 2004; CI completed five Research Methods modules from the (then) Department of Sociology and Social Policy's MSc in Research Methods, June 2004 - October 2004; literature review, November 2005 - February 2005; completion of local[117] Health Needs Assessments (HNAs) and local Prison Health Delivery Plans (PHDPs) for 2002 - 2004 (please see below), May/June 2005; application to Research and Development and Research Ethics Committees, June - August 2005 – writing chapters unrelated to fieldwork, i.e. introductory chapter and chapter on international comparisons of prison health care models, September 2005 - November 2005; fieldwork in Prisons and PCTs, December 2005 - January 2006; Interview Analysis, February 2006 – Analysis of PHDPs 2006, March 2006 - September 2006 writing up, discussion and dissemination.

As mentioned briefly above it is also proposed to analyse the annual HNAs and PHDPs for which are now jointly produced by prisons and PCTs. Using this information, health issues and problems among the prisoner population will be analysed and tracked. The level of PCT engagement with the process will also be tracked using this method.

Regarding 'researcher effects' and 'researcher bias' the CI has completed five postgraduate modules from the Research Methods Masters programme as stipulated by the Economic and Social Research Council (ESRC) when the studentship was awarded. These modules are designed to skill the researcher with regard to research practice and, for example, the conduct of in-depth interviewing and ethical principles. In addition, the CI's work is supervised by three qualified academics at the School of Applied Social Sciences as well as being overseen by the Steering Group mentioned above.

Date: 10th June 2005 Version 2

[117] 'Local' refers to prisons within the Durham and Tees Valley Strategic Health Authority Area.

## 5. Letters of invitation to Participants (on headed paper)

Dear Sir/Madam/Title

Research
Title_____

You are being invited to take part in a research study. Before you decide it is important for you to understand why the research is being done and what it will involve. Please take time to read the following research participant information sheet carefully and discuss it with others if you wish. Ask if there is anything that is not clear or if you would like more information.

I would be grateful if you could advise me of your decision by xx/xx/xxxx. Should you decide to become involved then I will contact you again to arrange a convenient time, date and location for the interview to take place.

Thank you for your time. I look forward to hearing from you.

Yours sincerely

---
John Quinn
Prison Health Care Researcher

Date: 14th June 2005 Version 2

## 6. Participant Information Sheet

1. Research Title

Organisational Adaptability and the Transfer of Funding for Health Care responsibility in Prisons in England and Wales

***2. The researcher is currently studying for a PhD. in the School of Applied Social Sciences at the University of Durham. Participants should note that the research is part of an educational qualification.***

3. Background

A collaborative research project between Durham University's Department of Sociology and Social Policy and the Health Development Agency (HDA) (North East), funded by the Economic and Social Research Council and the HDA, is investigating the implications of the transfer of responsibility for prison health from the Home Office to NHS Primary Care Trusts (PCTs).

This transfer of responsibility for prison health care to PCTs is part of the government's strategy for 'mainstreaming' prison health care in the NHS. By April 2006, PCTs will become responsible for the commissioning and provision of health services to prisoners in their areas. This transfer offers substantial opportunities to improve prison health services and the health of prisoners, for example, by improving the links between primary care inside and outside prisons and ensuring that prisoners benefit from health care improvements and initiatives in the wider NHS.

4. Aims

The research aims to explore the community health implications of prisoner health and to consider the factors that are likely to influence the success or otherwise of making PCTs responsible for prison health services. It will tackle a number of questions. For example:

- From what is known about the nature and range of health issues among the prison/ex-prison population, what are the public health consequences of these health issues and how might they be tackled?
- How, if at all, do PCTs and their communities understand the community health implications of prison health issues? What might help these links to be made?
- What information, collaboration and support do PCTs need to carry out their funding, commissioning and providing responsibilities in relation to prison health?

It is also planned that the research will provide the participating prisons with an understanding of the difficulties experienced by PCTs in aiming to eliminate inequalities between the provision of health care within prisons and that offered by the NHS in the wider community as well as bring to the attention of PCTs issues which are of concern to the prison estate.

In addition, it is hoped that the research will identify 'best practices' across the respondent institutions and professions which will be disseminated to the participating respondents/institutions locally as well as to policy makers at a national level, e.g. Prison Health within the Department of Health.

5. Participation is entirely voluntary and confidential.

No personal details apart from occupation will be included. In addition, the identity of the host organisation, i.e. the prison or PCT, will be coded rather than named thus reinforcing the anonymity of participants.

Also, each participant will be provided with feedback and the opportunity to comment on my draft analysis. Each interviewee will be asked to sign an informed consent form confirming their agreement to voluntarily participate in the study and will be provided with a letter outlining their guarantee of confidentiality.

Turning to the actual interviews each participant will be provided with a copy of the interview questions. The interview will be recorded using an audio recording device for the purpose of transcription. It is anticipated that each interview will last for no more than one and a half hours.

Finally, each participant will be provided with a copy of the 'best practice' procedures which have been identified during the study. These will be made available during the final stage of the research in September 2006.

Date: 3rd September 2005 Version 2

## 7. Research Participant Consent Form (on headed paper)

**CONSENT FORM**

Title of Project:

Name of Researcher:

1. I confirm that I have read and understood the information sheet dated …….. for the above study and have had the opportunity to ask questions.

2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason, without my legal rights being affected.

