OPTIONS FOR IMPLEMENTATION OF ICAS
(INDEPENDENT COMPLAINTS ADVOCACY SERVICE)
IN PRISONS

Prepared for the Department of Health by

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If you require a copy of the full appendices that accompany this report, please send an e-mail to Anita.Harris@dh.gsi.gov.uk.

About The Carers Federation Ltd

The Carers Federation Limited was established in 1992 and is managed by carers, former carers and service users. The organisation offers a wide range of services to diverse client groups and has particular expertise around Black and Minority Ethnic communities, young carers, adult carers, families affected by drug and alcohol misuse, counselling, Patient and Public Involvement Forums, ICAS, training and education.

The organisation is committed to working towards improved health and social care provision to people requiring services and support.

About ICAS

The Independent Complaints Advocacy Service provides support to people in England wishing to complain about the treatment or care they receive under the National Health Service (NHS).

Trained advocates (also known as caseworkers), with knowledge of the NHS complaints procedure, help clients to understand whether they wish to pursue a complaint and where needed, advocates provide support to clients in doing so. The support offered ranges from helping the client with initial preparation in ordering their thoughts and thinking about what a good resolution would look like to them, through to attendance at resolution meetings and helping people with correspondence.

Acknowledgements

We would like to sincerely thank all the participants of the research and pilots who so generously shared their time, experience and opinion.

Thanks also to our ICAS partners for their comments and support. Particularly, SEAP and POhWER for seconding staff members to the research team.

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We are also grateful to Anita Harris, National ICAS Manager, Department of Health for providing the opportunity to write this report, her support and commitment to this work has been invaluable.

Executive Summary

‘Options for Implementation of ICAS in Prisons’

This report was commissioned by The Department of Health to highlight design options for a national programme, enabling ICAS providers to deliver their service to prisons. The report was written by Julia D. Tabreham, Chief Executive of The Carers Federation Ltd and Juliet D. Whiteside, Service Director of East Midlands ICAS (which is a Carers Federation Ltd service) and was submitted to the Department on 14th March 2005.

Method

Five models for ICAS delivery in prisons were devised and consulted on. A wide range of techniques were used to gather data, including face-to-face and telephone interviews; internet discussion boards; focus groups; meetings and newspaper articles/newsletters. 209 structured interviews were completed over a two-month period, providing a wealth of material for analysis. An extensive literature review was also completed.

Proposed Models

Model 1: Full existing ICAS service model, telephone 0845 support, assisted correspondence and complaint construction, literature including self help pack and publicity, face-to-face advocacy
Model 2: As model 1 without option for face-to-face advocacy
Model 3: As model 1 with face-to-face advocacy delivered by partner agency
Model 4: As model 3 with option for ICAS to provide support when complaint reaches panel hearing stage or similar
Model 5: Prisoners trained to offer peer support to prisoners with health complaints

Summary of conclusions

The conclusion table below summarises the degree of support for each of the proposed models

Key:
GREEN = high AMBER = moderate RED = weak/none

Model	Pros	Cons
Model 1	Equitable with generic ICAS	High cost/labour intensive
	Supports diverse needs of prisoners, literacy & language needs met	Security difficulties in accessing clients in prison
		Not all staff happy to visit prisoners
		ICAS capacity issues
Model 2	Less labour intensive/more cost effective	Prisoner limited time for access to telephone and lack of privacy on wing for sensitive calls
	Impact on capacity issues less marked	Literacy levels prohibit many prisoners ability to read Self Help Pack, write/read letters. Danger complaint will not be made
	Lower security issues	Not equitable with external ICAS service
		Breaks ICAS Core Principles of accessibility and inclusion
		Threat of Judicial Review
Model 3	Partners have existing knowledge of system and security clearance	Partners unwilling to take on ICAS work, seen as specialist knowledge, majority of their staff volunteers
	Already trusted by inmates	High demand on ICAS for training and support
Model 4	As model 3 above	As model 3 above
	Higher level of knowledge required for Independent Review Panels	ICAS advocates feel taking client on at complex stage, unworkable
		Confusing for client
Model 5	Listeners already running in every prison with exception of YOIs	Prisoners would have access to confidential health information about their peers, potential to cause harm
	Evidence of reduction in recidivism	Training and supervision of peer workers time consuming, difficult to ensure consistency and access issues
	Availability of support 24 hours a day	Workload for peer support worker could be high
		Unlikely to work in YOI's & remand where the average length of stay extremely short

Model 1

Model 1 received overwhelming support from key stakeholders, this is also the preferred model of the IMB, and was piloted at HMP Morton Hall. The model embodies all ICAS Core Principles and would meet the need of the diverse prison population, particularly in relation to literacy and language.

This is also the preferred model for prisoners, 100% of which stated that they would prefer a face-to-face meeting with an advocate to construct their complaint.

Prisoner governors felt that everything the service would require to become operational, such as security clearance, contact details for booking clerks, visiting procedures, would easily fit in with existing prison procedures. Governors also suggested that ICAS advocates could book visits within Visitor Centres, which would simplify the process further.

The introduction of an 0845 number could be added to the prisoner PIN list nationally, and this procedure is extremely straightforward. It was stressed that a section on health and how to complain, understanding the difference between ICAS and PALS and how to contact them needs to be inserted into the prisoner induction pack which they all receive on arrival.

There are key security issues associated with this model such as: What areas of the prison would ICAS advocates have access to? How would their work complement the IMB and not get in the way? Who will carry out visit risk assessment and be responsible for the security of the advocate once on prison grounds?

Model 2

Model 2 was supported by a number of stakeholders and was rated second to Model 1 as the most preferred model option. Model 2 was piloted in 34 prisons. Advocates unwilling to visit prisoners preferred this model. The model is less labour intensive, and the ICAS capacity issues are less marked. The model cuts out many of the security issues, and the high travel and visiting time each complaint would demand with the face-to-face model.

The model is, however, not equitable with the generic ICAS service, and legal advice suggests prisoners could pursue judicial review against the Secretary of State for Health, under Human Rights legislation.

Major concerns with this model are that prisoners have limited time available to make telephone calls, and often the telephone is not available until evening. Telephones are on the wing, and there is little opportunity for privacy when discussing confidential/sensitive information. Literacy levels are very low in

prisons, and a wide range of languages are spoken, not all of which have a written format. It was felt that the lack of a face-to-face option may deter some people from complaining.

Model 3

Model 3 received some positive support from stakeholders, particularly a Strategic Health Authority who commented:

"I think the model proposing the use of a partner agency has a lot of merit. I assume this would/could be the IMB…"

It is important to note, however, that the IMB are unwilling to undertake this work on behalf of ICAS, and feel it would cause them considerable difficulties as their volunteers are unpaid and ICAS employs paid staff. Other stakeholders who participated in the research, particularly prisoner representative bodies felt the service required specialist knowledge and preferred to refer prisoners direct to ICAS rather than trying to undertake the work themselves. Stakeholders also spoke of the high demands on their time at the moment, and only two partners who returned completed questionnaires considered they had the time to take on this work.

Model 4

Model 4 was not supported. Advocates were particularly concerned at the thought of being asked to take over complex complaints at the stage of Independent Review Panel, without having built a working knowledge of the complaint or gathered an understanding of what outcome the prisoner is looking for. One ICAS advocate only, felt that supporting clients over the telephone or via correspondence could be useful, but lacked awareness of time constraints on telephone use in prisons.

There were particular concerns about recruitment and support of partner agencies to this model: who would screen them? Supervision, it was felt, could be extremely time consuming.

Everyone expressed concern that the model could be confusing for all parties, and the selection, training and supervision demand on ICAS time was considered very high.

Model 5

This model was considered unworkable in a YOI or Remand setting. There was a suggestion that it could be considered in long stay establishments, but here also support for this model was weak. The main areas of concern were some

prisoners may feel uncomfortable discussing personal matters with a peer. Training and supervision of peer support workers is time consuming and extremely difficult for an agency working on the outside to do effectively. Confidentiality and abuse of information given in trust was a major concern. Fears of peer support workers becoming 'over burdened' was also a worry to many.

One suggestion was that 'Listeners' may be willing to take this on, however when consulted they felt this would compromise their role which was to listen only. They also felt the skills required would not necessarily transferable.

Another concern related to peer advocates needing to move around the prison to support complainants, and governors expressed concern about the potential movement of drugs in particular.

Prisoner Health and Complaints data

The report contains extensive information about the current state of prisoner health, which is poor. Poor mental health in particular is an acute problem within the prison setting. Despite there being 75,145 prisoners in England as at 19th November 2004 – source Prison Reform Trust - there is little detailed breakdown of the nature of healthcare specific complaints, and this data is collected only on an ad hoc basis.

Current stakeholder issues

The Wish List section in the main body of the report provides a list of critical issues raised with the researchers during the course of this work and poses key questions for the Department of Health to consider. National guidance is urgently required, not just in relation to ICAS but NHS Complaints Procedures within the prison setting, the role of PCTs and PALs and the Patient and Public Involvement agenda in general.

ICAS Advocates/Caseworkers

Extensive research was conducted with existing ICAS Advocates and Caseworkers throughout the country. Every advocate was invited to participate and 79 out of a total of 158 responded with detailed feedback.

Key findings include:

- Concerns about client confidentiality;
- Requests for comprehensive training and support; and
- Concerns about personal safety.

Prisons Wave 1

Nineteen out of the 34 'Wave 1' prisons, agreed to be interviewed for this report.

Key findings include:

- Only eleven prisons had done any work around implementing the NHS Complaints Procedure;
- Only three prisons reported that procedures were working well with good relationships formed;
- Five prisons reported difficulties operating different systems; and
- One found working with lots of different organisations problematic.

Prisons Wave 2

Twenty-six out of the remaining 100 'Wave 2' prisons, agreed to be interviewed for this report.

Key findings include:

- Sixteen had done some work on implementing the NHS Complaints Procedure;
- Very few prisons allow incoming phone calls, which poses difficulties for a remote model of ICAS service delivery;
- The low levels of literacy and wide range of languages both spoken and written within the prison population, make correspondence difficult without the support of appropriate services.

Prisoners

Twenty-eight prisoners completed questionnaires.

Key findings include:

- 100% felt that they would prefer to speak to an advocate in person when making a complaint;
- Comments about prison healthcare and the current complaints system were overwhelmingly negative, with a general belief that prison healthcare is low down on the list of priorities within prisons;
- Medication and access to a doctor or dentist are key issues for prisoners.

Primary Care Trusts (PCT's) Wave 1

Eleven out of the 18 PCT's who have had responsibility for health commissioning and/or provision for just under a year for Wave 1 prisons, agreed to be interviewed for this report.

Key findings:

- Only two had any formal arrangements in place for NHS complaints;
- Others were still at the meeting/steering group phase or were awaiting National guidance;
- Four were unsure how many prisoner complaints they had received; and
- One PCT reported having received 120 complaints over the first year.

Primary Care Trusts Wave 2

Thirty-two 'Wave 2' prisons agreed to be interviewed for this report.

Key findings:

- Twenty-seven had carried out work on implementing the NHS Complaints Procedure;
- Nine considered their work to be well developed;
- One was awaiting national guidance from the Department of Health.
- Only three PCT's in the second wave had telephone arrangements in place;
- Three cited ICAS as the service to which they would turn to assist prisoners with literacy difficulties; and
- The number of complaints PCT's had received varied widely, between none and 63.

Patient Advice and Liaison Service (PALS)

Eighteen structured interviews were completed with PALS services.

Key findings:

- Seventeen PALS indicated that they had done some work on implementing their service into prisons;
- Two have a full service in place;
- Fifteen currently have no arrangements in place for prisoners to telephone them;
- Another two have a daytime and answer phone service only - it is important to note that the majority of prisons allow no incoming calls to prisoners, therefore the issue of responding to answer phone messages needs to be considered;
- Eleven respondents indicated that they have procedures in place to deal with confidentiality, but only one of these had thought of this in a wider prison context, stating that their procedures *"had yet to be determined".*

ICAS Providers

All four current ICAS Directors completed questionnaires; the Team Leader did so, on behalf of East Midlands ICAS to ensure no conflict of interest with colleagues writing the report.

