**Written evidence submitted by Dr J P White MRCPsych, Dr R Galway DClinPsy, Dr Rachel Beryl, Ms Yasmin Siddall, Dr S Afghan MRCPsych, and Ms D Wilkinson at the National High Secure Healthcare Service for Women, Rampton Hospital, Nottinghamshire Healthcare NHS Foundation Trust [WRH0040]**

## Introduction:

We are a group of multidisciplinary professionals working in the National High Secure Healthcare Service for Women at Rampton Hospital.

As a group of healthcare professionals, we have experience of working in secure services including secure hospitals and prisons and have extensive experience of working with women in secure settings.

We wish to submit evidence to illustrate the inequalities and challenges faced by women residing in secure institutions, in accessing reproductive healthcare and support; we would like the committee to highlight to the government the need for improved access and support in reproductive healthcare for women in secure settings.

The National High Secure Healthcare Service for Women has links with secure settings throughout the United Kingdom through consultation with our National Women's Outreach Service, access assessments for referrals into our service and through stepping patients down to lower tiers of security; as such we offer a unique insight into the challenges facing women in a variety of secure settings through the UK.

## What disparities exist in the treatment and diagnosis of gynaecological or urogynaecological conditions:

- Any woman detained within a secure institution by virtue of deprivation of liberty only has access to the physical healthcare facilities made available by the institution in which they reside.
  This removes the element of choice which would be present for women in the community and may lead to women choosing not to present earlier with minor symptoms due to a multitude of factors including interpersonal conflict, concerns about dignity and confidentiality or ease of access.

- There is no standard provision of healthcare for secure institutions which introduces disparity between different locations; a woman attempting to seek help in a smaller medium secure unit may have less access to physical health

provision compared to a woman in a larger medium secure unit elsewhere in the country.

- Women in secure inpatient settings have limited or different access to sexual health screening opportunities. For example, in our service, women are routinely screened for Human Immunodeficiency Virus (HIV) on admission and other Blood Borne Viruses (BBV). Women in prison and secure inpatient settings have limited or no access to specialist sexual health clinics compared to the community which offers increased choice and a more confidential service. On admission to secure hospital, women are often only screened for HIV/BBV (things that can cause harm to other people). They are not tested for any other Sexually Transmitted Infections, which can cause significant harm to women such as infertility and mental ill health.

- Due to the nature of incarceration in a secure facility, options for clothing and accessories are limited – this includes access to sanitary products by brand, alternative products (moon cups etc) or items of clothing which may be preferable depending on symptoms present; there is variability on the options available depending on location but all are reduced compared to the community.

- Women in inpatient secure settings and prison are financially disadvantaged and can be some of the most impoverished members of society – before, during and after their time in a secure setting. Period poverty is therefore likely to effect this group of women more widely than other groups of women across the UK.

- Many women within the service are obese due to a complex interplay of multiple factors such as medication, comfort eating as a trauma response, and limited opportunities for exercise. Obesity often impacts reproductive health – irregular periods, higher risk of certain cancers. Attending to female hygiene and using sanitary wear for obese individuals can be physically and logistically difficult. There are types of sanitary wear such as period pants, that can make this more accessible for obese people, however, these are not readily accessible across secure facilities.

- In the community, women may choose to attend appointments with a friend, relative or carer, or may choose to attend alone. Within secure inpatient settings or prison, these choices are either limited or not available; women are usually escorted to appointments with hospital or prison staff in attendance.

- Within secure settings the choice of prescription medication is often limited to a few proprietary brands or generic preparations, leading to a reduction in choice compared to community.

- There is significantly less access, or no access at all, to alternative medication or practitioners such as acupuncture, herbalism or homeopathy.

- Women in secure settings may not be responsible for the administration of their own medication, as medication is often centrally managed and dispensed by staff. This can impact on ability to engage in treatment as women are more likely to be reliant on others to administer or facilitate access to treatment than women in the community.

- Women in the community have access to online resources to increase their understanding and awareness of gynaecological or urogynaecological conditions, which can serve to increase confidence to raise concerns with GP or other medical professionals, increase understanding of potential diagnoses and treatment options available, increase understanding and reduce anxieties about what to expect from appointments or specific procedures. Additionally, online communities and support through social media can facilitate women connecting with others who have experienced the same or similar reproductive health needs, which can reduce a sense of isolation and increase normalisation. Within prison and secure inpatient services, women have limited, restricted or no access to the internet.