3. It is a condition of my participation that my identity will remain anonymous.

4. I agree to take part in the above study.

| | | |
|---|---|---|
| ---------- | ---------- | ---------- |
| Name of participant | Date | Signature |
| ---------- | ---------- | ---------- |
| Name of Person taking consent (if different from researcher) | Date | Signature |
| ---------- | ---------- | ---------- |
| Researcher | Date | Signature |

Date 18th May 2005 Version 1

**8. Confidentiality Letter (to be given to respondent after informed consent is obtained)**

Dear Sir/Madam

**Re: Research on Health Care in Prisons – Guarantee of Confidentiality**

Firstly, thank you for agreeing to participate in this research. This letter is your guarantee that no personal or place of employment details apart from occupation will be available in the researcher's draft or final thesis, reports or articles.

This commitment is re-stated below;

Participation is entirely voluntary and confidential. No personal details apart from occupation will be included. In addition, the identity of the host organisation, i.e. the prison or PCT, will be coded rather than named thus reinforcing the anonymity of participants.

Also, each participant will be provided with feedback and the opportunity to comment on my draft analysis. Each interviewee will be asked to sign an informed consent form confirming their agreement to voluntarily participate in the study and will be provided with a letter outlining their guarantee of confidentiality.

Should you have any queries or concerns regarding this then please do not hesitate to contact me via my above contact details.

Yours sincerely

---

John Quinn
Prison Health Care Researcher

Date: 15th June 2005 Version 2

## 9. Letter from Sponsor

Primary Care Research Management
& Governance Unit
Address anonymised

Date: 16th May 2005

Dear Sir/Madam

**Re: Prison Health and Public Health - Application Reference 05/Q0302/100**

I write to confirm that the University of Durham is acting as sponsor for the above research as detailed in the accompanying Research and Development application form.

The work is to be carried out by John Quinn, a PhD. student under my supervision.

On behalf of the School of Applied Social Sciences at the University of Durham I can confirm that I will be taking responsibility that the study will be carried out properly.

Yours faithfully

---

Tim Blackman
Professor of Sociology and Social Policy

Date: 16th May 2005 Version 1

**10. Letter from Funder** Date: 15th June 2005 Version 2

Letter provided 18th May 2005

Please note that the Health Development Agency has now merged with the National Institute for Health and Clinical Excellence (NICE) and an up to date confirmation letter from this body is therefore unavailable.

A copy of the letter from the Economic and Social Research Council is attached. If the original is required then please contact John Quinn on 0191-334 6835 or by e-mail on j.m.quinn@durham.ac.uk.

Appendix 6

NHS Research Ethics Committee Application Form

pp.323-350

Note 1: The NHS Research Ethics Committee application is completed online and once submitted is locked. No changes are subsequently allowed.

Note 2: In accordance with the ethical approval guidelines for the research it has been necessary to omit the pages which specifically referred to host institutions in this document. While this further compromises the utility of this appendix I feel that it is still worthwhile including as much of the document as possible as a guide for future researchers in this particular field.

Date: 26/07/2005 Reference: 05/Q0302/100 Online Form

**NHS Research Ethics Committee** NHS

# APPLICATION FORM

**This form should be completed by the Chief Investigator, after reading the guidance notes.**
See Glossary for clarification of different terms in the application form.

**Short Title and version number:** (maximum 70 characters – this will be inserted as header on all forms)
Prison Health and Public Health

**Name of NHS Research Ethics Committee to which application for ethical review is being made:**
South Essex Local Research Ethics Committee

**Project Reference number from above REC:** 05/Q0302/100

**Submission Date:** 26/07/2005

## A1. Title of Research

Full title: Organisational Adaptability and the Transfer of Responsibility for Health Care Provision in Prisons in England and Wales.

Key words: Prisons, Health, Primary Care Trusts, Public Health, Organisations, Partnerships

## A2. Chief Investigator


Title: Mr

Forename/Initials: John M

Surname: Quinn

Post: PhD Research Student

Qualifications: BA (Hons) Sociology, MSc Criminology and Criminal Justice Studies

Organisation: University of Durham

Address: School of Applied Social Sciences
32 Old Elvet
Durham

Post Code: DH1 3HN

E-mail: j.m.quinn@durham.ac.uk

Telephone: 0191-334 6827

Fax: 0191-334 6821


*A copy of a current CV, (maximum 2 pages of A4) for the Chief Investigator must be submitted with application*

## A3. Proposed Study Dates and Duration

Start Date: 01/10/2003

End Date: 30/09/2006

Duration: Months: 0 ; Years: 3

**A4. Primary purpose of the research:** *(Tick as appropriate)*

- ☐ Commercial product development and/or licensing
- ☐ Publicly funded trial or scientific investigation
- ☑ Educational qualification
- ☐ Establishing a database/data storage facility
- ☐ Other

**A5. Tick the box if your research:**

- ☐ Involves testing a medicinal product
- ☐ Involves investigating a medical device
- ☐ Involves additional radiation above that required for clinical care
- ☐ Involves using stored samples of human biological material (e.g. blood, tissue)
- ☐ Involves taking new samples of human biological material
- ☐ Involves only patient records or data, with no other direct patient contact
- ☐ Involves prisoners or others in custodial care
- ☐ Involves adults unable to consent for themselves through physical or mental incapacity
- ☑ Has the primary aim of being educational (e.g. a student project, or a project or research necessary for a postgraduate degree or diploma)

**A6. Do you consider that this research falls within the category where there is no need to appoint a Principal Investigator at each site?**

○ Yes ◉ No

*If Yes, please justify:*
The research is being conducted by one PhD student who will be the sole researcher at each site as well as fulfilling the role of Chief Investigator. All sites are situated within one Strategic Health Authority.

*Advice can be found in the guidance notes on this topic. Some studies do not require further consideration of site-specific issues by local research ethics committees, but will still require approval to proceed from the host organisation(s).*

**A7. What is the principal research question/objective?** *(Must be in language comprehensible to a lay person.)*

1. What are the implications of a public health as opposed to a criminal justice approach to prison health care? For example, to what extent has the public health agenda, as outlined in 'Health Promoting Prisons: A Shared Approach' (Prison Health, 2002), been incorporated into prison health services?