Key findings include:

- Two of the ICAS providers have worked in prisons to date, and of these only one has worked specifically on ICAS provision with other stakeholders;
- One provider had some plans in place to begin the process of service delivery;
- Two providers are looking to the ICAS Prison Pilot to develop procedures;
- One provider currently working with prisoners has over a three month period received 22 complaints direct from prisoners and 8% of these were considered appropriate for ICAS support;
- The time consuming nature of working in prisons is of concern to all providers;
- The willingness of existing advocates and caseworkers to visit prisons was raised;
- Training for ICAS staff was considered an urgent priority;
- The vulnerability particularly of female staff was raised;
- Concern about the likely increase in complaints when ICAS is implemented in prisons, and the absence of resources to meet this increased demand was raised by several providers.

Training

Training is considered by all stakeholders consulted during this research to be a top priority.

Key issues include the need for training in the following areas:

- Personal safety and prison security regimes – staff working with this client group will need extensive training regarding boundary management in addition to the physical aspects of personal safety;
- Prison culture, terminology and routine;
- Knowledge about what to expect on a prison visit, what items may be carried into prisons and appropriate codes of conduct;
- Confidentiality protocols which may differ within the prison environment;
- Comprehensive understanding of mental health issues and substance misuse.
- Extensive policies and procedures will be needed, adherence to which must be monitored via rigorous supervision;
- Training must extend to <u>all</u> staff communicating with prisoners via telephone and in written correspondence; and

- IICAS will need to work alongside the prison system to develop such training if at all possible.

Diversity issues

Low levels of literacy within prisons and the wide range of spoken and written languages pose significant challenges to the ICAS service. There are 9,000 foreign national prisoners spread across nearly every prison service establishment. The physical challenge of the environment is difficult for prisoners who have impaired mobility or are frail and elderly. The Human Rights Act 1998, which incorporates the rights contained in the European Convention of Human Rights (The Convention) into UK Law is relevant to challenging discrimination. Article 14 of the Convention prohibits discrimination on many grounds, including sex, religion and political opinion as well as any other status. Other status has been interpreted broadly to cover for example; marital status, sexuality, prisoners and would more than likely cover disability.

Final comments

- The model must work with the prison regime in order to be accessible, and it must be able to cope with the rapidity with which people move around and in and out of the prison service – *the churn*. It may not be possible to have just one model for implementation, particularly in a remand setting where length of stay may only be days, and robust arrangements with external ICAS will be essential.
- Communication with partners will be key to the success of implementation of ICAS into prisons. One governor made the point that all prisons are different and commented "*Where do the prison staff become involved in any of this? Prison officers have complete control over access to phones etc. If prison officers do not understand why a prisoner would need to access ICAS they won't allow them to do so."*
- It became clear very early on in this work that two very different cultures within the prisons and PCT's are coming together rapidly, with little or no understanding of each other. There is an urgent need for National Guidance and support and for the issues raised in the wish lists contained in the full body of the report to be addressed.

Method

Prison Pilot Team Induction

Whilst there were three Carers Federation Ltd staff working on the pilot from the beginning (the Chief Executive, ICAS Service Director and Prison Advocate), when the scope of the project was extended in December 04, a number of additional staff were recruited.

It was felt important to meet as soon as the team was formed. The new team members had all started at the beginning of January, and a two day induction event was planned. Events over the two days included presentations regarding the project aims and objectives and presentations from each team member regarding their own background and interest in the project. As most of the staff were seconded from ICAS services, the training regarding ICAS was fairly limited and followed up at a later date for the two members of the team who did require additional training. Time was spent discussing the proposed models, personal safety, methods of ensuring cross team consistency and ensuring that everyone understood the project brief sufficiently. Sadly 2 members of the team withdrew in the 1st week due to ill health.

Anita Harris National ICAS Manager, Department of Health, also attended the second day of the induction event and gave a talk regarding the importance of the project from the Department of Health's perspective.

The social element of the event was also felt to be very important as the team members would be working from home in virtual isolation for much of the project and thus would need to feel confident to pick up the phone and communicate with colleagues.

From a practical perspective, this was also the occasion to distribute computer equipment and stationery.

(Full agendas are included in the appendix)

'0845' telephone number

In our generic ICAS service the '0845' number is the primary route for new referrals, so it was felt to be important that we offered a similar line for the prison pilot as swiftly as possible.

'0845' is a local call rate number and is used only by clients. Any stakeholders or staff use the Pilot office number to make contact.

A Senior Support Officer seconded across from the generic service is the first

person to answer these calls, with advocates and management also available to take the calls if necessary.

One of the main hurdles in the pilot was enabling clients access to the number. Letters were sent to every 'First Wave' PCT and Prison requesting that they add this number to Prisoners 'PIN' list in their respective establishments (see telephone section for further detail).

It was unclear as to whether this responsibility should lie with the PCT or the prison, as we were receiving mixed messages from different areas.

Towards the end of the pilot, we were put in touch with a central office within Prison Headquarters who were able to make the 0845 number available to all prisons (or a selection) in one action.

Publicity

Using the generic publicity materials as a basis, the team created posters and leaflets for distribution in the first 34 prisons.

The leaflets were kept as similar as possible to the generic material to ensure the service offered is equitable.

Sample publicity was then sent to every first wave prison and associated PCT, along with an introductory letter explaining the Pilot. Copies were also sent to Prisoner Support Groups and other interested stakeholders. Following feedback received during the focus groups, we have sent the publicity to a prisoner group at HMP Cookham who are redesigning the material to make it as accessible as possible to the prison population.

Self Help Information Pack

We have adapted the current Self Help Information Pack for use in prison and included this in Appendix Twenty Three. We would recommend that this pack is not used in its current format as National Guidelines for the handling of NHS complaints in prisons do not exist at the present, therefore the use of the pack may be misleading in certain prisons. This is an area that we believe needs to be worked on as a priority.

These are the main issues the pilot team identified in compiling the SHIP:

1. The Help Pack should be simplified further in terms of language content – in addition to the changes made for relevance due to low literacy levels.

2. The pack should be available in other languages and formats.

3. Clarification as to whether it is the Head of Healthcare within the prison or the Complaints Manager at the PCT who shall be the first point of contact (Procedures across the country appear to vary).

4. Telephone contact – access would need to be clarified.

5. The Guidelines for Meetings section will need adjusting according to the level of provision that PCT's and ICAS are going to offer.

6. Contacts – telephone numbers could only be included if assessed as appropriate for the use of prisons patients

7. Arrangements for access to Healthcare Commission and Ombudsman.

8. Distinction between Prison and Healthcare Complaints – who is responsible?

9. The use of staples are prohibited

Web Based Discussion Boards

The initial purpose of the web based discussion boards was to gather data whilst the Pilot team were on leave over the Christmas period and to provide a forum where stakeholders could enter into meaningful dialogue with each other, putting forward ideas and questions and providing answers for others.

The initial set up period took longer than expected but was all complete in the first week of January.

Stakeholders were advised of the discussion board in a variety of ways such as through the monthly newsletters, via e-mail and during telephone and face to face contacts.

Subjects on which stakeholders can post information include:

1. How much do you know about ICAS? Do you have any questions?
2. ICAS Advocates/Caseworkers - How do you feel about working in prisons? Do you have any concerns, worries or questions you would like to share?
3. IMB members - what are your opinions regarding the introduction of ICAS in prisons? What model do you think is most appropriate? Have you worked with the PPI forums in your local prison? How have you found it?
4. Has PALS (Patient Advice & Liaison Service) been implemented within your local prison? How have you found this experience?
5. Prison healthcare staff - how do you see the introduction of ICAS affecting

you?

6. What do you think of the five proposed models? Would they work for you? (View them here)
7. Do you have any suggestions for other topics you would like to discuss on this board?
8. What arrangements are in place in your area for advocates or other support agencies to gain access to prisons?
9. How many healthcare complaints do you deal with in your prison?

A general information board at the top of the page gives web users the following information:

> *'We have established these boards to enable any interested stakeholders to post their comments regarding our work and their thoughts on how we may be able to establish the ICAS service in prisons.*
>
> *Please note that messages will be used to form part of our research and may appear in our final report.*
>
> *Upon posting a message you will be asked for your name and prison or area. This is entirely optional.*
>
> *The Carers Federation Ltd reserves the right to remove any messages which we believe to be abusive or potentially harmful to other users of the boards without prior warning.'*

When stakeholders post a comment a message is sent to the inbox of the Service Director who then has the option to post or delete the message. The option to delete has not been used throughout the pilot, but it was felt that it was important to have a method of filtering out inappropriate content.

Interviews

In order to collate as much possible data from all interested stakeholders we devised a number of different questionnaires and interviews.

Questionnaires and interviews were designed to gather the widest range of opinions possible, and questionnaires were piloted first on a small number of participants before the final versions were rolled out. In some instances, these were designed to be posted to participants who would then respond via post, and in others it was agreed that the best method of conducting the interview would be face to face or over the telephone. In these instances, the team of researchers would be responsible for booking appointments to carry out these interviews over the telephone or in person, and transcribe the conversation into a blank response sheet.

Where the questionnaire was sent to the participant, guiding notes were given

explaining the purpose of the research, how the data would be treated and the participant's right to withdraw. Those completed by the researcher had prompt notes for the researcher to explain the purpose of the interview, confidentiality, right to withdraw etc.

The participants selected represented all interested stakeholders, with the most senior members of each group asked to participate. Where this was not possible, we requested that our intended participant nominate the appropriate person. The participants were split into four groups based on their location, and were allocated to the four researchers. The researchers aimed to conduct interviews with the 34 'First Wave' prisons first and their associated PCT's and other stakeholders. Once these were complete to the best of our ability the second wave of prisons were interviewed.

Categories of interviews are:

1. First Wave Prison (Governor and/or Healthcare Manager)
2. PCT (Complaints Manager or Prison Lead)
3. PALS representative in relevant PCT's
4. Other Stakeholder
5. Prisoner/Ex-offender
6. Second Wave Prison (Governor and/or Healthcare Manager)
7. ICAS Provider (Service Director)
8. ICAS Advocate/Caseworker

The first four categories were carried out as face-to-face or telephone interviews whereas the final four categories were completed by the participants themselves and posted back to the office.

The Models

It was decided by the research team that to gather the best possible data in such a short period of time, we should put together a number of potential models for ICAS service delivery based on our knowledge of the generic service. The five models were built upon the generic service currently offered (see model 1 for the closest comparison), with variations to account for the different environment with its associated physical and security issues that need to be taken into account. It was never the researchers' intention that these would be the best, nor indeed the only possible models of service delivery, but they give a starting point to stimulate conversation and debate and focus conversations.

Model 1

ICAS sole delivery

1. Literature to include self help pack and publicity
2. Telephone assistance 0845 line
3. Assistance with correspondence and constructing complaint
4. Face to face advocacy where required

Model 2

ICAS sole delivery

1. As model 1 without face to face advocacy
2. 'Telephone model'

Model 3

ICAS & Partner agency approach

1. As model 1 with face to face advocacy delivered by partner agencies with a remit to support prisoners

Model 4

ICAS & Partner Agency approach

1. As model 3, with option for ICAS to provide face to face support when complaint reaches complex stages such as panel hearings only

Model 5

ICAS & Peer Support approach

1. Prisoners to be trained to offer peer support to other prisoners wishing to complain

These models were widely consulted upon and formed the basis behind the rest of the interviews, discussion boards and focus groups. In essence we were exploring the potential to operate each of these models and asking all interested stakeholders to draw upon their expertise to critically evaluate each one.

Model 1 was trialled in HMP Morton Hall during the pilot and model 2 was offered to all 34 'Wave 1' prisons via the 0845 number. We consulted a number of prisons and stakeholders regarding models 3 and 4 but none were willing or able to establish a trial for these models in the short time frame available. We held

discussions with the Samaritans regarding Model 5, as they successfully run a peer support scheme in most English prisons. We seconded a member oif the team across to assist us, but sadly she had to withdraw on health grounds within the first week. Preliminary discussions did take place in HMP Birmingham regarding the implementation of model 5, but without the relevant staff member and with time drawing short, we were unable to proceed any further with this model on a practical level.

Focus Groups

Three events were held at the beginning of February in Leeds, Nottingham and London. These three locations were chosen for ease of access from the North, Midlands and South of the country respectively.

Delegates were invited to the events in a number of ways:

1. Via the monthly newsletter
2. A round robin email to all email addresses on our contact list
3. Telephone
4. Invitations during telephone interviews
5. Personalised invitations to all named contacts

The main purpose of the day was to consult interested stakeholders regarding the five proposed models and consult for alternative suggestions, concerns and ideas.

