Written evidence from CNWL NHS Foundation Trust Health and Justice Services Directorate

We are one of the leading NHS providers of healthcare in UK prisons, working across the male, female and youth estate. In the female estate, we provide physical and mental health (MH) care in HMP Send and HMP Downview and secondary MH care in HMPYOI Bronzefield.

Women in prison tend to have a history of complex trauma, substance misuse, social deprivation, poor MH and domestic violence. They have multiple diagnoses and treatment needs and often find it difficult to engage with community services to receive the assistance they require.

Whole System Approach

The MH presentations of women in custody are multifactorial in origin. They include mental illness, cognitive impairment, intellectual disability, substance misuse, physical disability and functional impairment; all of which can impact on women's ability to cope. As a consequence, women in prison require a system that is able to identify, support and offer joined up care to best meet their needs in a flexible and timely way.

Women in prison face different challenges to their wellbeing at different points in their life and at different points within their sentence. A whole system approach needs to reflect these differences in the stage of someone's life and the stage of their sentence alongside difference in cultural and religious backgrounds, all of which impact on an individual's experience of custody.

It is not a one size fits all. A young woman remanded into custody for the first time with no dependents has very different needs to women in their middle and old age who have been in custody for long sentences and who frequently have co morbid physical health needs.

The perinatal period, the menopause, the loss of mobility and cognitive decline in older age all need to be reflected in the services that are offered. Similarly, the MH consequences attributed to the period after being remanded, sentenced, prior to parole and in the build up to release can be times of heightened distress. Women with little prospect of release face different, more chronic challenges relating to the acceptance of their detention, their crime and in most cases the separation from their family.

One of the advantages of prison is that many of the relevant agencies who are required to contribute to women's care in prison are located in the same environment. This includes primary care, MH, substance misuse, education, resettlement, safer custody, OMU, IMB and chaplaincy teams. Their diversity, in terms of goals, approaches and governance and accountability structures can be a strength but can also be a complication. For example, the whole system being trauma informed (TI) is an admirable goal but if the primary task of prison is viewed as punishment, rather than rehabilitation, this becomes impossible.

Many of these agencies work well together to best meet women's needs particularly with women with high-risk, high-need presentations and those who have lengthier sentences. For women who have shorter sentences this is often not as fluid. A whole systems approach may

become easier with the roll out of OMIC and key-working but we are yet to see how this works in a non-covid world. It has also been complicated in the past by the arrangement and split in probation services.

There remain complications. Primary amongst these is that there is not a single, joined up plan for care and management, or a single lead person to coordinate this across agencies. In practice, this can lead to competing pressures and a lack of joined up work; it might involve a woman being enrolled for education at the same time as therapy groups or she might be transferred between prisons with limited or no notice, disrupting care and the very important attachments that can be built. Much of our work requires the building of therapeutic rapport and a sense of safety, already complicated in traumatised women and easily ruptured by such changes.

The custodial secondary MH teams adhere to the national framework for a Care Programme Approach (CPA) which offers a holistic package of needs assessment for women with more severe and complex MH needs. The intention being to acknowledge and unite the variety of agencies which may input into an individual's care, but they are not prison specific and are not always able to offer the patient driven care which they are designed to do, owing to the physical constraints of custody.

The CPA approach is particularly useful for allowing women to access ongoing community support after release. However, it is only applicable for those with more severe MH needs. The majority of those under our care are not subject to a CPA approach and there is no equivalent framework to help them navigate custody and further care in the community.

Furthermore, there can exist considerable overlap in the deficits of women with brain injuries, some neurodevelopmental and psychiatric disorders and intellectual disability. These cases require joined up working between MH, primary care services, HMPPS and social care services. As these agencies work within different legislative frameworks, have differing thresholds for intervention and receive funding from different sources, joint working between them to achieve a comprehensive package of care is challenging

Constraints on room availability, technology and information sharing makes joined up working difficult. It is often difficult to meet colleagues and you cannot easily find out about work with a particular person because of the different systems and access required. It can also be hard for the women, to have any autonomy in managing their needs.

A further example of these difficulties is the intricacies surrounding assessing and funding community care for women in prison with complex needs. Some of these women, especially those with significant mental illness or physical health needs will be eligible for publicly funded support and care in the community under The Care Act 2014. However, accessing this funding can be highly complex for women who have lived in multiple areas, registered with a number of GPs in different CCGs. Establishing who should pay for what, for prisoners is a time-consuming and frequently involves disagreement between LAs and CCGs. This ultimately leads to women who need and are eligible for community support leaving prison without this in place, exacerbating their vulnerabilities and making it more likely that they will re-offend.

