**Physical Health Inequalities in Imprisoned Women with Serious Mental Illness: How can prison and community general practitioners work together?**

**Women in prison**

People with severe mental illness (SMI) have a life expectancy that is reduced by up to 20 years compared to the general population and primary care has a key role in reducing this mortality gap.1 Providing primary care in the prison setting requires special consideration. People in prison have multiple complex health and social care needs including higher rates of physical and mental health needs. There are up to 80,000 people in prison in England and Wales at any one time, and imprisoned women make up around 5% of this population.2 Women in prison often have dis-proportionately higher levels of serious SMI, substance use disorders (SUD) and self-harm compared to men in prison. Complicating these high rates is the high comorbidity and complex needs arising from experiences such as Adverse Childhood Experiences (ACEs), trauma, abuse, being separated from their children and family, homelessness and unemployment, and a relatively high proportion have a history of substance and alcohol misuse.3 According to the Prison Reform Trust 25% of women in prison reported symptoms indicative of psychosis.3 The rate among the general population is about 4%.

There are no reliable data reporting whether women with SMI in prison access primary care services pertaining to their physical health care needs (such as cardio-metabolic problems, access to screening services including cervical and breast screening) and whether these physical health needs are being adequately met. It is likely that this will differ between different female prisons in England.

**Women’s prison health policy and strategy**

Since 1999 there have been several policies which aim to improve the way in which health care is provided in prisons. Initiatives are guided by the principle of ‘equivalence of care’, that is, prisoners have the right to the same standard and range of physical and mental health services as they would have in the community.4 This was followed by the UK government publishing a health promotion strategy for prisons in England and Wales based on a ‘healthy settings’ approach.5 However, it is unclear what impact, if any, this has had on prisons and prisoner health.6 In 2007 the Corston Review7 made 43 recommendations that advocated holistic and integrated health and criminal justice solutions for women at risk of offending, and woman-centred custodial regimes for those who need to be imprisoned. However, the lack of progress and implementation of the recommendations of the Corston report has been the subject of many UK reviews since 2007. For example, the national UK charity Women in Prison conducted a detailed review of each recommendation in the Corston report.8 This review concluded that just two of the 43 original recommendations had been fully implemented. In 2018 the Ministry of Justice published the Female Offender Strategy9. This had three strategic priorities: earlier intervention, community-based solutions, and making custody effective and decent as possible for imprisoned women. An analysis of the Female Offender Strategy published by the Prison Reform Trust in May 202110 suggested that the government had fully implemented only 31 of 65 commitments. Many of the promises made in the Female Offender Strategy remain unachieved or partially achieved nearly three years on. A key point to note is that although the Female Offender Strategy was strongly influenced by the Corston Review and it has delivered on several key recommendations such as the Concordat on women in or at risk of contact with the Criminal Justice System (2021)12 and services committing to becoming trauma- and gender-informed by January 2022. It is also very clear that the Ministry of Justice and the Female Offender Strategy is still very far away from supporting the recommendations of the Corston report with the announcement in January 2021 to build 500 new prison places for women. In 2006, Baroness Corston concluded that prison isn’t the right place for women who are not a risk to the public - yet in 2021, 77% of women who are in prison have been convicted of non-violent offences. Building new prison places for women does nothing to address the root causes of women's offending and is a long way from an evidence-led, rehabilitative and humane policy agenda.

**Primary health care in prisons**

There is persuasive evidence that short custodial sentences of less than 12 months are less effective in reducing re-offending than community penalties, yet women are often given custodial sentences, and this, together with release without notice, leads to significant disruptions to family life.12 We also know that custody can be particularly damaging for women, whose rates of self-harm are nearly five times higher than those of men.13 So imprisoned women have most need but least care – an example of the inverse care law.14

Unmet healthcare needs have also been shown to predict return to custody.15

Providing healthcare in prisons presents unique challenges for GPs and other primary care and allied health professionals. In 2018, the Royal College of General Practitioners released a position statement16 on the difficulties of providing health care in secure environments which emphasised that people in prison should be 'afforded provision of or access to appropriate services or treatment,' which are 'at least consistent in range and quality with that available to the wider community'.