We started the days with a short introduction from our Chief Executive explaining why the Carers Federation Ltd is involved in the pilot. Our Service Director followed with a short presentation explaining what ICAS is and why we now need to implement the service in prisons. A final presentation followed regarding the five proposed models. At each event we had a guest speaker from a Trust or the Department of Health to add a different perspective to the day.

Following on from these presentations, the delegates split into groups to look at the advantages and disadvantages of each model. This information was then fed back to the main group.

In the afternoon time was set aside for the participants to raise any concerns or issues that were important to them. This session was particularly illuminating as it raised wider issues regarding the PPI agenda.

A full copy of the day's agenda can be found in the appendices.

The combination of attendees represented a wide cross section of the interested stakeholders with representatives from Complaints departments, PALS, Prisoner representative groups, Prison Governors, Healthcare Managers, Prison Officers

and ICAS staff all in attendance. The days were incredibly successful, as stakeholders commented on the proposed models, indicating potential problems with models and suggesting alternative routes.

Interaction between ICAS providers

It is incredibly important that the views of all four current providers of ICAS are involved. Therefore each provider was invited to nominate some staff members to take part in the pilot as researchers and/or advocates. Additionally, at the monthly Providers' meetings the Carers Federation presented a pilot update. Presentations were also given on request to other staff members and each provider was invited to attend the Focus Group events.

Key Objectives of the Report

The Vision

"To produce a report by mid March 2005 to the Department of Health highlighting design options for a national programme to enable ICAS providers to deliver their service to prisons."

The Aim

"Development of a cohesive national model, which takes into account the different security status and special needs of prisons".

Key objectives

1. To identify the aspirations of providers in implementing ICAS in prisons.
2. To identify the potential role of IMB's or other key-holders in providing face to face support, supplementing any remote advocacy delivered by ICAS.
3. To identify the training, legal and resource implications of using other bodies to support ICAS delivery.
4. To identify potential demand for ICAS from prisoners.
5. To enable the Department to be confident that the safety and security of prisoners and any people delivering ICAS is protected.
6. Design a programme, which will build stakeholder buy-in and allow for action learning from the NHS Prison Authorities, ICAS advocates, and prisoners.
7. Report mid-March to the Department of Health on 'options for implementation of ICAS in prisons', which incorporates:

    The views of IMB's
    The views of prison governors
    The views of SHA's
    The views of prisoners

Core Principles

It was a requirement of this report that the ICAS Core Principles should be enshrined within all five of the proposed models.

ICAS Core Principles

ICAS delivers a free and professional support service to clients wishing to pursue a complaint about the NHS. Its core principles are:

Empowerment: ICAS empowers people by providing them with information and guidance, enabling clients to decide whether they wish to pursue a complaint about the NHS and where needed for an advocate to support them in doing so

Independence: ICAS is not tied to, or controlled by the NHS, enabling ICAS to work solely on behalf of its clients

Confidentiality: ICAS treats all interactions between clients as confidential. For more detailed information on ICAS confidentiality policy, please contact your local ICAS provider

Inclusion: ICAS respects the diversity of clients and ensures it is accessible to all, both in terms of the physical environment where support is delivered, and the mode of communication used

Resolution: ICAS supports clients in trying to achieve their desired resolution within the NHS complaints procedure

Partnership: ICAS supports the aspirations of the NHS in improving the patient experience and works with NHS colleagues to promote positive change in the NHS, whilst maintaining the independence of the service

The Duty to provide ICAS

Health and Social Care Act 2001 Section 19A Independent Advocacy Services

1. It is the duty of the Secretary of State to arrange, to such extent as he considers necessary to meet all reasonable requirements, for the provision of independent advocacy services.

2. “Independent advocacy services” are services providing assistance (by way of representation or otherwise) to individuals making or intending to make-

(a) a complaint under a procedure operated by a health service body or independent provider,
(b) a complaint to the Health Service Commissioner for Wales
(c) a complaint of a prescribed description which relates to the provision of services as part of the health service and-

> (i) is made under a procedure of a prescribed description, or
> (ii) gives rise, or may give rise, to proceedings of a prescribed description.

3. In subsection (2)-

"Health service body" means a body which, under section 2 (1) or (2) of the Health Service Commissioners Act 1993, is subject to investigation by the Health Service Commissioner for England or the Health Service Commissioner for Wales;
"Independent provider means a person who, under section 2B (1) or (2) of that Act, is subject to such investigation.

(4) The Secretary of State may make such other arrangements as he thinks fit for the provision of assistance to individuals with complaints relating to the provision of services as part of the health service.

(5) In making arrangements under this section the Secretary of State must have regard to the principle that the provision of services under the arrangements should, so far as practicable, be independent of any person who is the subject of a relevant complaint or is involved in investigating or adjudicating on such a complaint.

(6) The Secretary of State may make payments to any person in pursuance of arrangements under this section."

Prisoner Health & Complaints Data

"When you think about providing services within a prison, you have to think about it in a different way. Prisons are a closed community, and lots of things are going on within them. People cannot easily access the things we take for granted on the outside, so services offered to the community need to look different inside a prison, if prisoners are going to be able to use them."

(Quote IMB)

Prisoner Health

It is important to recognise that prisons cannot be considered entirely separately from the community. Large numbers of individuals are admitted and discharged from prison each year. Prisons must be seen as part of the community and the health care that is delivered must reflect the medical services provided for the rest of the community, and access to ICAS is, therefore, their right. It must also be recognised that there are special needs of those in prison and the services provided must reflect these.

"Many individuals admitted to prison have not made appropriate use of health resources while in the community for a variety of reasons. While prisons do predominantly hold a skewed and younger percentage of the population there is

a significant morbidity as has been shown by the OPCS survey in England and Wales (OPCS, 1991).

Five main factors have been identified which affect the health of prisoners (McCallum 1995). These are:-

1. The social demography of the prison population
2. The built environment of the establishment
3. The organisational culture in the prison
4. Relationships between prisoners, and with the external world
5. Specific medical issues facing the prison population

The health status of prisoners coming into the prison system is often poor, coming as many do from a life of poverty and social exclusion. Their access to and use of health care services has often been low and prison populations show high incidence of problem alcohol and drug use (SPS,1998) The prison population also has a high incidence of mental health problems (Liebling, 1995). The over representation of prisoners coming from low socio-economic status inevitably generates prison populations at the bottom end of the health inequalities gradient." Source 'The SNAP Programme'

Prison Health has to respond to the complex health needs of prisoners, who often have a multiplicity of health problems.

"Many are poorly educated and have a history of being marginalized within society. In the UK, minority ethnic or migrant groups are over-represented in the prison population (Levy, M (1997). Prisoners have higher than average rates of mental illness. Gunn, J., Swinton, J, (1991), and substance abuse Mason, D. In England, repeated surveys have shown that a large proportion of young offenders in particular come into prison from unstable living conditions. Many have experienced homelessness and have lived on the streets. A 1997 survey the Prisons Inspectorate, for example found that a quarter of young prisoners were homeless on reception into prison, Cavadino, P. (1999)

In 1999, some 26% of all prisoners and 38% of those under the age of 21 had previously been in the care of the local authority, compared with 2% of the general population. (Ibid). Prevalent in the prison population are problems common to marginalized peoples such as infectious and sexually transmitted diseases, HIV infection and AIDS. Weild, A., et al. In the UK, children and young people constitute a quarter of all known offenders and are also among those likely to have health problems."

In 1996 an important discussion paper by Sir David Ramsbotham, 'Patient or Prisoner?' was strongly endorsed by the BMA, emphasised 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"

Ramsbotham, D 1996.

"In spite of strengthened procedures, improvements in detoxification and the efforts of many prison staff, the rate of self-inflicted deaths in prisons continues to run at nearly two a week. This is the tip of an iceberg of distress: in the reporting year, 228 prisoners were resuscitated and there were 17,678 self-harm incidents."

(Annual Report of HM Chief Inspector of Prisons for England and Wales 2003-2004)

Remand prisoners

Remand prisoners suffer from a range of mental health problems with more than 75% of male remand prisoners diagnosed with a personality disorder (Singleton *et al* 1998). 20% of the female prison population are on remand (Home Office 2004). Women suffer from numerous mental health problems with 2 out of 3 having at least 1 neurotic disorder (for example, depression); over 75% of male remand prisoners have a personality disorder (Singleton *et al* 1998). Half of the population are on prescribed medication such as anti-depressants and there is evidence that the use of medication increases whilst in prison. A survey in 2001 showed that nearly two thirds of women have a drug problem. The Prison Reform Trust report that 'research has found that nine percent of remand prisoners require immediate transfer to the NHS' (2004:6)

Young Offenders

Young offenders have poor literacy and numeracy skills (Social Exclusion Unit (2002) ; are more likely than adults to suffer mental health problems and they are more likely to attempt/commit suicide (Singleton *et al* 2000). 88% of children aged 16-20 show signs of personality disorder and 10% show signs of a psychotic illness such as schizophrenia (Singleton *et al* 2000). Drug and alcohol abuse are also a big problem with more than 50% reporting drug dependency in the year prior to their imprisonment. Furthermore, 50% of women and over 65% of men had a hazardous drinking habit before being imprisoned (Singleton *et al* 2000).

Elderly prisoners

In 2002, 2.4% of men 0.7% of women prisoners were aged 60 or over (information supplied by the Prison Service and cited in Prison Reform Trust 2004). A Dept. of Health study in 1999/2000 on 203 male prisoners reported that 85% had one or more major illnesses reported in their medical records. Furthermore, 83% reported at least one chronic illness/disability when they were

interviewed. The most common illnesses are psychiatric, cardiovascular, musculoskeletal and respiratory (Prison Reform Trust 2003). More than 50% of elderly prisoners have a mental disorder: most commonly depression, due to being imprisoned (Prison Reform Trust 2003). The Dept. of Health plans to develop a health policy for older prisoners (Prison Reform Trust 2004:18).

Research into health care needs for older women reported that many of the older women in prison complained about the unnecessary use of restraints when they visited outside hospitals (Wahidin 2003). Consequently, the following indignities can act as barriers to seeking medical attention:

> Humiliation of being handcuffed
> Indignity of being strip searched in order to receive hospital treatment

Careful assessment of their health needs has at times been remiss which has led to cases of neglect whilst also fostering feelings of isolation, fear and humiliation. An example is given of a female prisoner who was in her mid 60's when she had a coronary attack and ended up in hospital. The woman suffered a lack of after care provision in that:

> There was no exercise due to a lack of staff
> She was shackled to male prisoners
> Food was given to her through a hatch in the door
> The windows in the hospital room were whitened
> (Wahidin 2003)

Other problems include the location of an older woman's cell, i.e. not all older women are on the ground floor and stairs can pose the problem of other prisoners pushing past thus increasing the risk of injury. Also, not all prisons have the basic facilities of: onsite medical centre, adequate after care provisions and ground floor rooms (Wahidin 2003).

<u>Mental Health</u>

72% of male and 70% of female sentenced prisoners have two or more mental health disorders, with 20% having four of the five major mental health disorders (Goggins 2004). Of those disorders, 40% of men and 63% of women suffered from neurotic disorders, which is three times the level of that experienced in the general population. 64% of men and 50% of women had a personality disorder and 71% of men and 14% of women suffered from a psychotic disorder (Prison Reform Trust 2004:19). The annual review of the Chief Inspector (Anne Owers) highlights the fact that despite the NHS taking over responsibility for prison healthcare last year, the scale of mental health problems is so great that only inmates with "severe and enduring" illnesses are treated' (Batty 2005). The report states that "in most prisons, there is inadequate provision to look after mentally ill prisoners" (quoted in Batty 2005). Research shows that prisoners suffering from

mental health problems have fallen through 'inadequate mental health services in the community' (Smith 1999:954).

J. Shaw suggests that the high prevalence of serious mental illness necessitates an efficient screening procedure for mental health problems at reception. Reed & Lyne (2000:1031) concluded that 'the quality of services for mentally ill prisoners fell far below the standards in the NHS'. Allison and Cooksey (2005) reported in the Guardian on the death of Jolene Willis in Styal prison. The jury commented that Willis' death was as a result of "inadequate treatment following inappropriate perceptions of her behaviour" during the period before her death.
Whilst the same treatment principles apply to prisoners, as to the general population, "consideration needs to be given to the adaptations that would be required to introduce treatments into a custodial setting" (Shaw, J, page 6). Specialist prisons, such as HMP Grendon, provide the opportunity for further evaluation of treatment outcomes (Shaw, J).