2. From what is known about the nature and range of health issues among the prison/ex-prison population, what are the public health consequences of these health issues and how might they be tackled?

3. How do Primary Care Trusts (PCTs) and prison authorities understand the community health implications of prison health issues?

4. What information, collaboration, support, etc. do PCTs need in order to carry out their commissioning/providing responsibilities?

5. What are the barriers and facilitating factors which have become apparent as PCTs seek to mainstream NHS services within prisons?

6. How have two identifiably different organisations managed this change? Here, the emphasis will be on understanding organisational cultures and how processes and management structures have been/are being put in place locally in compliance with national policy directives.

7. What evidence is there that the transfer of the commissioning of primary care to PCTs is working and producing positive outcomes?

**A8. What are the secondary research questions/objectives?** *(If applicable, must be in language comprehensible to a lay person.)*

1. To produce a literature review relating to prison and prisoner health.
2. To produce an annual analysis of Prison Health Delivery Plans.
3. A comparison of prison health care systems in other countries will also form one chapter of the final thesis.

**A9. What is the scientific justification for the research? What is the background? Why is this an area of importance?** *(Must be in language comprehensible to a lay person.)*

Over the last decade, a number of reports have expressed concern about prisoner health and prison health care (Singleton et al, 1998; Joint Prison Service and NHS Executive Working Group, 1999; Marshall et al, 2000; Prison Health, 2002). There is plenty of evidence that the health status of prisoners is relatively poor, notably in relation to mental health problems. There is a high incidence of smoking, histories of excess alcohol consumption and other drug misuse. There have also been reported problems with the nature and standards of prison health care, historically the responsibility of prison governors rather than part of the NHS. Failure to tackle the health problems of prisoners can have far-reaching implications, not only for prisoners themselves and their families, but also for the (often disadvantaged) communities into which they are released. Crime has considerable and wide-ranging costs for health, in terms of the impact on victims and health services. Improving the health of prisoners could reduce re-offending, most evidently in relation to drug and alcohol related offences.

PCTs are operating in a context which stresses the need to meet targets and deliver on improving services for acute health care (Hunter, 2002). Noting these operational pressures it is relevant to explore whether service providers will actually be in a position to prioritise prison health or will it be considered to be less important than meeting expectations in respect of other priorities, for example, acute care waiting list targets?

Funding responsibility for prison health services is being transferred from the Home Office to the Department of Health. This is the first step in a process that over the coming years will see PCTs becoming responsible for the commissioning and provision of health services to prisoners and ex-prisoners in their areas. This represents a major shift and raises important research issues. Prison health care, although sometimes staffed by local GPs, has been planned and commissioned separately from other health services, shaped by and in tension with the security and correctional aspects of prison life, and concerned primarily with the treatment of illnesses and reducing health damaging behaviours within the prison walls. PCT responsibility will bring new challenges to both the prison service and primary care. These two lead organisations and those who work in them may have conflicting approaches and priorities. Decisions on the amount and nature of resources to be

allocated to prison health care relative to other areas will be more transparent and are likely to be contentious. The links between health in prisons and wider, public health issues in the community could become more evident from a health care perspective. PCTs are responsible authorities together with the police and local authorities. The Crime and Disorder Act (1998) places a clear obligation on the responsible authorities to develop and implement jointly a strategy for tackling crime and disorder. In this context it is worth exploring the investment potential of a public health approach to prison health.

A11. Will any intervention or procedure, which would normally be considered a part of routine care, be withheld from the research participants?

○ Yes ◉ No

A12. Will the research participants receive any clinical intervention(s) or procedure(s) including taking samples of human biological material over and above that which would normally be considered a part of routine clinical care?

○ Yes ◉ No

**A13. Will the research participant be subject to any non-clinical research-related intervention(s) or procedure(s)?**
*(These include interviews, non-clinical observations and use of questionnaires.)*

◉ Yes ○ No

| Additional Intervention | Average number per patient | Average time taken (mins/hours/days) | Details of additional intervention or procedure, who will undertake it, and what training they have received. |
|---|---|---|---|
| Face to Face Interview | 0 | 75 mins | The interview will consist of semi-structured questions. It is to be undertaken by the Chief Investigator who has completed the required Research Methods training as determined by the Economic and Social Research Council. The interviews are to take place at the respondent's place of work or, if a suitable confidential environment is not available and the respondent is willing, at the School of Applied Social Sciences. The 'average number per patient' has been set at zero as no patients are to be interviewed. |
| Audio Recording | 0 | 75 mins | An audio recording device will be used during the interviews. Other details are as above. |

**A14. Will individual or group interviews/questionnaires discuss any topics or issues that might be sensitive, embarrassing or upsetting, or is it possible that criminal or other disclosures requiring action could take place during the study (e.g. during interviews/group discussions, or use of screening tests for drugs)?**

*Question A14 below is not applicable if No is selected in question A13.*

○ Yes ◉ No

*The Information Sheet should make it clear under what circumstances action may be taken*

**A15. What is the expected total duration of participation in the study for each participant?**

Interviews are expected to last between 60 and a maximum of 90 minutes.

**A16. What are the potential adverse effects, risks or hazards for research participants either from giving or withholding medications, devices, ionising radiation, or from other interventions (including non-clinical)?**

The research does not involve any clinical interventions. It is not considered that any potential adverse effects, risks or hazards apply.

**A17. What is the potential for pain, discomfort, distress, inconvenience or changes to lifestyle for research participants?**

Not applicable.