Even for women who are not eligible for public funding for care, arranging community psychiatric follow up can be extremely difficult. Very often a woman will be released NFA. Without an address, one cannot be referred to community services in advance and so there is no-one providing support during the risky transition period from custody to the community. This directly contributes to the elevated risk of re-offending and also of self-harm and suicide

As more is understood about the highly complex needs of women in custody, it is clear that there are emerging areas of need which have not been fully appreciated. These include neurodevelopmental disorders such as autism and ADHD, perinatal mental illness, brain injuries, intellectual difficulties and cognitive impairment, all of which require specialist input to be brought into a whole systems approach.

What factors contribute to the high levels of self-harm?

Women in prison tell us they self-harm for a multitude of different reasons, most commonly we see it as a proxy measure of emotional distress and lack of alternative ways of coping. It is frequently seen in women who struggle to ask for help and in those who want (often unconsciously) to punish themselves, in those who are desperately trying to feel something or in those who are trying to block or numb distress or difficult memories. It can also be about a need to communicate, either distress or unmet needs; a way of eliciting the required care and attention.

Many women who self-harm in custody have a history of self-harming in the community. Others initiate self-harming once in custody. For some women the self-harming can be chronic during their time in custody, whilst for others it is more episodic. Research has shown that whilst self- harming prisons is much more common than in the community, it is also true that a very large number of incidents originate from a relatively small number of women (those who self- harm prolifically).

Almost universal to all of the women who self-harm in custody are significant trauma histories. These include significant sexual, physical and emotional abuse which have often begun early in their lives. They have also come from highly disadvantage backgrounds characterised by poverty and disadvantage. Those with histories of trauma are at an increased risk of self-harm, and custodial environments can trigger and retraumatise women, making acts of self-harm, more likely.

Self-harm is often reported by women as their way of trying to regulate their distress. Distress can be generated by being separated from friends and family/children, missing birthdays and events. It can also relate to anniversaries of particularly difficult experiences including abuse and loss.

The environment of the prison itself can also trigger self-harm. Women feel stripped of any autonomy and often access to activities or support to help manage their self-harm is limited. Women report that they can feel isolated on the wing or be subject to bullying or get into debt which can further exacerbate self-harm.

Many women report that they use substances in the community, (illicit and prescribed), to numb themselves to their experience of past trauma. Without access to drugs and some

prescribed medications women report struggling to manage their distress in custody which can precipitate self-harm.

What is being done?

Self-harm is managed through the safer custody teams and the ACCT process. This allows a multi-agency discussion and care map in order to support the woman, it also mandates frequency of observations and conversations. Some women very much appreciate the support of the ACCT, others find it aversive. When run well, this process is extremely helpful. Sometimes though the pressures on the prisons of numerous ACCTs and inconsistent staffing mean different ACCT managers lead on each meeting and different staff, including from MH attend (or don't) and this inhibits its utility.

Other programmes and work ongoing to address self-harm in custody include the OPD commissioned Options Programme, which provides DBT informed interventions and has been shown to reduce levels and frequency of self-harm

Furthermore, there is a (suspended because of COVID) national randomised control trial called WORSHIP-III which is evaluating a specific psychological intervention for those who self-harm in custody. This followed a positive pilot study and is a promising intervention.

At HMP Bronzefield we are trialling a partnership approach between our MH team, our OPD team and the Sodexo prison team to support enhanced ACCT reviews for those women whose self-harm is prolific and dangerous. This involves the use of psychological formulation staff training and supervision and is extremely well received by the prison and has shown promising results.

Supervision is important (especially in a TI environment) as self-harm can be an extremely distressing, and traumatising thing for staff to manage. Women cut their arms but they also inflict burns, ligatures, insert objects into wounds, head bang, hit or bite themselves and tie ligatures. When severe, protracted and frequent, this can lead to significant injury and disfigurement and can be extremely distressing to witness.

What more can be done?

From a MH point of view, more support for relevant group and individual therapy which can target both self-harm and the underlying psychological distress and trauma. From a prison point of view, we hypothesise that anything that helps to reduce distress and support coping. Improving levels of autonomy within prison, access to children and families via telephones in cells, more frequent visits, keeping busy and building self-esteem via activities, education and employment opportunities such as working in the gardens. Addressing bullying and issues of debt, especially drug related also remain of paramount importance.