Nurse *et al* (2003) describe a focus group study undertaken to look at the influence of environmental factors on mental health within prisons. The study highlighted, among other things, the need for extra mental health services to be provided in prisons. Nurse *et al* refer to the recent guidelines which recommend that 'mental health services for prisoners should be equivalent to those provided by the NHS' (Nurse *et al* 2003:484*).* Environmental issues such as long periods of isolation and little mental stimulation in a remand prison exacerbated existing frustrations. Similarly, Reed & Lyne (2000) reported that the average length of seclusion for mentally ill patients was 50 hours. Reasons for the use of seclusion differ for prison health care and the NHS. In prisons the primary reason is the risk of self-harm whilst in hospitals it is risks to other patients and staff. Arrangements for psychiatrists to visit and access prisoners were evident in the prisons included in Reed & Lyne's study. Statistics showed, however, that prisoners experienced long waits in prison (an average of 11 months) before getting a hospital bed (Reed & Lyne 2000). Reed and Lyne proposed that those prisoners not eligible under the Mental Health Act to be transferred to hospital should receive their inpatient care from doctors and nurses with appropriate training, and that those meeting the criteria for transfer to the NHS should be transferred promptly.

In addition to this, prisoners, remand and sentenced, raised the issue of often waiting all their association time to use the telephone and then being unable to due to insufficient time and telephones (Nurse *et al* 2003). This is especially relevant for the female prisoners who participated as they expressed problems with maintaining regular family contact. Healthcare staff in the groups expressed concerns regarding safety especially if they are expected to interview a prisoner alone and in inadequate facilities (Nurse *et* al 2003). Although since 1991 the prison service has aimed to provide healthcare of the same standard as the NHS the following were identified by Reed & Lyne (2000:1031)

"Not all nursing staff are registered nurses; a proportion are non-nursing qualified healthcare officers who have received six months healthcare training as well as prison officer training".

The issue of trained staff in accordance with the healthcare standards were highlighted by Reed & Lyne as falling below the standards. For example: only some of the doctors in charge of inpatients had received specialist psychiatric training.

Research suggests that prisoners are twice as likely to be refused treatment for mental health problems inside prison, compared to outside (Singleton *et al* 1998). In 2002 there were 39,000 admissions to prison health centres and approximately 30% of these were for mental health reasons (Hansard House of Commons 2003). Furthermore, there are likely to be at least 40 prisoners who have been assessed but have waited 3 months or more before being transferred to hospital. Many prisoners also have to wait a long time before an assessment takes place.

There are mental health in-reach teams working in 90 prisons in England and Wales (Prison Service 2004) and they are currently operational in all women's prisons (Hansard, House of Lords 2004). Research shows that 28% of male prisoners with evidence of psychosis said they had spent 23+ hours in their cells This is double the number than those without mental health problems (Prison Reform Trust 2004). 41% of prisoners held in health care centres should be in secure NHS accommodation and there are up to 2,500 patients in prison health care centres whose mental health problems are sufficiently severe as to require NHS admission (HM Inspectorate of prisons 2004).

50% of those sentenced to custody are not registered with a GP prior to entering prison (Social Exclusion Unit 2002). Two years ago research showed that over 75% of mentally disordered prisoners had not been given an appointment with outside carers (Melzer *et al 2002*).

A review and research was undertaken into establishing mental health in-reach services for prisons in HMP Usk & Presoed (Salathial 2004). The review found among other things:

> Healthcare teams were working with very complex clients and there were no mental health specialists in either team
> The environment was a contributory factor to their mental health condition

During the first 18 months of the assessment a number of prisoners were found to have been either placed on medications inappropriately or they did not receive any due to being lost in the prison system. The mental health in-reach service practitioners found that more often than not, in prison, there are not any medical records or histories of sufferers' mental health problems (Salathial 2004).

The Gwent Healthcare Trust uses Epex3 which is a patient information system that can be used in a variety of settings. A single patient record is created for each individual, which links to both the hospital and external services. Epex3 supports Care Programme Approach as it keeps an end to end case management record (Salathial 2004).

Drugs

In 2003/4 nearly 50,000 assessments of prisoners with drug needs were carried out by CARAT (Counselling, Assessment, Referral, Advice and Through care team) (Prison service 2003). There were 53,000 admissions to detoxification (detox) programmes for drugs misuse in the same period. Arrangements for detox vary considerably between the prisons (Home Office 2003). Just under 50% of those who start drug treatment programmes fail to complete them (Prison Reform Trust (2004:22). One reason for this could be because of transfers between prisons due to overcrowding. Approximately 33% of prisons would be unable to continue treatment of prisoners transferred to them (National Audit Office 2002). Once out of prison, treatment and support services are very limited (Prison Reform Trust 2004).

In another study, data indicates that among new receptions into prison the levels of drug misuse are very high with approximately 40-50% of men and 60% of women having chronic substance misuse problems that require medical treatment (Spurr 2004). Furthermore, approximately 66% of offenders entering custody dependent on drugs have had no previous contact with drug service treatments in the community (Spurr 2004). Last year there were 13 suicides among female prisoners and 66% of those had drug problems (Bright 2005). Despite evidence substantiating the positive response when placed in a women-only residential treatment area, women continue to be placed in a mixed environment (Bright 2005).

Achievements in the area of dealing with drug problems include:

> There were no drug workers in prisons in the mid 1990's and there are now 600+ dedicated drug workers (CARAT).
> Detox programmes have significantly increased.
> (Spurr 2004)

In a recent inspection into a prison in Hertfordshire, inspectors found that the drug problem was on the increase to the extent that it was threatening the jail's security as well as the prisoners' safety (Andalo 2005). Anne Owers also highlighted the lack of drug testing at weekends and the 'scarce treatment for crack and cocaine users' (Batty 2005).

Healthcare in prison

Bolger (2005:39) proposes that 'many UK prisons do not have health facilities that are appropriately staffed and commensurate with the National Health Service'. Consequences of these constraints can include a reduction in the opportunity to treat prisoners as individuals as well as a reduction in the opportunity to involve family members when the prisoner is suffering from a chronic illness. Research has shown that often, upon entry to prison, this is the first contact many individuals have had with health services for many years (Bolger 2005). It is entirely possible, therefore, that illnesses as serious as cancer (for example) may have gone undetected for some time (Bolger 2005). The issue of life-threatening illnesses raises many concerns and fears for prisoners, not least of all the prospect of dying in a secure environment, *'where simple gestures such as touch may be frowned upon, without family and friends… and where the opportunities to discuss the dying process and make decisions about care may be limited'* (Bolger 2005:40). Bolger proposes that consideration needs to be given to the following if palliative care services are to be developed for prisoners:

> Conducting a more comprehensive health needs assessment of the prisoner's palliative care needs
> The training and development needs of prison healthcare staff need to be analysed
> Staff's palliative care skills and the links with PCT's and voluntary agencies for the purposes of supporting palliative care work need to be developed
> Care protocols need to be adapted, especially those relating to the use of controlled drugs
> Prisoners' palliative care experiences need to be examined

Healthcare screening was recognised as not up to scratch. For example, findings of one study showed that only 2 out of 24 acutely psychotic men were identified during screening (Leech & Cheney 2002).

A report by the Home Office in December 2000 into the treatment and conditions for unsentenced prisoners in England and Wales concluded that unsentenced prisoners had more health problems, particularly mental health, than sentenced prisoners and the general population. Also, a large percentage of remand prisoners were prescribed drugs for anxiety and a large number of unsentenced prisoners showed evidence of mental disorder.

The report suggests the capabilities within prisons to identify mental disorders are inadequate. Furthermore, provision should be made to include the effective diversion of the mentally ill and effective support for those whose problems are greater than can be met by healthcare staff alone. The report also identified the lack of exchange of healthcare information between the NHS and prisons and between prisons and the police. Greater liaison was stressed along with the need to issue medical letters whenever a prisoner is transferred to court or police

custody. The report identified the need for improvements in the identification, diagnosis, treatment and continuity of care based on the high level of drug use by people prior to custody.

Prisoner Numbers

Figures from the Prison Reform Trust on 19 November 2004 show that there were 75,145 prisoners the breakdown of which is shown below:

Group of prisoners	Figure
Male	70,774
Female	4,371
Remand	12,391
Under 21	10,838

Complaints

Complaints are an important source of information on the health of an organisation. Both internal and external studies have concluded that complaints from prisoners are underreported. Reasons for failing to report a complaint can include:

- Having to put up with those things outside prison so continue to do so inside
- They are about to be released so they do not want any trouble
- Complaining won't make a difference and may even result in adverse factors such as an unwanted transfer
- They do not know how to complain: this may be particularly true of foreign nationals
- They just want to get through their sentence with the minimum of fuss

(Source Baskerville 2001)

The generic prisoner's complaints system (formerly requests/complaints) was revised in 2002 with a view to introducing this across the establishment. New procedures should result in the delivery of a more certain and swifter response for all complaints. The essential changes to the previous procedure are:

- The separation of requests from complaints: requests are to be dealt with using the application system and anything going beyond that should be deemed a complaint
- Complaints forms are to be available to prisoners
- Any complaints are to be posted in locked boxes on the wings and only the complaints clerk has access to that
- Ordinary complaints are to be considered and responded to in 3 internal stages which are:

- *Stage 1* – a response from the wing officer within 3 weekdays
- *Stage 2* – a response from a Governor Grade within 7 weekdays
- *Stage 3* – (the final appeal stage) is a response from the Governing Governor within 7 weekdays – thereafter the next course of action is for the prisoner to go directly to the Prisons and Probation Ombudsmen
  (Leech & Cheney 2002:313)

As is shown above the first 3 stages are dealt with locally, though Shaw is eager to point out that 'local resolution is not local 'negotiation' and that decisions remain with him and him alone (2004:13).

Prisoners can make a complaint/ request by using the following methods:

> The internal request and complaints procedure
> The Board of Visitors (IMB) if the matter can be dealt with inside the prison
> The Prison Service Area Manager if the matter relates to disciplinary adjudication and can therefore only be dealt with at a higher level
> Stephen Shaw, Prisons and Probation Ombudsmen
> Their MP, solicitor, probation officer, reform groups
> (Leech & Cheney 2002:308)

Shaw (2004) informs us that over the past 3 years the Prisons Ombudsman has received approximately 3000 complaints each year and of those, about 25 and 30% are eligible for investigation. The main reason for ineligibility is the failure to exhaust the internal remedies. The table below shows complaints received in 1998 by subject category:

Subject	**Percentage**
Adjudications	25
Property and Cash	14
General Conditions	12
Transfer and Allocation	9
Letters/Visits	7
Miscellaneous	7

Pre-release and Release	6
Regime Activities	6
Security/Categorisation	5
Assaults	3
Medical	3
Food	1
Race	1
Segregation	1

(Source Shaw 2004:12)

Those who complain primarily adults (aged 30-50) who are serving long term sentences and are often in high security prisons. Shaw (2004) admits that whilst his office is quite successful in dealing with complaints from foreign Nationals, they are '*very unsuccessful in respect of youngsters and remand prisoners'*

Prisoners' complaints of racism

Consultation with an advisory group on race and a number of race relation liaison officers produced a revised Annex F form that has been used, on a trial basis, in a variety of establishments (Baskerville 2001). A new feature on the form is a tick box for the complainant to identify if there is a racial element and if ticked this information would pass to the race relations liaison officer. Also included is a tear off section which is kept by the prisoners giving them proof of the complaint in case it is lost – a common complaint across all prisoners. HMP Winchester & HMP Parkhurst, were the first to try the revised form and experienced few problems. Confidential boxes with supplies of blank forms were provided on the wings for the prisoners and also in other general association areas, such as the library and recreation areas (Baskerville 2001).

It is important to establish that the forms can be used by anyone connected to the prisons. It is also important to ensure that the information is used effectively to identify and address causes of complaints (Baskerville 2001).