**A18. What is the potential for benefit to research participants?**

Through dissemination each participant would be informed of 'best practice' procedures as identified in other PCTs/prison environments which could be used to address existing problems.

It is also planned that the research will provide the participating prisons with an understanding of the difficulties experienced by PCTs in aiming to eliminate inequalities between the provision of health care within prisons and that offered by the NHS in the wider community as well as bring to the attention of PCTs issues which are of concern to the prison estate.

**A19. What is the potential for adverse effects, risks or hazards, pain, discomfort, distress, or inconvenience to the researchers themselves?** *(if any)*

None.

**A20. How will potential participants in the study be (i) identified, (ii) approached and (iii) recruited?**
*Give details for cases and controls separately if appropriate:*

As indicated above (A10) a maximum of 40 interviews will be conducted with;

– Key postholders in a varied sub–sample of three PCTs with prisons in their area (Chief Executive, Non–Executive Director, Prison Health Liaison Manager).

– Key postholders in a varied sub–sample of four prisons (The Governing Governor, Prison GP, Prison Medical Centre Staff – Nurse, Detoxification team member, CARATs team member, Mental Health In–reach team member, Health Centre Administration Staff member, Prison Officer – Prison Officers Association representative, a member of the Independent Monitoring Board).

These respondants will be identified from local prisons and PCTs. Approaches are to be made through official channels, i.e. via the Chief Executives of the PCTs and Prison Governors. It is anticipated that some will be recruited through personal introductions, while others will be approached through a request, e.g., by letter or telephone, for an informal meeting at which the research aims would be outlined and access to relevant personnel requested. Informed consent would be sought at each stage.

**A21. Where research participants will be recruited via advertisement, give specific details.**

☑ Not Applicable

*If applicable, enclose a copy of the advertisement/radio script/website/video for television (with a version number and date).*

**A22. What are the principal inclusion criteria?** *(Please justify)*

The research seeks to achieve its aims by interviewing prison and PCT personnel who have significant experience as skilled professionals in the area being researched. Ideally, those chosen will have experience of working under the old prison health care regime and will also be working through the transitionary period.

**A23. What are the principal exclusion criteria?** *(Please justify)*

Potential respondents who have only very limited experience of working in prisons or PCTs, for example, those with less than six months experience. The rationale behind this is that more experienced professionals are likely to be in the best position to provide better quality data on their environments.

**A24. Will the participants be from any of the following groups?** *(Tick as appropriate)*

- ☐ Children under 16
- ☐ Adults with learning disabilities
- ☐ Adults who are unconscious or very severely ill
- ☐ Adults who have a terminal illness
- ☐ Adults in emergency situations
- ☐ Adults with mental illness (particularly if detained under Mental Health Legislation)
- ☐ Adults suffering from dementia
- ☐ Prisoners
- ☐ Young Offenders
- ☐ Adults in Scotland who are unable to consent for themselves
- ☐ Healthy Volunteers
- ☐ Those who could be considered to have a particularly dependent relationship with the investigator, e.g. those in care homes, medical students
- ☐ Other vulnerable groups

*Justify their inclusion.*

**A25. Will any research participants be recruited who are involved in existing research or have recently been involved in any research prior to recruitment?**

○ Yes ◉ No ○ Not Known

*If Yes, give details and justify their inclusion. If Not Known, what steps will you take to find out?*

**A26. Will informed consent be obtained from the research participants?**

◉ Yes ○ No

*If Yes, give details of who will take consent and how it will be done. Give details of any particular steps to provide information (in addition to a written information sheet) e.g. videos, interactive material.*

*If participants are to be recruited from any of the potentially vulnerable groups listed in A24, give details of extra steps taken to assure their protection. Describe the arrangements to be made for obtaining consent from a legal representative.*

*If consent is not to be obtained, please explain why not.*
The CI will produce a clear written statement of the research background and goals for each potential participant prior to any interview taking place.

*Copies of the written information and all other explanatory material should accompany this application*

**A27. Will a signed record of consent be obtained?**

◉ Yes ○ No

*If Yes, attach a copy of the information sheet to be used, with a version number and date.*

**A28. How long will the participant have to decide whether to take part in the research?**

Potential respondents be invited to confirm within a fortnight whether they will be willing to participate in the research.

**A29. What arrangements have been made for participants who might not adequately understand verbal explanations or written information given in English, or who have special communication needs?** *(e.g. translation, use of interpreters etc.)*

Not applicable

**A30. What arrangements are in place to ensure participants receive any information that becomes available during the course of the research that may be relevant to their continued participation?**

Respondents will have the opportunity to comment on my draft analysis of the interviews and invited to make any comments.

**A31. Does this study have or require approval of the Patient Information Advisory Group (PIAG) or other bodies with a similar remit?***(see the guidance notes)*

○ Yes ◉ No

**A32a. Will the research participants' General Practitioner be informed that they are taking part in the study?**

○ Yes ◉ No

*If Yes, enclose a copy of the information sheet/letter for the GP with a version number and date*

**A32b. Will permission be sought from the research participants to inform their GP before this is done?**

○ Yes ◉ No

*If No to either question, explain why not*

*It should be made clear in the patient information sheet if the research participants' GP will be informed.*

**A33. Will individual research participants receive any payments for taking part in this research?**

○ Yes ◉ No

**A34. Will individual research participants receive *reimbursement of expenses* or any other *incentives or benefits* for taking part in this research?**

○ Yes ◉ No

**A35. What arrangements have been made to provide indemnity and/or compensation in the event of a claim by, or on behalf of, participants for *negligent* harm?**

The University's Insurance Officer has confirmed that there are no insurance implications for the research.