Whilst at early stages, we would also support the wider role out of the Self-harm Strategy piloted at Bronzefield.

Trauma informed approaches

There has been an increasing recognition of the multiple vulnerabilities inherent in the female offender population often underpinned by histories of severe and protracted trauma. The Corston report in 2007 and the work of charities including One Small Thing has highlighted the need for custodial settings to be TI and responsive environments. The female estate is ahead in terms of thinking about these issues, of training staff and of making adaptations.

Whilst the culture of female prisons has moved towards becoming TI, this aim is often at odds with what is seen by many as the purpose of prisons; to punish. There are pockets of really inspirational practice and individuals who are committed to this approach and live its values, but the task is not easy. The training and supervision of all staff and women in prison is imperative in achieving the aim of the prison service becoming comprehensively TI and responsive. This requires the recognition of a TI service which treats the prison community, (staff and residents), in a humane and respectful manner.

There are multiple barriers to this being comprehensively achieved. The broader themes relating to staff and prisoners is a lack of awareness and a lack of a perception of autonomy that both staff and prisoners can affect change in themselves, their peers and their environment.

The physical environment of the prison can also be a barrier to becoming fully TI and responsive. The state of the cells, the lack of privacy, the lack of telephone access in some prisons which reinforces a sense of isolation, the noisiness of some landings and even the act of being physically locked into a cell can be highly triggering for many prisoners.

Restraints, searches and segregation; which all occur frequently in prison need to be especially sensitively managed within this framework and whilst de-escalation can be done in respectful and safe ways, this is not always the case; especially in high pressure and frightening situations.

Bullying and drug use on the wings can also undermine the creation of a safe environment. Women face the threat of physical and verbal abuse and find leaving the cell to attend to their basic hygiene (which happens in a communal shower area in most cases) or to collect their food and medication, too risky. Access to a therapeutic, green outdoor space for exercise is also often limited.

Community transition

The point of transition back into the community for female offenders is often fragmented and uncertain. Owing to the strain on the system, in many instances, women in custody do not know where they will be relocated to until the day of their release. This makes planning for referral into onward MH services difficult as for secondary MH services. Women require an address, phone number and ideally a GP in order to ensure that their care can be adequately handed over.

Many community services will not accept referrals for women with MH needs who have more severe histories of offending, however they do not qualify for Community Forensic Services as they are not stepping out of secure care services (which is often the entry requirement). In addition, the complex nature of women's MH needs in prison, largely underpinned by significant trauma does not meet the threshold for many CMHTs. Many

CMHTS focus on supporting those with severe and chronic mental illness which falls into the category of psychotic disorders and bipolar affective disorder. The diagnoses of those in the female estate tend towards significant anxiety disorders, PTSD and personality pathology. Their needs are deemed to be better served by IAPT services accessed via primary care, however the women often have high rates of self-harm and suicide attempts meaning that they are not eligible for these services. In short, accessing MH services in the community is by no means straight forward and woman are expected to have the agency and skills to navigate what is often a confusing pathway. To do this without support and in addition to the multiple other demands that they face when leaving prison can often be overwhelming and result in women not accessing the support they need.

Constraints on time, security and the means to communicate with agencies in the community such as MH services, GPs, friends and family to provide vital collateral information, means that significant parts of the women's life outside of prison are not taken into account. In addition, their relationships with their children as care providers are often not discussed or supported during their time in custody, when they are treated in isolation.

Youth to adult transition

The transition between the youth and adult estate is challenging. The youth estate has made progress in embedding a TI approach in its management of child prisoners. Using Secure Stairs, an integrated care approach, which means that all members of staff in the youth estate are aware of the impact of trauma and child development, child prisoner's emotional and psychological needs are better addressed than in the adult estate. Moving between this environment which has a more containing and understanding approach to the adult estate which is undoubtedly more procedural and punitive, with less individual support, can cause significant distress. We are of the opinion that the Secure Stairs approach should be rolled out prison wide to bring it's benefits to all who are incarcerated

Conclusion

It must be acknowledged that those who work with female offenders strive to work with compassion and understanding. However, the complexities of the female prison population coupled with resource limitations, lack of acknowledgement of the effects of trauma and multiple stake holders working under a vast array of intricate legislation means that very often women in the criminal justice system do not receive the care and support that they deserve.

Often the criminal justice system fails to support these women in the same way that they have been failed by the education system, social services and most significantly, family members. Ensuring a TI, joined up system of care that is adequately funded will provide significant benefits to these women, their children and society as a whole. As a civilised society we must, and should, do better.

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