Steven Shaw highlighted the increase in eligible complaints to the Prisons and

Probation Ombudsmen. The increase was seen as a positive indication of prisoners' readiness to use the system. The report highlights the following as the most significant categories of complaint:

Prison discipline
Loss of/damage to property
Security categorisation
Prison conditions
Transfer and allocation details

One of the examples of a complaint cited by Shaw tells of how a prisoner was told his sudden transfer was due, in part, to his attitude to staff. Following investigation by the Ombudsmen it was revealed that part of his "attitude" was his readiness to complain. This was substantiated by a document in the prison service records which criticised the prisoner for *'using the complaints system to his advantage "generating paperwork"'.*

Transfer of prison health to the NHS

In 1999 the Department of Health and the Home Office commissioned the report 'Improving Prison Healthcare' which called for a need for better provision and a much better working relationship between the Prison Service and the Health Service. At the time there was evidence of wide ranging differences between healthcare provisions across the services, ranging from day-time cover with part time staff to in-patient facilities with 24 hour nursing cover. A new health development team embarked on a programme in January 2001 to *"change the status quo, create fresh relationships within the NHS and therefore, transform the healthcare offered to prisons."* The team approached the Centre for Public Innovation (CPI) to help it create its plans and work in partnership to bring about change. The main issues for further development were identified as:

Mental health
Workforce recruitment
Training and education
Communication
Primary care
Substance misuse
Joint prison and health working

Main obstacles to change were identified as:

People and culture
Structural issues
Organisational resistance
Fear and confidence

Lack of knowledge
Limited resources

An example of an innovative project selected for funding was a diabetic care project which addressed the management of diabetes in prison. It was found that prisoners were suffering from high blood sugar, poor diet and using incorrect dosages of insulin. The prisoners were not receiving the same level of support and up-to-date clinical expertise that is available in a conventional primary care setting. Prison staff were found to be isolated and out of date with good practice and current trends. There was a need to bring them up to date with new working practices.

The project resulted in an easily recognisable card that was produced for the instant clarification of current treatment plans, medication and blood test concerns. Staff received a wide range of training, and were given a good range of literature and resources to support prisoners' education and treatment. All diabetic prisoners were given a medic alert bracelet to alert others to their condition and what to do if they were unwell. Prisoners said this helped them to feel looked after.

It was announced in September 2002 that budgetary responsibility for all prison health services would transfer to the Department of Health from 1 April 2003. Subsequently, responsibility will be evolved to NHS Primary Care Trusts (PCT's) mainstreaming this activity within the NHS. Full devolution to PCT's in England will take place from 1 April 2005.

When healthcare is commissioned or provided by the NHS, the National Health Service (Complaints) Regulations 2004 S/1768 must now be met. Regulation 9 3.32 states that "Where a person wishes to make a complaint under these regulations, he may make the complaint to the complaints manager or any other member of the NHS body which is the subject of the complaint…These arrangements should ensure complaints are dealt with quickly and effectively. These arrangements should ensure that complainants are made are of the role of advocacy services, such as the Independent Complaints Advocacy Services (ICAS), and how they may be contacted".

"Prison healthcare has shown considerable improvement. It has moved from a shaming inadequate service to one that increasingly bears comparison with practice outside. It has benefited from the skills, resources and professionalism of the National Health Service; though it is important that this is integrated into prison management and culture. But here too healthcare staff struggle with the scale of the task. Mental health in-reach teams in some prisons can do little but skim the surface of the severity and breadth of mental illness contained in prisons."

(Anne Owers CBE Chief Inspector, Annual Report of HM Chief Inspector of

Prisons for England and Wales 2003-2004)

The 2003-2004 Annual Report of HM Chief Inspector of Prisons found that there were, however, “wide variations in the provision of clinical supervision for staff. In most prisons, no time was allocated for supervision, or staff did it in their own time. Others, such as Featherstone and Brixton, ensured that there was protected time: indeed, Brixton had eight trained supervisors in the healthcare team.

Dental lists were unacceptably long in the majority of establishments. At Eastwood Park 65% of women surveyed stated that the quality of care provided by the dentist was either bad or very bad, and Lincoln had no dentist and no procedures for prisoners needing urgent treatment. By contrast Wormwood Scrubs, Brixton and Spring Hill had accessible and well managed systems.

There was a distinct lack of chronic disease registers in the majority of establishments visited. Some had not thought about the need for registers, others blamed a lack of IT equipment. Where they were used, for example at Wymott and Garth there was good follow up for patients with long term conditions such as heart disease and diabetes.

Nurse staffing shortages, which affected delivery of service and care, were evident in a number of establishments; Wakefield, Long Lartin and New Hall all had 50% vacancies at the time of the inspections. However, action has been taken to resolve some of the long delays in obtaining security clearance, highlighted in the last report.

Though the majority of establishments claimed to undertake nurse triage when assessing patients, none had any formal protocols or algorithms. This is of concern, as prisoners may not be receiving consistent advice and care.

During the year significant improvements have been noted in healthcare overall. Most doctors now have qualifications in general practice, often operating from local GP practices. To that extent, there is equivalence with care outside prisons. However, in some cases, salaried doctors were supplemented by a number of locums, so that continuity of care was compromised.

Most prisons now have the services of a mental health in-reach team. This has provided much-needed additional support for mentally disordered prisoners. However, in many cases, the scale of need means that the teams are only able to see patients with ‘severe and enduring’ mental illness: the most acute cases, especially if their work is not fully integrated into the prison as a whole this leaves a majority of mentally disordered prisoners without additional support.

There remains a lack of primary mental health provision in a number of establishments. There was also a general lack of any service that could begin to

meet the needs of the many prisoners (both male and female) who might want to disclose histories of significant physical, emotional or sexual abuse and the relationship of that to subsequent offending behaviour.

We found that the three-month target for transferring patients assessed as requiring NHS secure care was being met. However, we also found that there were significant delays in some areas, in making the assessment following a referral.

Of concern were the particular mental health care needs of young people, for whom there is very little provision in the community.

Most establishments now recognise the need for administrative staff to work in healthcare, so that nursing staff can concentrate on clinical rather than administrative tasks.

Medicines management was improving, particularly in prisons where there was active involvement of the PCT pharmacy adviser. There were, however, notable exceptions, for example Brixton. The absence of IT systems often hampered the ability of pharmacy staff to collect quality aggregated prescribing data to inform effective medicines management. Often prescriptions were routinely transcribed or photocopied for subsequent faxing to a remote pharmacy site: with the obvious potential for error.

Examples of good practice identified are:

1 Critical incident analysis and risk management (Wealstun)
2 Active health promotion work (Garth)
3 Examples of holistic care, such as leg ulcer clinics (Wymott and Garth) and open discussion of self-harm (Styal)
4 A ‘coffee club’ where prisoners in need of support could discuss their anxieties (Wellingborough)
5 A healthcare users’ forum (Cookham Wood)
6 A system to combine the clinical record with a nursing care plan, with comprehensive entries and a clear audit trail (Brixton)”

The prison governor or IMB may grant extra visits if they are considered necessary for the welfare of them or their family.

Prisoner reception into prison and access to services

Classification, Categorisation and Allocation

Differentiated Regimes

All prisoners, including unconvicted and civil prisoners, are required to be

classified in one of three regimes: basic, standard or enhanced. The prison governor, based on your performance in custody – for example, disciplinary record, takes this decision. Each regime offers a different level of incentives, and privileges and commonly, prisoners on the basic regime will receive the bare legal minimum in terms of visits or access to privacy and wages. Those on the standard and enhanced regimes will receive progressively more favourable facilities, although the precise nature of these will vary according to each prisoner's security category. These regulations also require a number of key items such as phone cards, cigarettes and stamps to be purchased from the private cash allowance.

(Source Liberty Guide to Human Rights)

Prison Categories

There are broadly five categories of prison:

1 Local prisons for unconvicted and short-term prisoners
2 Dispersal prisons for high security prisoners
3 Training prisons for long-term prisoners who do not need the highest security
4 Category C prisons, which are closed but have less internal security
5 Open prisons for prisoners not believed to be a risk to the public or in danger of escaping

Male and female prisoners will be held completely separately from each other, although may be in the same prison. Immediately after conviction, a male prisoner will be held in a local prison while his security categorisation and allocation are decided. Because there are fewer young offenders and women prisoners and prisons, the arrangements are not the same. Women's prisons and young offenders' institutions are simply divided into open and closed establishments.

Categorisation

There are four security categories:

Category A: prisoners whose escape would be highly dangerous to the public, security of the State and for whom the aim must be to make escape impossible

Category B: prisoners who do not need the highest conditions of security but for whom escape must be made very difficult

Category C: prisoners who cannot be trusted in open conditions but who do not have the ability or resources to make a determined escape attempt

Category D: prisoners who can reasonably be trusted to serve their sentences in open conditions

Category A prisoners also have an escape risk classification based upon their ability or willingness to escape. The classifications are exceptional, high and standard escape risk.

Women prisoners and young offenders may be made Category A, but normally they will either be allocated to open or closed conditions.

Category A prisoners have greater restrictions upon them for security reasons, and their visitors will be vetted by the police on behalf of the prison authorities. These prisoners will be entitled to a formal, annual review of their security categorisation during which the material prepared on them will be disclosed and the prisoner invited to make written representations to the decision-making committee. Legal advice and assistance can be sought in making these written representations.

The governor makes categorisation decisions (other than for category A prisoners and lifers) and the prisoner casework unit through the complaints or requests procedure review these. A prisoner can either make a complaint to the Ombudsman if the decision is considered to be unfair. Alternatively, he or she could apply to the High Court for judicial review of his or her categorisation if there were evidence that it had been arrived at unlawfully, for example, by taking account of irrelevant information or applying the wrong criteria.

Allocation

Prisoners may be allocated to any prison in England and Wales according to the offence, sentence, security category and individual circumstances of the prisoner. There is no right to be located close to home, but prisoner can apply for transfer – as can their family who wish to put in evidence, for example, from a GP about the difficulties illness causes if travelling long distances. The Ombudsman can intervene in an allocation decision if it can be shown to be unfair. An application can be made to the High Court if the decision is wrongly motivated, especially if it deprives an un-convicted prisoner of access to his or her lawyers and family.

Source Liberty Guide to Human Rights

Reception

On reception into prison, prisoners will be searched and may be photographed. Property the prisoner is not allowed to keep with them in the prison will be taken, checked and signed for. All cash will be paid into an account, which is under the governor's control. All prisoners should be issued on arrival with a copy of the

Prison Information Handbook. A copy of the Prison Rules must be made available to any prisoner who requests it.

Visits

Convicted prisoners are entitled to a visit on reception to prison and then a minimum of two visits every four weeks. Governors should allow more visits if facilities and staffing make this possible and many prisons do so for prisoners on the standard and enhanced regimes. Prisoners will be issued with visiting orders (VO's), which must be sent out, with visitors' names on them. Visitors then present the order on arrival at prison. Most prisons now require visitors to telephone in advance of their visit to ensure that there is sufficient space for it to take place.

Unconvicted prisoners may have daily visits. These should total at least one and a half hours a week, though in practice such visits are likely to be limited to short daily visits. NOMS (National Offender Management Service) has issued instructions to prevent prisoners who are convicted of violent or sex offences from receiving visits from children in certain circumstances. Prisoners in this group can only receive visits from their biological children or from children with whom they lived before being imprisoned. Exceptions will only be made to this rule on an individual basis.

Visits from legal advisers and probation officers do not count against visit entitlements. Nor is there a restriction on the number of visits allowed from legal advisors.

The Assisted Prison Visits Scheme exists to help close relatives with the cost of travel to see prisoners, and convicted and unconvicted prisoners are eligible for assisted visits if the relative(s) because of their low income.

The prison governor or IMB may grant extra visits if they are considered necessary for the welfare of them or their family.

Visitors' Centres

Many prisons have Visitors' Centres, often very well run by charities.

Centres aim to provide:

1. Information about the prison they are visiting including visiting procedures
2. Liaison and negotiation with prison staff: representing prisoners needs
3. Information on relevant support and advise groups and organisations
4. Emotional support – staff available to listen and advise in confidence and without judgement
5. Support and guidance for families visiting prisoners with drug and alcohol

problems
6. Information and guidance for parents and carers supporting children of prisoners
7. Information on financial assistance with travel and low cost overnight accommodation
8. A staffed play area in the prison visiting hall
9. A coffee bar serving low cost refreshments
10. Toilets and baby changing facilities
11. A welcoming environment where visitors can wait before their visit and prior to travelling home

Restrictions

It is a criminal offence to pass items to a prisoner during a visit, for which the visitor can be fined or imprisoned. Most prisons only allow property to be handed in through official channels and not on a visit.

The governor has the power to refuse or restrict visits on the grounds of security, good order and discipline, or if he or she believes doing so will prevent or discourage crime. The governor can:

1 Refuse visits from certain people
2 Order supervised visits, that is, in a small room with a prison officer present
3 Order closed visits where there is a glass partition between prisoner and visitor

There is power to search and strip-search visitors entering or leaving prisons. This is provided that no more than reasonable force is used, that the decision to search is not perverse and that the search is conducted in a seemly and decent manner and only by members of the same sex as the visitor.