*Please forward copies of the relevant documents*

**A36. What arrangements have been made to provide indemnity and/or compensation in the event of a claim by, or on behalf of, participants for *non-negligent* harm?**

The University's Insurance Officer has confirmed that there are no insurance implications for the research.

*Please forward copies of the relevant documents*

**A37. How is it intended the results of the study will be reported and disseminated?** *(Tick as appropriate)*

- [x] Peer reviewed scientific journals
- [x] Internal report
- [ ] Conference presentation
- [x] Other publication
- [x] Submission to regulatory authorities
- [ ] Access to raw data and right to publish freely by all investigators in study or by Independent Steering Committee on behalf of all investigators
- [x] Written feedback to research participants
- [ ] Presentation to participants or relevant community groups
- [x] Other/none e.g. Cochrane Review, University Library

*If other/none of the above, give details and justify:*

**A38. How will the results of research be made available to research participants and communities from which they are drawn?**

The analysis of the Health Needs Assessments and Prison Health Delivery Plans will be disseminated annually to the PCT bodies and Prison Authorities concerned. A report will also be produced at the end of the project and circulated to all nine Government Offices and National Regional Prison Health Task Forces, the Prisons themselves, and PCTs who had participated in the research work. Articles would be submitted to Public Health and Criminal Justice Journals.

**A39. Will the research involve any of the following activities at any stage (including identification of potential research participants)?** *(Tick as appropriate)*

- [ ] Examination of medical records by those outside the NHS, or within the NHS by those who would not normally have access
- [ ] Electronic transfer by magnetic or optical media, e-mail or computer networks
- [x] Sharing of data with other organisations
- [ ] Export of data outside the European Union
- [ ] Use of personal addresses, postcodes, faxes, e-mails or telephone numbers
- [x] Publication of direct quotations from respondents
- [ ] Publication of data that might allow identification of individuals
- [x] Use of audio/visual recording devices
- [ ] Storage of personal data on any of the following:
  - [ ] Manual files including X-rays
  - [ ] NHS computers
  - [ ] Home or other personal computers
  - [ ] University computers
  - [ ] Private company computers
  - [ ] Laptop computers

*Further details:*

**A40. What measures have been put in place to ensure confidentiality of personal data? Give details of whether any encryption or other anonymisation procedures have been used and at what stage:**

No personal data will be published. Confidentiality will be guaranteed to each participant as part of the statement of research interests (see A26).

**A41. Where will the analysis of the data from the study take place and by whom will it be undertaken?**

In the School of Applied Social Sciences, University of Durham, 32 Old Elvet, Durham DH1 3HN. It will be undertaken by the Chief Investigator.

**A42. Who will have control of and act as the custodian for the data generated by the study?**

The Chief Investigator and the Academic Supervisors.

**A43. Who will have access to the data generated by the study?**

In addition to the groups identified above for dissemination, the PhD thesis would be available in the library of the University of Durham.

**A44. For how long will data from the study be stored?**

Years Months

*Give details of where they will be stored, who will have access and the custodial arrangements for the data:*
The thesis would be maintained at the University of Durham's library indefinitely.

**A45. How has the scientific quality of the research been assessed?** *(Tick as appropriate)*

- ☐ Independent external review
- ☐ Review within a company
- ☐ Review within a multi–centre research group
- ☑ Internal review (e.g. involving colleagues, academic supervisor)
- ☐ None external to the investigator
- ☐ Other, e.g. methodological guidelines

*If you are not in possession of any referees or other scientific critique reports relevant to your proposed study, justify and describe the review process and outcome. If review has been undertaken but not seen by the researcher, give the details of the body which has undertaken the review:*
The research will be reviewed by the university's academic supervisors.

*A copy of any referees' comments or other scientific critique reports relevant to the proposed research must be enclosed with the application form.*

**A46. Has similar research on this topic been done before?**

○ Yes ◉ No

**A47. Have all existing sources of evidence, especially systematic reviews, been fully considered?**

◉ Yes ○ No

*If Yes, please give details of search strategy used. If No, explain why not.*
Searches have been conducted using various academic databases such as Zetoc, Web of Knowledge, and Athens. In addition, the library resources at the University of Durham, (including Social Policy, Health, and Criminal Justice Journals) have been utilised as well as official papers/reports produced on the topic by both the Home Office and the Department of Health as well as their web resources.

**A48. What is the primary outcome measure for the study?**

Submission of the PhD.

**A49. What are the secondary outcome measures?** *(if any)*

A report containing an analysis of the prison's Health Needs Assessments and Prison Health Delivery Plans will be produced for the Health Development Agency annually.

**A50. How many participants will be recruited? How many of these participants will be in a control group?**

A maximum of 40. No control group will be used.

**A51. Has the size of the study been informed by a formal statistical power calculation?**

○ Yes ◉ No

**A52. Has a statistician given an opinion about the statistical aspects of the research?**

○ Yes ◉ No

*If Yes, enclose a copy of comments. If the comments are not available then please enclose a summary of the opinion.*

**A56. In how many and what type of host organisations (NHS or other) in the UK is it intended the proposed study will take place?**

*Indicate the type of organisation by ticking the box and give approximate numbers if known:*

| | Number of organisations |
|---|---|
| ☐ Acute teaching NHS Trusts | |
| ☐ Acute NHS Trusts | |
| ☑ NHS Community and/or Primary Care Trusts | 3 |
| ☐ NHS Trusts providing Mental Healthcare | |
| ☐ NHS Care Trusts | |
| ☐ Social Care Organisations | |
| ☑ Prisons | 3 |
| ☐ Independent hospitals | |
| ☐ Educational establishments | |
| ☐ Independent research units | |
| ☐ Other (give details) | |