Little is known about how imprisoned women with SMI use primary care services and to what extent services are meeting their physical health care needs are less well known. The evidence that is available has predominantly been drawn from international studies17 or studies conducted several years ago.18

NICE guidance recommends that every prisoner should be seen by a health professional at the time of reception and seen by a doctor soon after reception.19 This ‘First Night’ assessment is intended to detect the immediate risks posed to a woman’s physical and mental health following their arrival in prison and should assess for the presence of significant physical health problems and long-term conditions requiring treatment overnight, level of risk to self (including risk of self-harm and suicide), history of recent injury and/or serious illness and withdrawal from substance misuse and/or alcohol dependence. NICE Guidance19 recommends that a ‘second stage’ assessment should take place within one week of arrival in prison to establish if the person requires more detailed assessment and investigation in order to establish the presence of any ongoing unmet care needs and in this way provides an opportunity for the detection of previously unknown long-term physical health conditions. Completion of ‘First Night’ and second-stage assessment helps to support engagement, may help to reduce high levels of anxiety and distress, and ensure that an appropriate care plan and follow-up arrangements are made. The quality of these assessments can vary between different prison estates because female prisons are of different sizes and have different security levels. In addition, different governance arrangements influence care offered.

**What can we learn from general practice?**

Drawing on some of the attributes of UK general practice might help strengthen the care given to imprisoned women (Table 1).

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| * Biopsychosocial model * Relationship-based care,20 person-centred care21 along with continuity22 (which is important for people with SMI) – neither of which seem at first sight to apply * Continuity of care22 (i.e. Through the Gate resettlement services that aim to provide a transistion between prison and the community by providing assistance with accomdation, finance and work; communication/ and linked IT systems) * The need for robust multi-disciplinary/professional team working – collaborative care models24 |

Table 1. The attributes of UK general practice relevant to primary care in prisons

The NHS Long-Term plan states that a priority in services for the most vulnerable group of patients is improving continuity of care.24 The care after custody service, RECONNECT, starts working with people before they leave prison and helps them to make the transition to community-based services, including GP services, that will provide the health and care support that they need.

**On release – what should GPs do to support women released from prison?**

Community GPs need to trust that prison GPs are more experienced in certain areas and support decisions that have been made in prison e.g. gabapentinoid detoxes. Mixed messages confuse the women and promote distrust.

There is a need for proactivity from the woman’s registered general practice and advocacy for the women, who can be overwhelmed with problems and appointments on release from prison. Health can become much less of a priority than sorting housing and benefits for example; use of third sector organisations can help with this.

Ideally the released woman should be offered a named GP for continuity of care. However, this patient group is complex and are more at risk of self-harm and suicidal behaviour, so there is a need for shared responsibility and support for all healthcare professionals invovled.

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| *Pre-release planning when release date is known* | *Unplanned releases* |
| * Ensure woman is registered with a general practice | * Remind woman to register with general practice |
| * Supply of medications (usually 7 days) | * Provision of FP10/FP10 MDA can be provided in case of unplanned relase |
| * Discharge summary to include any alterations in treatment, new diagnoses and outstanding follow-up or secondary care referrals/investigations that have not been completed | * Summary provided to registered general practice where possible |
| * Contact details to be provided in order that community general practice can contact prison healthcare team | * Prison healthcare team to liaise proactively with general practice |
| * Details of date and time of any outstanding hospital/secondary care appointments provided to woman and practice in order that they can attend on release | * Details of date and time of any outstanding hospital/secondary care appointments in order that they can attend on release provided to woman and general practice |

Table 2. Primary care across the prison/community interface

The authors are part of a multidisciplinary, cross institution, group within the ‘Closing the Gap’ network25 which aims to strengthen links between academics, clinicians, individuals with lived experience, charities and industry partners working in the field of primary care in female prisons. We aim to identify new approaches and ways of addressing inequalities in physical health among imprisoned women with SMI.

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