The right to receive visits falls within Article 8 of the Convention, which protects the right to a private and family life. However, Article 8 does allow restrictions to be placed on rights where the governor believes it necessary to prevent crime or to preserve prison security and good order and discipline. It is this proviso that allows the governor to stop visits or ban visitors, but in each case, the prison governor will be required to explain why the restriction is necessary.

(Liberty Guide to Human Rights)

Prisoners' Rights

Consideration is now being given to the creation of a single criminal justice inspectorate, covering the work of police, courts, CPS, probation and prisons.

Prisoners retain certain basic rights, which survive despite imprisonment. The right of access to the courts and of respect for one's bodily integrity. The test currently applied is that the State can only place limits on prisoner's rights if this is necessary for the prevention of crime or for prison security. Any limitations placed on such rights must also be proportionate to the aim that the authorities are seeking to achieve.

"The culture of a prison, the extent to which people are treated with dignity, the quality of relationships between prisoners and staff, are all critically important This is reflected in the standards against which the Chief Inspector of Prisons inspects, of a "healthy prison", which meets standards of decency, safety and respect. This culture, as research appears to confirm, is fundamental to prisoner safety, and therefore to the protection of rights under Article 2 the right to life "

Annual Report of HM Chief Inspector of Prisons for England and Wales 2003-2004

Prison Rules

Prison Rules provide a structure and framework for the regulation of prison life. Legal challenges to the Rules have been successful in cases where the courts have held that the Prison Act 1952 does not authorise the scope of a particular Rule.

More detailed instructions are given in the Standing Orders and Prison Service order Instructions. These are internal directives, which govern prison life. They do not have any direct legal force, and can be challenged if they breach the scope of the Prison Act or Prison Rules. They are, however, a vital source of information about prisoners' rights and entitlements and provide important information as to the proper practice that should be adopted by the prison authorities.

<u>Use of telephones</u>

The issue of access to telephones is complex and cannot be viewed in isolation from Prison Rules and the basic rights of prisoners, which survive despite imprisonment.

Mandatory requirements include:

Prisoners should be given access to phones during association and at other times as are reasonably practical, though this is dependant on the establishment's regime. Card phones should normally be available for use for not less than 2 hours a day. In the instances where demand is heavy, a time limit and/or booking system may be imposed thus ensuring everyone has the opportunity to use the phone.

Source Leech and Cheney 2002:322

The card system is currently being phased out, and everyone will be transferred onto the pin phone system detailed below instead. The main problem with the card phone system relates to cards being used inappropriately as currency between prisoners.

The PIN phone system

Phone numbers, known as 'Global Calls' which relate to helpful organisations can be called in addition to those on the selected list (Leech and Cheney 2002:323). Global calls are regarded as privileged in the same way as legal calls and as such are not monitored or recorded. When a call is made the person receiving the call will hear a message informing them that it is a call from prison and it's then their choice if they wish to receive the call. Each prisoner wishing to make calls is given a PIN number which they enter and the phone operates in the normal way. The system operates on a credit basis and credit can be purchased from the prisoner's spends account in £1 units. Calls are charged in the public payphone rates in 1p units as opposed to the 10p units used in the card phone system. The call is charged from the moment the recorded message begins playing (see above). Money can be saved if the call recipient presses the 'accept call' button on their phone at any time during the message. There are 2 BT rates for all times of the day when calling payphones:

Local calls	67 seconds for 10p (9p per minute)
Long distance calls	43 seconds for 10p (14p per minute)

Reference for all the above information
(Leech, M. & Cheney, D. (2002) 'The Prisons Handbook' Waterside Press: Winchester)

Information regarding solicitors' correspondence in prison

Letters from a prisoner to a legal advisor cannot be opened as they are afforded legal privilege unless there are 'identifiable grounds for believing it is not to or from a lawyer or that it contains illicit enclosures' Leech and Cheney 2002:321. Letters written to legal advisors can be sealed before being posted and the envelope can be appropriately marked: 'Prison Rule 39', 'Young Offenders Institution Rule 14' or 'SO 5B 32 (3)', If mail is being sent in from a legal aid it should be sealed inside a second, outer envelope which should be addressed to the governor and contain a letter from the legal advisor requesting that the governor passes on the enclosed sealed envelope to the prisoner, unopened.

Letters

Convicted prisoners may send one letter a week on which the postage will be paid – the 'statutory letter'. They will also be able to send at least one privilege letter, the postage for which must be paid for out of prisoners' private cash allowance. The statutory letter must not be withdrawn or withheld as part of punishment for a disciplinary offence. In addition, prisoners may also be granted special letters, which do not count against the statutory or privilege letters allowance.

Prisoners in many prisons may send and receive more letters than this minimum allowance, and prisoners in open prisons have no restriction on the volume of correspondence.

Unconvicted prisoners may send as many letters as they wish at their own expense and will be allowed two second-class letters a week on which the postage will be paid by the prison authorities.

Censorship

Mail is censored in high security prisons and for all Category A prisoners, but otherwise letters will not routinely be read. Additional powers exist to vet letters sent by prisoners convicted of sexual offences against children. There is a power for the governor to return 'excessive' numbers of letters from correspondent, and if they are 'overlong' the governor may request letters be limited to four sides of A5 paper.

Letters from prisoners and their advisers are protected from interference and may not be stopped. There may be examination of such correspondence only to the minimum extent necessary to check that it is legal correspondence, if the letter is inspected it must be done in the presence of the prisoner.

Access to prison records

The Data Protection Act 1998 allows prisoners to have copies of their prison records. Applications should be made in writing to the Discipline/Custody Office, Personnel Department or Library. A fee of £10 is payable to obtain these.

Disclosure can be refused on a number of grounds, including that the information identifies third parties or that disclosure may prejudice the detention or prevention of a crime. Prisoners do not need to be told whether exempt information has been withheld, and have no right to be told whether they have been given access to the full or only an edited version.

Interview & Questionnaire Responses

ICAS Advocates & Caseworkers

ICAS advocates play a vitally important role in supporting and empowering patients to make informed choice about their complaint about NHS treatment or care.

At the time of writing this report there are 103 advocates/caseworkers and 55 client support workers, employed throughout England. All of these received a confidential advocate/caseworker questionnaire which could be completed anonymously. All four ICAS providers distributed the questionnaires to their own staff, and responses were returned direct to The Carers Federation Ltd for analysis. We had 79 returned.

We asked the following questions

Work undertaken

1. Have you personally been involved in any work around implementing the NHS Complaints Procedure in prisons within your area?

   Response

Yes	No
5	74

Prisoner Support

2. Are you aware of any support agencies available in your local prisons?

   Response

Yes	No
19	60

   Of the 19 who indicated yes, the agencies of which they had awareness were listed

3. If so, are you working with them?

Yes	No
3	76

4. What hours do you work? Do you have a set lunch time? How flexible can you be in your hours?

Yes	No
66	9
4 did not respond	

5. What facilities do you currently have in place for face to face meetings? Do you visit clients in their own homes or other venues?

Home and other venues (to include people also listed in the 47 below in the next category)	62
Indicated office work place	47
Indicated home only	12

6. Are you able to drive? Do you have daily access to a vehicle? What other methods do you use to travel to clients?

Yes	No
71	8

7. What are the safety procedures currently in place within your team during client meetings?

Capacity to double up with a colleague	51
Mobile phones and safety calls	49
Diary system at Head Office	22
Personal alarm	19
Panic button at office base	15
Risk assessment	9
Meeting at a neutral venue	7
Code word system	5
Case worker sitting close to door	4
Safety training at induction	4
Special office phone, triggers response to call police	2
Visits during office hours	1
Self defence training	1

8. How would you feel about working in prisons?

Ok (5 of these had previous experience)	38
Already doing so	13
Prison staff should do it	12
Willing provided adequate training and support received	11
Serious reservations	11
Apprehensive but willing	10
No due to conflict of interest	10
Unsure	9
Not at all willing	9

"I would welcome the opportunity. I have met with NHS patients at a medium secure NHS Mental Health Act section or court order. I consider it essential that prisoners have the same access to advocacy as other members of the public. I believe prisoners have the same right to quality healthcare as other members of the public.

"Not significantly different to other ICAS work. Having worked on a case where someone received treatment at a NHS hospital while under custody there seem to be some interesting issues. Certainly the client group is at a disadvantage. I think it would be difficult for a woman outside of womens' prisons".

The majority of advocates indicating their willingness to work in prisons had no previous experience of having worked in a prison environment. A number of those indicating a definite refusal to do so had previously worked in prisons, or know someone who had done so, and made a number of points relating to their personal safety.

"I know people who have worked within the prison system and have experienced abuse/harassment outside of work e.g. car tyres slashed, windows broken. Not sure how comfortable I would be with prisoners knowing my name. I am aware that this may only be a small number of people who behave like this, but I do find it frightening for me, my family and home."

A key issue for ICAS providers holding the current round of contracts to provide the service is whether they could reasonably expect their existing staff to expand their role to include working with prisoners. The legal advice obtained on this point is unhelpfully split as to whether this is a fair to do so. We are advised by external consultants under contract to The Carers Federation Ltd that

We asked:

"Is it reasonable for ICAS Providers to expect their advocates to work with prisoners when they were not specifically recruited to do so?"

And received the following response

"It would be advisable to approach the issue on a basis of requesting volunteers. If none were forthcoming payment could be offered along the lines of an anti-social hour's arrangement. All four national providers would need to do this individually with their own staff members."

They went on to say that in their opinion *"there is a strong argument to suggest that It is exactly the same job, as the current advocates have traditionally offered visits outside the office and supported clients remotely via the telephone or through correspondence. Advocates would not be able to complain about additional monies paid to colleagues visiting prisons if they didn't volunteer themselves to do so, they would have all have had the same chance"*

The approach of asking for volunteers is sensible given some of the strong opinions expressed in returned questionnaires

"I do not want to work in prisons, this was not an issue raised during my interview. I have serious reservations as to whether the level of support to staff to carry out this challenging task. At present there is not sufficient support, for this reason and safety concerns I would not work in a prison."

"I would not feel confident working in prisons or feel that I have the necessary expertise for dealing with this work or client group. I would feel more comfortable operating a telephone advice line but only following training and with additional funding".

(ICAS Advocate)

The Carers Federation Ltd also asked the same external consultancy firm what issues would be important to the organisation as an employing body of advocacy staff and were informed that

"Stress could be a really serious issue. Close watch will need to take place on all members of staff exposed to the stresses and threats present within the prison environment. This will not be something everyone is cut out for and many people will be unaware of the issues involved until they have already been exposed to some of them."

9. Please list what issues would be important to you were you to work in prisons

Safety and security	59
Client confidentiality	60
Accessibility to client	61

Prison staff support	62
Prison policies	63
Training	64
Double up on visits	65
Anonymity in visits	66

"Very nervous – unsure what to expect".

"I would be concerned that it would be difficult to maintain client confidentiality when any appointment prisons have will be obvious to all staff. I would worry they could suffer for raising concerns".

The key issue of concern to advocates is their personal safety and security. It is essential that whichever model of provision the Department of Health chooses, advocates must receive robust training to ensure they are safe to work with prisoners. This will also be essential if advocates work with prisoners at a distance as they will still be at risk of disclosing personal information unless aware of the dangers associated with doing so. A couple of advocates felt that they would actually feel safer visiting clients within prisons due to the security arrangements already in place. Recommendations for the content of a training programme for ICAS prison advocates are included in the training section later in the report.

Another key source of support suggested by advocates is that required from prison staff. This point was echoed during the focus groups, at which prison staff stated a desire to be supported by colleagues in healthcare. A number of suggestions have been put forward to facilitate this, also outlined in the later training section. Although it falls outside the scope of this report there are clearly similar issues to consider for Patient Advice and Liaison Services (PALS) and Primary Care Complaints leads, who may also be required to visit prisoners.

Client confidentiality is a key concern to a high percentage of advocates, and a number expressed concern that security arrangements would inevitably lead to a lack of privacy for client conversations. Safety and security, however, is of paramount importance.

Building good relationships prior to taking on prisoner complaints was stressed by several, and this was also found to be essential during the pilot phase of this work.

Clear policies and procedures are also considered essential.

Being fore-warned of any challenging behaviour, the nature of the crime and the sentence are also things a number of advocates felt they should be informed about. One advocate expressed that she felt it possible that she would object on moral grounds to supporting some prisoners depending on the nature of their

crime, another expressed fear of catching disease.