*Other:*

**A57. What arrangements are in place for monitoring and auditing the conduct of the research?**

Academic supervision and guidance by the Research Steering Group

**Will a data monitoring committee be convened?**

○ Yes ◉ No

*If Yes, details of membership of the data monitoring committee (DMC), its standard operating procedures and summaries of reports of interim analyses to the DMC must be forwarded to the NHS Research Ethics Committee which gives a favourable opinion of the study.*

**What are the criteria for electively stopping the trial or other research prematurely?**

None in place

**A65. Other relevant reference numbers if known***(give details and version numbers as appropriate):*

Applicant's/organisation's own reference number, e.g. R&D (if available): 000415884 Uni of Durham
Sponsor's/protocol number: PTA-033-2003-00040 ESRC
Funder's reference number: PTA-033-2003-00040 ESRC
International Standard Randomised Controlled Trial Number (ISRCTN):
European Clinical Trials Database (EudraCT) number:
Project website:

**A66. Other key investigators/collaborators***(all grant co-applicants should be listed)*

Title:
Forename/Initials: Surname:
Post:
Qualifications:
Organisation:
Address:
Telephone:
Fax:
Postcode:
E-mail:

**A67. If the research involves a specific intervention, (e.g. a drug, medical device, dietary manipulation, lifestyle change etc.), what arrangements are being made for continued provision of this for the participant (if appropriate) once the research has finished?**

☑ Not Applicable

**A68. What do you consider to be the main ethical issues or problems which may arise with the proposed study and what steps will be taken to address these?**

Maintaining respondent confidentiality. Informed consent will be obtained from each respondent and a written guarantee of confidentiality provided. No personal details will be recorded and the prisons and PCTs involved will only be indentified by codes. In addition, case study localities will be anonomysed.

**A69. Do you need to add further information about certain questions in Part A?**

This question is not applicable for the online version of the REC form.

**A70. Give details of the educational course or degree for which this research is being undertaken:**

Name and level of course/degree:
PhD

Name of educational establishment:
University of Durham
School of Applied Social Sciences
32 Old Elvet
Durham
DH1 3HN

Name and contact details of educational supervisor:
Tim Blackman
Prof. of Sociology and Social Policy
School of Applied Social Sciences
32 Old Elvet
Durham DH1 3HN
Phone: 0191–334 6827
Fax: 0191–334 6821
E–mail address: tim.blackman@durham.ac.uk

**A71. Declaration of Supervisor**

I have read and approved both the research proposal and this application for the ethical review. I undertake to fulfil the responsibilities of a supervisor as set out in the Research Governance Framework for Health and Social Care. I can confirm on behalf of my academic institution that any necessary indemnity or insurance arrangements are in place.

Signature: .....

Date: (dd/mm/yyyy)

Print Name: Prof. Tim Blackman

*A one–page summary of the supervisor's CV should be submitted with the application*

– The information in this form is accurate to the best of my knowledge and belief and I take full responsibility for it.

– I undertake to abide by the ethical principals underlying the Declaration of Helsinki and good practice guidelines on the proper conduct of research.

– If the research is approved I undertake to adhere without unagreed deviation to the study protocol, the terms of the full application of which the main REC has given a favourable and any conditions set out by the main REC in giving its favourable opinion.

– I undertake to inform the main REC of any changes in the protocol, and to submit annual reports setting out the progress of the research.

– I am aware of my responsibility to be up to date and comply with the requirements of the law and relevant guidelines relating to security and confidentiality of patient or other personal data, including the need to register when necessary with the appropriate Data Protection Officer.

– I understand that research records/data may be subject to inspection for audit purposes if required in future.

– I understand that personal data about me as a researcher in this application will be held by the relevant RECs and their operational managers and that this will be managed according to the principles established in the Data Protection Act.

Signature: .....

Date: 26/07/2005 (dd/mm/yyyy)

Print Name: John Quinn

**1. Do you need to add further information about certain questions in part B?**

*This question is not applicable for the online version of the REC form.*

*ENSURE THAT YOU COMPLETE AND SIGN THE FORM, AND ENCLOSE ANY RELEVANT ADDITIONAL DOCUMENTS*

**12. Who is the Principal Investigator or Local Collaborator for this research at this site?**

| Title: | Forename/Initials: | Surname: |
|---|---|---|
| Mr. | John | Quinn |

Post: PhD Research Student

Qualifications: BA(Hons)(2.1) Sociology, MSc Criminology and Criminal Justice Studies (with Distinction)

Organisation: Schoool of Applied Social Sciences

Work Address: University of Durham
32 Old Elvet
Durham

Postcode: DH1 3HN

E-mail: j.m.quinn@durham.ac.uk

Telephone: 0191-334 6835

Fax: 0191-334 6821

Mobile:

| | R&D Only |
|---|---|
| a) Will this person interact with research participants, their organs, tissue or data in a way that has a direct bearing on the quality of care? | ○ Yes ○ No |
| b) Does this person hold a current substantive or honorary contract with the NHS organisation or accepted by the NHS organisation? | ○ Yes ○ No |

*Please provide a copy of the c.v. for the PI.*

*If an honorary contract is held, a copy of the contract should be submitted, unless previously provided to the R&D office.*

**13. Give details of other members of the research team responsible to the Principal Investigator at this site:**

1. Research Member

Title: Forename/Initials: Surname:

Employing organisation:

Post:

Qualifications:

Role in research team: other:

**14. Give details of all other members of the research team at this site, including academic supervisors and all people who will interact with research participants, their organs, tissue or data in a way that has a direct bearing on the quality of care.**

1. Research Member

Title: Forename/Initials: Surname:

Employing organisation:

Post:

Qualifications:

Role in research team: other:

prisons and PCTs. However, the School of Applied Social Sciences would be willing to make an office available for conducting interviews should the need arise.