- Within secure settings the trauma histories of each woman is often well known and professionals involved in their care and support develop an understanding of the impact of their trauma experiences; these formulations consider their ability to engage in physical health care provisions. Within the National High Secure Healthcare Service for Women (NHSHSW), a multidisciplinary team are currently developing and embedding the Trauma-Informed Cervical Screening Support Pathway, with a focus on identifying barriers to engagement in the screening programme, support to make informed choices about whether to engage or not, and support to develop and implement plans to help them safely attend and engage in cervical screening appointments. This can include psychoeducation using bespoke and accessible resources (e.g. Easy Read, communicated through a Deaf interpreter etc); collaboratively developing care plans and using sensory items to help women cope with any difficult emotions that may arise during their appointments. Whilst this will be available to all women within NHSHSW, we are mindful that this is not available in all forensic inpatient services, prisons, or indeed the community and we want to highlight that women in all walks of life may have experienced trauma which may impact on their ability to engage in physical health care, particularly reproductive health care and this is rarely considered or accommodated for in the provision and commission of services.

- Women in secure inpatient settings, and to a lesser degree the women's prison estate, benefit from a more readily accessible multidisciplinary team of professionals – particularly Psychologist and Psychological Therapists, in

comparison with women in the community who often face extensive waiting lists for any assessments and subsequent therapies.

- Post, peri and ante-natal care provision is subject to significant barriers and disparity for women in prisons, with campaigns by Women in Prison and the Centre for Women's Justice providing platforms for women's voices to share their experiences.

**What barriers exist in the treatment and diagnosis of gynaecological or urogynaecological conditions:**

- There is a lack of accessible information or training for healthcare professionals to increase awareness or provide education around women's reproductive health issues, therefore vulnerable individuals or women with an Intellectual Disability or Autistic Spectrum Disorder are disproportionately disadvantaged; proactive education and resources could help restore this imbalance.

- The lack of education and normalisation of open discussion about female reproductive health, sex, menarche, menstruation, menopause and dysfunction in society has created stigma which prevents recognition and awareness of abnormality and changes, and a perception of shame and lack of self-awareness.

- Prisoners are frequently relocated between prisons for a variety of reasons throughout the course of their sentence, this is often to manage risk, capacity or due to their stage in the legal process; physical health records and continuation of investigation or treatment is often poorly communicated between providers, particularly if this involves a large geographical move and transfer of care between NHS Trusts.

- The secure arrangements for escort and transport dictated by the Ministry of Justice for prisoners or restricted patients and local procedures for the management of secure patients is often highly restrictive and compromises dignity and privacy; with a national shortage in healthcare and prison workers this can also create significant challenges from an operational capacity in conveying the individual to hospital or place of treatment. Whilst public protection and safety must remain paramount in the management of risk outside of a secure setting, consideration should be given to the creation of guidance to maintain privacy and dignity during treatment and diagnosis which would take a person-centred approach. Additionally, there are

resourcing and logistical issues that can impact on women's ability to attend healthcare appointments outside of their place of residence, such as insufficient transport available on the date of appointments, staffing levels required for the escort and to cover the wards or wings.

- Where a woman is managed in Segregation, Seclusion or Longer-Term Segregation due to risk of violence, access to some physical health interventions are limited based on risk presented – whilst basic emergency healthcare will be made available it is not possible in many cases to undertake more advanced investigation or treatment measures which could lead to a delay in diagnosis or break in treatment.

- The presence of poorly controlled Severe Mental Illness (SMI) in any secure setting can be a significant barrier in accessing treatment or diagnosis and introduces complex legal difficulties such as capacity and consent which is often poorly understood by professionals within secure services and physical healthcare providers. There should be more proactive healthcare interventions directed towards women with SMI in secure settings aimed at increasing surveillance and awareness of reproductive health problems. Although training on capacity and consent is mandatory in the majority of healthcare settings this is clearly insufficient, and more education and clarity is required around such complex cases.

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