Another issue raised by advocates was the speed prisoners move in and out the prison. A number expressed concern about what would happen should clients be moved during the course of a lengthy NHS complaint.

The ability to be able to refuse to support clients if they made advocates feel *"unsafe, uncomfortable, vexatious or manipulated"* was also expressed.

One advocate felt that because prisoners have a lot of free time to spend on their complaint, they may have unreasonable expectations that the advocate can also spend the same amount of time on it, there might be daily calls and requests for extra meetings.

Ex-Offenders

The research team wrote a specific questionnaire to gauge the opinions of ex-offenders and a number of our stakeholders were contacted to request their assistance in reaching our target audience. We regret to say that during the short time span that the pilot was operational we were unable to gather any data in this group.

Independent Monitoring Boards (IMB)

Acknowledgement

We are particularly grateful to Sheila Royle, National Council North West Representative National Healthcare and Segregation lead, and Steve Kilbey Deputy Head Independent Monitoring Boards Secretariat and Freedom of Information Access Officer (IAR), for giving their time and knowledge so generously to this report.

Independent Monitoring Boards (IMB's) perform a 'watchdog' role on behalf of Ministers and the general public by providing an in dependent oversight of the care of those held in custody or detention in prisons and immigration removal centres.

The Boards are made up entirely of volunteers and have a valuable and important role to play in ensuring that prisons and detainees are cared for decently and humanely. There is a Board attached to each of the 138 prisons and nine immigration removal centres in England and Wales.

Duties of Independent Monitoring Boards

IMB members in prisons are appointed under the Prisons Rules 1999 (as amended) and Young Offender Institute Rules 2000. IMB members in

immigration removal centres are appointed under the Immigration and Asylum Act 1999.

Note: Until April 2003, IMB's were known as 'Boards of Visitors' (in prisons) and Visiting Committees (in immigration removal centres). They are still referred to in the legislation under their old titles.

Boards are required to satisfy themselves about:

1. The treatment of the prisoners (or detainees)
2. The state of the prison (or immigration removal centre) premises
3. The administration of the prison (or immigration removal centre)

Members are encouraged to visit the establishment on a regular basis and to get to know the prisoners (or detainees), staff and management whilst maintaining their independence. They have access to the establishment at any time and may interview any prisoner (or detainee) who wishes to see them, if necessary out of the sight and hearing of a member of staff. They may also be asked to attend serious incidents to monitor what is taking place.

Boards meet regularly, usually monthly, to consider various issues brought to their attention during visits by members, by prisoners (or detainees) or by staff. In addition Boards are required to inquire into and report upon any matter into which the Secretary of State asks them to inquire and to direct the attention of the Governor, Centre Manager or Secretary of State (as appropriate) to any matter which they consider calls for their attention.

Each Board submits an annual report to the Secretary of State reporting on the above issues and including any advice and suggestion it considers appropriate.

<u>The Role of 'The National Council'</u>

The National Council for Independent Monitoring Boards is made up of nine elected Board members plus up to three non-voting members, co-opted to assist the Council in specialist areas. The Council's main purpose is to provide strategic direction, policy development, and guidance on recruitment, communications, training and quality control to Boards to help ensure they fulfil their statutory duties effectively.

The National Council is also responsible for liaison with the Prison 'Service, Immigration and Nationality directorate (IND) and other organisations. Both individually and collectively, promote issues raised by Boards and endeavour to influence policy makers on the basis of Boards' considerable experience.

The National Council is chaired by a non-executive President, appointed by the

Secretary of State.

The Role of the Secretariat

Independent Monitoring Boards are supported by a Secretariat in the Home Office, whose main objectives are as follows:

1. To ensure that IMB's, the National Council and the Secretariat are adequately funded
2. To give advice to Ministers on matters relating to Boards
3. To support IMB's and ensure effective communication with them
4. To manage IMB events and publications and develop and maintain external communications
5. To develop the skills and knowledge of IMB's and the Secretariat
6. To support the National Council

The Secretariat works with the National Council, and while no policy can be developed without the approval of the Council, so no policy can be implemented without the agreement of the Secretariat. In the unlikely event of irreconcilable differences between the Council and the Secretariat, the President would raise the issue with the Minister.

Appointments to Independent Monitoring Boards

Independent Monitoring Board members are appointed by the Secretary of State, although they act independently of the Home Office. It is important that Boards are made up of a cross-section of the local community, and applications are encouraged from members of the general public from all walks of life, ethnic backgrounds, religious and age groups.

No special qualifications are required as all training is provided, but Board members should live within a 20 minute radius of the establishment to which they are appointed and should possess the personal qualities, interest and time to make a full contribution to the work of a Board.

Members are appointed for periods of up to three years, although if they wish they may be considered for reappointment at the end of each three-year period.

Source Independent Monitoring Board April 2004

Key issues raised in our discussion with the IMB Board & Secretariat

There are nearly 2000 IMB Board members who are all unpaid volunteers. It is possible that Board members will feel a deal of resistance to the fact that ICAS advocates are paid. It is vital that the independent role of IMB members is not compromised in any way, they would therefore welcome a supporting

complementary role with ICAS, but not a partnership. Volunteers currently spend a great deal of time in prisons, and they would struggle to take on additional work. The support of ICAS is to be welcomed as it will enable IMB members to get on with their whole spectrum of prisoner monitoring work, It is essential that the role of IMB members is not undermined, and currently there is some concern that IMB members feel their role is "becoming more onerous, but authority is being undermined." IMB members are also subject to complex monitoring arrangements, and the transfer of prison health to the responsibility of the NHS is welcomed.

Particular issues for ICAS in prisons identified by the IMB

"The Churn" is the name given to the constant flow of prisoners around the prison system. It is difficult to obtain medical records of prisoners, or a clear picture of current medical need. Many of the complaints prisoners make relate to their being unable to obtain medicine they request. Requests are not always genuine, as prescribed drugs have a sale value within the prison.

To be successful ICAS will need a sound understanding of the prison environment, and this will be a key training issue.

Getting information about the availability of ICAS to prisoners will be essential, and the IMB suggest including a new section on healthcare into the Prison Induction System. This should include also information about ICAS, Patient and Public Involvement Forums, Patient Advice and Liaison Service (PALS) and how to make an NHS complaint. Publicity also needs careful consideration, Young Offender Institutes for example prefer a pictorial format. The placement of posters advertising ICAS should be placed in the private visiting booths in every prison, these are used by solicitors in particular who may be a key referring body.

The health needs of prisoners can be particularly complex, due to a number of factors, these include:

1. Neglect of health needs over several years prior to admission into prison
2. Drug misuse can have a serious impact, particularly on the teeth
3. Mental health issues affect a large proportion of the prison population
4. Medical practitioners may be particularly reluctant to work in the prison setting, leading to scarcity of supply. This is particularly the case in dentistry.

Teasing out what is and is not a healthcare issue is essential, and to date, no work appears to have been done on this. A major healthcare problem relates to prisoners with acute mental health conditions that require care outside the prison environment. These patients are often placed in prisons because there is nowhere else for them to go, even if a prisoner is sectioned they may still have to remain in prison as space may not be available in specialist mental health

establishments. Untrained prison officers have to cope with the situation on a daily basis, which will include people with personality disorders who can be extremely disruptive leading to their segregation from other prisoners. The Mental Health Act does not apply in Prisons, therefore healthcare can only treat with the permission of the patient. It is intended that the new Mental Health Act will overturn this, however this will not be for some time.

The IMB have also posed the question of whether ICAS and prison health will become subject to inspection and monitoring by the Chief Inspector of Prisons.

IMB Healthcare complaints data

The IMB Secretariat also provided a collective response to the IMB Structured Questionnaire, the results of which appear below:

1. Do you receive complaints about healthcare or treatment from prisoners?

"Yes, through the IMB applications procedure."

2. How many would you expect to receive over a year?

"Varies from Board to Board. There are 59 different establishments."

3. What are the main healthcare concerns prisoners have?

"medication''
''waiting times, primarily dentistry"

4. Are you familiar with the NHS Complaints Procedure?

"Boards would not be familiar with advocacy services but would be aware of the Patient and Public Involvement Forums".

5. Would you prefer to assist prisoners yourself with the procedure, or do you think this service should be provided by ICAS?

"Boards would signpost but would not get involved with the formulation of the complaint to the PCT".

6. If you would prefer to assist prisoners to complain about healthcare or treatment yourself, what assistance would you require from ICAS?

Training
Telephone Support
On-line Support
ICAS Advocate attendance at complaint panel hearings

Self Help Pack
Assistance with correspondence
Other

"More information about the role of ICAS and information from ICAS about healthcare complaints received by ICAS and at which particular prisons"

7. How often do you visit your designated prison?

"At least once a week, on average two and a half days per week."

8. Do you hold 'surgeries' or do prisoners make appointments to see you?

"Both. Prisoners usually apply to see Board members or even approach in passing".

9. What arrangements do you have in place to assist people who may have problems with literacy (unable to complete forms)?

"Help prisoners to submit applications but not its content''

10. What arrangements do you have in place for prisoners for whom English is not their first language?

"Either fellow inmate, member of staff or translator (language line)''

11. Which of the five models do you prefer?

"Model 1. IMB would advise where to go"

What is your reason for this preference?

"ICAS assisting with complaints, face-to-face last resort".

12. Please use this space to tell us anything else you think we should know

Induction pack to prisoners to include information on ICAS
IMB's happy to report on healthcare complaints but this needs to be reciprocal. Boards need to identify where particular problems arise.
Meetings with IMB's important following national introduction

59 Annual Reports analysed
21 Negative comments about healthcare - waiting times to see professionals & medication
22 positive comments about healthcare i.e. dental services provided
7 complaints about dentistry

Recommendations

1 Work should be urgently undertaken to determine what is and is not a healthcare complaint. The picture is currently confused greatly by prison regime issues such as inability to access medication due to work duty rotas, or members of staff not being available to take prisoners to hospital appointments.
2 When the Department of Health make a decision about the preferred model of ICAS delivery into prisons the IMB must be promptly informed to prevent confusion and resistance. The IMB Board and Secretariat have then offered to:
3 Promote the ICAS service as a positive development which should be welcomed
4 Inform the chairs of all IMB's throughout England
5 Information about ICAS will be required for all IMB members to include the role, referral procedure, contact details.

Patient Advice and Liaison Service (PALS)

Eighteen structured interviews were completed by PALS services, the results of which appear below:

Structured interview

Work undertaken

1. Have you done any work around implementing PALS in prisons within your Primary Care Trust region?

Yes	No
17	2

2. Who have you worked with? (e.g. complaints department, local prison)

Prison	13
Primary Care Trusts	10
Complaints department	5
IMB	4
Patient & Public Inv. Forum	4
ICAS	3
Joint commissioning manager	1
General health manager	1
Department of Health	1

Health lead in prison	1
StHA	1
PALS	1
None	1

'Within the Durham Cluster of Prisons, PALS Clinics are being established. One of the prisons now runs a fortnightly clinic that prisoners can self-refer or staff refer them to. This Service is in its infancy. Promotional material and awareness raising with both prisoners and staff will be crucial to ensure the service is utilised. However, it is recognised that a number of previous complaints were in relation to issues that would be best suited to PALS Service.'

3. Are any plans in place to begin the process?

Yes	No
18	1

4. How far has the procedure been developed?

Early stages	15
Well developed	3
None	1

5. What kind of feedback have you had? (omit if not relevant)

Yes	6
Not applicable	6
None	5
No comment	2

<u>Prisoner Support</u>

6. Are you aware of any other support agencies available in your local prisons?

Yes	No
11	8

7. Have you worked with them in introducing your service? Is so, what response have you received?

No	7
Yes	6
No comment	4
Limited	2

Access

8. Telephone arrangements - have you put in place arrangements for prisoners to telephone you, if so, how does the process work?

No	15
Daytime and answer phone	2
In place	2

9. Are you offering a face-to-face meeting option?

No	9
Yes	7
No comment	3

10. Are arrangements are in place to protect client confidentiality?

Yes	11
None	8

'We also have consent forms that need to be signed. We ask for consent over the form but if a form needs signing I would meet with the prisoner to do this. I wouldn't send a consent form through the post as it will alert the other prisoners as opposed to a meeting held during the day when prisoners are out and about at work and education anyway.'