The proposed timescale is as follows; October 2003 – May 2004; CI completed five Research Methods modules from the (then) Department of Sociology and Social Policy's MSc in Research Methods, June 2004 – October 2004; literature review, November 2005 – February 2005; completion of Health Needs Assessments (HNAs) and Prison Health Delivery Plans (PHDPs) for 2002 – 2004 (please see below), March/April 2005; Application to Research and Governance Scientific Committee for Local Strategic Health Authority, June/July 2005; Application to NHS Research Ethics Committee, September – November 2005; fieldwork in Prisons and PCTs, October 2005 – January 2006; Analysis of HNAs and PHDPs for 2005, February 2006 – September 2006 writing up, discussion and dissemination.

Regarding 'researcher effects' and 'researcher bias' the CI has completed five postgraduate modules from the Research Methods Masters programme as stipulated by the Economic and Social Research Council (ESRC) when the studentship was awarded. These modules are designed to skill the researcher with regard to research practice and, for example, the conduct of in–depth interviewing and ethical principles. In addition, the CI's work is supervised by three qualified academics at the School of Applied Social Sciences as well as being overseen by the Steering Group mentioned above.

**18. Details of clinical interventions** *(populated from A12 where enabled)*

| Additional Intervention | Average number per participant | | Average time taken | Details of additional intervention or procedure, who will undertake it, and what training they have received. |
|---|---|---|---|---|
| | Routine Care | Research | | |
| | | | | |

**19. Details of non–clinical interventions** *(populated from A13 where enabled)*

| Additional Intervention | Average number per participant | Anticipated average time taken | Details of additional intervention or procedure, who will undertake it, and what training they have received. |
|---|---|---|---|
| Face to Face Interview | 0 | 75 mins | The interview will consist of semi–structured questions. It is to be undertaken by the Chief Investigator who has completed the required Research Methods training as determined by the Economic and Social Research Council. The interviews are to take place at the respondent's place of work or, if a suitable confidential environment is not available and the respondent is willing, at the School of Applied Social Sciences. The 'average number per patient' has been set at zero as no patients are to be interviewed. |
| Audio Recording | 0 | 75 mins | An audio recording device will be used during the interviews. Other details are as above. |

**20. Will any aspects of the research at this site be conducted in a different way to that described in Parts A and B or the study protocol?**

◯ Yes ◯ No

*If Yes, explain and give reasons.*

**21. How many research participants/samples is it expected will be recruited/obtained from this site?**

The maximum number of participants is 40.

**22. Give details of how potential participants will be identified locally and who will be making the first approach to them to take part in the study?**

**23. Who will be responsible for obtaining informed consent at this site? What expertise and training do these persons have in obtaining consent for research purposes?**

The Chief Investigator. In addition to holding a first degree in Sociology from the University of Durham and an MSc in Criminology and Criminal Justice Studies from the University of Wales in Cardiff, the research student has also completed the necessary number of Research Methods modules at the University of Durham, as stipulated by the Economic and Social Research Council when the studentship was awarded. The issue of informed consent was covered within the modules completed.

Regarding experience 'in the field' the CI has also worked as an interviewer on a CASE sponsored research project, which was organised by the University of Durham, on the subject of social exclusion.

**24. What local arrangements will be made to seek consent from a legal representative on behalf of adults unable to consent for themselves?**

**26. What is the procedure and contact point for any complaints from potential or actual participants whether before, during or after the study?**

School of Applied Social Sciences
University of Durham
32 Old Elvet
Durham
DH1 3HN

Tel: +44 (0)191 334 6827
Fax: +44 (0)191 334 6821

**27. Is there a contact point where potential participants can seek independent advice about participating in the study?**

No

R&D Only

**28. Please provide a copy on headed paper of the participant information sheet and consent form that will be used locally.** *This must be the same generic version submitted to/approved by the main REC for the study while including relevant local information about the site, investigator and contact points for participants (see guidance notes).*

*If you consider that changes should be made to the generic content of the information sheet to reflect site-specific issues in the conduct of the study (see 20), give details below. A substantial amendment may need to be discussed with the Chief Investigator and submitted to the main REC.*

**29. What arrangements have been made for participants who might not adequately understand verbal explanations or written information given in English, or who have special communication needs?** *(e.g. translation, use of interpreters etc.) (Populated from A29)*

Not applicable

**What local arrangements have been made to meet these requirements (where applicable)?**Not applicable

**30. What arrangements will be made to inform the GP or other health care professionals responsible for the care of the participants?**

It is not anticipated that this question is relevent as no patients/vulnerable people will be interviewed.

**31. What special measures (e.g. facilities, staffing, psychosocial support, emergency procedures) will be in place at the site, where appropriate, to minimise the risks to participants and staff and deal with the consequences of any harm?**

*In the case of Phase 1 trials in healthy volunteers, confirm that the unit's normal SOPs will be followed. Comment where appropriate on any particular risks arising from this trial and outline any additional emergency measures.*

No procedures or interventions will be undertaken. None

**32. What measures will be in place to prevent over-volunteering?**

**33. What arrangements (e.g. facilities, staffing, psychosocial support, emergency procedures) will be in place at the site, where appropriate, to minimise the risks to participants and staff and deal with the consequences of any harm?**

No procedures or interventions will be undertaken. None

**34. Give details of the arrangements for the management and monitoring of the research at this site.**

*In the case of Phase 1 trials in healthy volunteers, confirm that the unit's normal SOPs will be followed. Comment on any particular measures in place for this trial.*

**R&D Only**

**35. What are the arrangements for the supervision of the conduct of the research at this site?** *Give name and contact details of any supervisor not already listed in the application.*

**36. What arrangements will be made for insurance and/or indemnity to meet the potential legal liability of the Principal Investigator, the site management organisation and other members of the research team arising from harm to participants in the conduct of the research at this site?**

*Please enclose a copy of all relevant documents*

**R&D Only**

**37. Will any external funding be provided for the research at this site?**

◯ Yes ◯ No

*If Yes, indicate the source and details of the funding:*

**R&D Only**

**38. Which organisation will receive and manage this funding?**

**R&D Only**

**39. Authorisations required prior to R&D approval**

*This section deals with authorisations by managers within the NHS organisation. It should be signed in accordance with the guidance provided by the NHS organisation. This may include authorisation by line managers, service managers, support department managers, pharmacy, data protection officers or finance managers, depending on the nature of the research. Managers completing this section should confirm in the text what the authorisation means, in accordance with the guidance provided by the NHS organisation. This section may also be used by university employers or research staff to provide authorisation to NHS organisations, in accordance with guidance from the university.*

**Declaration by Principal Investigator**

1. The information in this form is accurate to the best of my knowledge and I take full responsibility for it.
2. I undertake to abide by the ethical principles underpinning the World Medical Association's Declaration of Helsinki and relevant good practice guidelines in the conduct of research.
3. I undertake to comply with the Medicines for Human Use (Clinical Trials) Regulations 2004 in the conduct of this trial.
4. If the research is approved, I undertake to adhere to the study protocol, the terms of the full application of which the main REC has given a favourable opinion and the terms of this application.
5. I am aware of my responsibility to be up to date and comply with the requirements of the law and relevant guidelines relating to the conduct of research, including legislation on human tissue and personal data.
6. I undertake to disclose any conflicts of interest that may arise during the course of this research, and take responsibility for ensuring that all staff involved in the research are aware of their responsibilities to disclose conflicts of interest.
7. I understand and agree that study files, records and data may be subject to inspection by the main REC or the SSA REC for audit purposes.
8. I understand that personal data about me as a researcher will be held by the relevant RECs and their operational managers and that this will be managed according to the principles established in the Data Protection Act 1998.
9. I understand that the information contained in this application, any supporting documentation and all correspondence with Research Ethics Committees or their operational managers relating to the application:

    - Will be held by the REC system until at least 3 years after the end of the study.
    - May be disclosed to the operational managers or the appointing body for the REC in order to check that the application has been processed correctly or to investigate any complaint.
    - May be seen by auditors appointed by the National Research Ethics Service to undertake accreditation of the REC.
    - Will be subject to the provisions of the Freedom of Information Acts and may be disclosed in response to requests made under the Acts except where statutory exemptions apply.

Signature of Principal Investigator: .....

Print Name: John Quinn

Date: 08/08/2005

**Declaration on behalf of Site Management Organisation**

I confirm that:

- The Principal Investigator has a contract with the SMO to conduct this research.
- All insurance and indemnity arrangements described above will be in place before the study starts at the site.
- The employer's procedures for compliance with the Ionising Radiation (Medical Exposures) Regulations 2000 will be followed in the conduct of the study.
- The arrangements described above for management and monitoring of the research will be implemented.

Signature: .....

Print Name:

Date:

**Declaration by Principal Investigator or Local Collaborator**

1. The information in this form is accurate to the best of my knowledge and I take full responsibility for it.
2. I undertake to abide by the ethical principles underpinning the World Medical Association's Declaration of Helsinki and relevant good practice guidelines in the conduct of research.
3. If the research is approved by the main REC and NHS organisation, I undertake to adhere to the study protocol, the terms of the application of which the main REC has given a favourable opinion and the conditions requested by the NHS organisation, and to inform the NHS organisation within local timelines of any subsequent amendments to the protocol.
4. If the research is approved, I undertake to abide by the principles of the Research Governance Framework for Health and Social Care.
5. I am aware of my responsibility to be up to date and comply with the requirements of the law and relevant guidelines relating to the conduct of research.
6. I undertake to disclose any conflicts of interest that may arise during the course of this research, and take responsibility for ensuring that all staff involved in the research are aware of their responsibilities to disclose conflicts of interest.
7. I understand and agree that study files, documents, research records and data may be subject to inspection by the NHS organisation, the sponsor or an independent body for monitoring, audit and inspection purposes.
8. I take responsibility for ensuring that staff involved in the research at this site hold appropriate contracts for the duration of the research, are familiar with the Research Governance Framework, the NHS organisation's Data Protection Policy and all other relevant policies and guidelines, and are appropriately trained and experienced.
9. I undertake to complete any interim and/or final reports as requested by the NHS organisation and understand that continuation of permission to conduct research within the NHS organisation is dependent on satisfactory completion of such reports.
10. I undertake to maintain a project file for this research in accordance with the NHS organisation's policy.
11. I take responsibility for ensuring that all serious adverse events are handled within the NHS organisation's policy for reporting and handling of adverse events.
12. I understand that information relating to this research, and about me as a researcher, will be held by the R&D office and may be held on national research information systems, and that this will be managed according to the principles established in the Data Protection Act 1998.
13. I understand that information relating to this research, and about me as a researcher, will be held by RECs undertaking site–specific assessment and their operational managers and that this will be managed according to the principles established in the Data Protection Act 1998.
14. I understand that the information contained in this application, any supporting documentation and all correspondence with the R&D office and/or the REC system relating to the application will be subject to the provisions of the Freedom of Information Acts and may be disclosed in response to requests made under the Acts except where statutory exemptions apply.
15. I understand that information relating to this research (including my contact details) may be publicly available through the National Research Register.

Signature of Principal Investigator or Local Collaborator: .....

Print Name: John Quinn

Date: 08/08/2005