11. What interpreting and translation arrangements do you have in place should they be required?

Language Line	9
PCT to provide	4
Contact local council	1
None	1
Interpreting services	1

Hibiscus	1
Intran	1
Community interpreting service	1

12. What arrangements are in place to assist those with low levels of literacy in making a complaint?

Nothing	6
PALS to write	4
Contact ICAS	2
Language Line	2
Help with letter writing	2
Face to face	2
Signposting	1
Inside prison	1
Easy to read literature	1

'There is a need for ICAS due to low literacy levels'

13. How many contacts have you received to date from prisons? What percentage of these do you think would be appropriate for ICAS support?

None	15
8 healthcare concerns	1
2 (Morton Hall)	1
1	1

2 out of the 3 listed above were considered appropriate for ICAS support

14. Do you think the introduction of PALS and ICAS in prisons will affect demand? If so, how?

Yes	No
78%	22%

'It is reassuring to know that ICAS will be inclusive for the whole population'

'For those prisoners rebelling against the system it will give them an option of missing work/education and also possible tie up staff's time by acting as escorts.'

'I don't expect much contact with the Young Offenders as this group in the wider community rarely access our service.'

15. Do you have any further comments?

Need for face to face support
Great idea
Needs adequate resources
Need for continuity when prisoner is released
Should be introduced into prisoner package
Accessibility and confidentiality is an issue
Will ICAS have the capacity to work with prisoners?
Training issues for Patient Forums. PALS and ICAS, needs to be a joint approach
Need to iron out all of the problems

In total nineteen PALS questionnaires were completed, and seventeen of these had done some work towards implementing their service in prisons. Of concern were the number of PALS services who have had meetings with prison healthcare groups, Patient and Public Involvement Forums, and individual ICAS offices to "agree a way ahead". For ICAS this raises the unfortunate scenario that individual workers may be implementing the ICAS service into prisons without any knowledge of the complex training, risk assessment and support requirements highlighted in this report, and prior to any decision having been taken by the Department of Health on the appropriate model for implementation.

A number of PALS services indicate that they are developing a poster and leaflets to inform prisoners about their service, and have or are planning to talk to prison staff about what their service can offer. Only one PALS service indicated that they had made any modifications to their current service model to accommodate the access requirement of prisoners. A number of PALS workers who attended the focus groups expressed concern at their lack of readiness for April 1st 05. One in particular said;

"It's horrendous, I've simply been told I've got to visit prisoners, but don't have any training or support and I really don't want to do it".

Seven of the services who responded indicated that they intended to offer face to face meetings for prisoners.

One PALS service expressed concerns about the lack of equity of their service.

"PALS has a freephone number and the prison is averse to letting the prisoners access a freephone line. PALS have concerns about equity of service".

These are lots of complex issues around this. Prisoners access to telephones is set out in the telephone section of this report, and discriminatory practice is covered in the legal section.

Despite 17 PALS services indicating that they had done some work on implementing their service into prisons, 15 have no arrangements in place for prisoners to telephone them at this point, only two have their service in place, and another two have a daytime and answer phone service only.

Although 11 respondents indicated that they have procedures in place to deal with confidentiality, only one of these had thought of this in a wider prison environment and indicated that although they had considered the matter procedures had yet to be determined. None of the respondents raised the complex matter of transfer of information between partner agencies, informed consent, venues and protocol for face to face meetings. All, however, had a good understanding of safe storage of records.

Of particular concern, is the lack of arrangements in place for literacy support for prisoners. Two respondents indicated that they would pass requests through to ICAS, and there is evidence elsewhere that this is happening often and is an inappropriate use of the service. Six of the respondents indicated that they had nothing in place at all, despite the high number of prisoners who have literacy support needs.

The overwhelming opinion was that introducing PALS and ICAS into prisons would lead an increased level of demand. Comments included;

"It could increase demand because it will give the prisoners something else to do and somewhere else to go".

"Yes, from our discussions with prison healthcare staff, it is clear that they have been inundated with informal enquiries/complaints".

"Yes as it makes another avenue available to prisoners".

Final comments included;

'I am sorry that my answers have been so sparse. I fully expect, even within six months time, that this will alter considerably. PALS for the prison is definitely on my list of priority things to do.'

'This is a great idea. I would like to see a copy of the report when it is finished to be able to read other people's feedback. '

'It is also early days – we are incredibly keen to do the work. It's about us trying to find some new ways of working together – we are still working out a model. It's also about healthcare and prisoner see the work. If negative, then it's all pointless. This is both challenging and exciting.'

'To make sure that however the service is implemented that it is adequately resourced.'

'It would have been helpful to have an induction into prison systems and procedures prior to starting the pilot project meetings. Understanding how the prison works, impact of security requirements on the prisoners etc is key to being able to consider how to implement the PALS service.'

'Think this is a good thing bringing in another service to look at the issues raised as it gives another perspective.'

'I think it will be very advantageous for PALS to hear how other agencies have started this process, to understand what works and what doesn't.'

PALS, has no reservations about being involved with the prisons and already have links with ex prisoners who use their service successfully. PALS hopes they will be able to build on these links.

I would like to see PALS link worker training which would mean making sure they know about ICAS and patient forums. These workers would be based in the prisons/part of the healthcare team and could be approached by prisoners for support. I am looking to ensure that structures are in place once we have got the go-ahead. Some public/prisoner involvement is going on because it involves prison staff – this has been initiated/guided by the prison as opposed to the PCT. I think partnership working is important for the future, there needs to be a mutual reporting system between prisons/PALS/ICAS/PPI forums to ensure that Trusts can make appropriate service improvements.

We have to make sure that we have ironed out all the problems in order to make this service run smoothly. We will glean as much information from those people who have already got some experience in working to implement the new healthcare provision.

Very conscious of how they two systems are going to marry together. Concerns especially, over accessibility and confidentiality. There may be some conflict between PALS philosophy and how the prison systems work.

PCT's 'Wave 1'

Eleven PCT's (one agreed to two interviews from two leading staff members) agreed to participate and submitted to following data:

Work undertaken

1. Have you done any work around implementing the NHS Complaints Procedure in prisons within your PCT regions?

Meetings & discussions	3
Working on two procedures	3
Steering groups	1
In place	1
Final draft agreed	1
Pilot implemented	1
No	1

'' Worries about raising expectations of prisoners and then being unable to deliver the appropriate service.''

"The SHA haven't yet given guidance"

"The complaints procedure is in place but the question is at which point the prisoners access it: this isn't clear"

2. Who have you worked with? (e.g. complaints department, local prison)

Prison staff	9
Primary Care Trust	7
Patient Advice and Liaison Service	5
ICAS	3
Strategic Health Authority	3
Department of Health	2
Not applicable	1

''Very supportive between prison and ourselves''

3. Are any plans in place to begin the process?

In place	2
Due April 2005	2
Developmental stage	1
NHS alongside prison group	1
Await National Guidance	1
Operational by Sept 2005	1
Due first March 2005	1
Meetings	1
Begun	1

''We're commissioning the service not providing it so see the Healthcare

Manager at the prison dealing with the complaints just as with Practice Managers in GP's surgeries."

4. How far has the procedure been developed?

Not applicable	3
Final stages	2
Interim process	1
In place	1
Date set	1
Pending meetings	1
Early days	1
Written protocol	1

"Wrote back and explained that the system was different and that they should contact the Healthcare Manager at the prison as the PCT didn't deal with Healthcare complaints."

5. What kind of feedback have you had? (omit if not relevant)

Positive	3
None	2
OK	1
Negative from DoH	1
Not applicable	1
Too early to say	1
Limited	1
System works	1

<u>Prisoner Support</u>

6. Are you aware of any other support agencies available in your local prisons?

No	3
Independent Monitoring Board	3
Chaplaincy	1
Peers	1
Health promotion	1
Buddy	1
Hibiscus	1
Not applicable	1
Yes	1
WISH	1
Mental Health in-reach	1

Diabetics	1
Nurses	1
Wing meetings	1

Access

7. Telephone arrangements - have you put in place arrangements for prisoners to telephone you, if so, how does the process work?

No	6
Unsure	3
Not applicable	1
In process	1

"Have agreed this may not be most effective way. As prisoners may not be able to phone when a person is here, have agreed a process by form."

8. Are you offering a face-to-face meeting option?

In discussion	3
No	2
Yes	2
Not applicable	1
If requested	1
May be beneficial	1
Depend upon complaint	1

9. Have you created a special complaints form for NHS complaints, and if so, what arrangements are in place to protect confidentiality?

No	4
Not yet	2
Form designed	2
Use prison form	1
Not applicable	1
No decision made	1

Prisoner Profile

10. What interpreting and translation arrangements do you have in place?

Through PCT	4
Unsure	2
Patient Advice and Liaison Service	1
None	1
Language Line	1
Not applicable	1
Through prison	1

''However we do recognise that our prison population are likely to be more diverse, and once we have ascertained what the needs are, information will be available in other languages, large print, cassette tape etc.''

11. What arrangements are in place to assist those with low levels of literacy in making a complaint?

Prisons staff	3
Unsure	2
Not applicable	2
Nothing yet	2
ICAS	1
Citizens Advice Bureau	1
Patient Advice and Liaison Service	1
Wing meetings	1

''Hopefully ICAS as well as the practice manager helping prisoners (with low literacy levels) to complete complaint forms. Complaints also made verbally will be investigated.''

''..We would do the same as in the community – staff would help – or refer to ICAS. We would use the support that is already on offer within PALS.''

'I understand that (assisting clients with low literacy levels) is a big part of ICAS role and it's undertaken by the CAB'

'There is a need for ICAS due to low literacy levels'

Healthcare specific questions

12. How many complaints have you received to date from prisons? What percentage of these do you think would be appropriate for ICAS support?

a

Unsure	4
None	4
one hundred and twenty	1
one	1
Not applicable	1

b

None	5
Not applicable	4
Few	1

13. Do you think the introduction of ICAS in prisons will affect demand? If so how?

Unsure	3
No increase	2
Initially yes	1
Increase	1
Impossible to say	1
Too early to say	1
Yes	1
Possibly	1

''Possibly as prisoners may feel more confident they will be listened to.''

Eleven out of a total of eighteen 'Wave 1' PCT's took part in interviews. Despite prison healthcare having transferred out to their commissioning responsibility a year ago, only two had arrangements in place, others were still at the meeting, steering group stage or were awaiting National Guidance.

Only one PCT was in the process of putting telephone arrangements in place and a further three were unsure about this, a further six had nothing in place at all. Only two PCTs had designed a special complaints form and two had nothing in place to assist with literacy requirements.

Despite running their service for a year, four of the eleven were unsure how many prisoner complaints they had received. This contrasted sharply with one PCT which reported having received 120.

Comments included;

''Worried about raising expectations of prisoners, and then being unable to deliver the appropriate service.''

'If things can be sorted out locally then there may be no effect on demand. More serious issues can go to ICAS, there is a need for ICAS due to low literacy levels.'

'I am concerned about inappropriate use of the service.'

When asked how many complaints have you received to date from prisons?

"I don't know, the stats will be with the Clinical Governances Department. We don't leave them lying around, it's not a big deal, we just deal with them when they come up".

'Prisoners on the whole probably complain more than the general public. I don't think ICAS will affect demand.'

'Hopefully ICAS will be a softer way to have a conversation with someone – rather than solicitors letters etc. Hopefully, ICAS will help normalise the communication. I can't believe there will be an increase.'

PCT's 'Wave 2'

1. Have you done any work around implementing the NHS Complaints Procedure in prisons within your PCT regions?

Yes discussions	10
Yes	3
No	2
yes, drafted service level agreement	2
No, contracted out/deferred	2
Yes action plan	1
Using guidance from 1st wave	1
Yes, procedure and policy agreed	1
Yes, using prison complaints procedure	1
Yes, already receive complaints	1
Not applicable	1
Yes, working on joint protocol	1
Yes draft protocol	1
Yes, set up Clinical Governance Group	1
Not yet	1
Yes, set up publicity	1

'No because the care is going to be provided by the Prison – we've contracted out. It will go under the regulations for contractor complaints.'

2. Who have you worked with? (e.g. StHA, local prison)

Prison leads and healthcare	19
Primary Care Trust	11
Strategic Health Authority	10
Not applicable	8
Patient Advice and Liaison Service	4
ICAS	3
Mental Health Services	1
Family practitioners	1
No-one	1
Department of Health	1
Prison complaints department	1

3. Are any plans in place to begin the process?

Yes April 05	14
Not applicable	9
Discussion beginning	5
Unsure if handing over commissioning	1
Yes, well developed	1
Organise corporate management group	1
Yes, modifying patient leaflet	1

"It's all very difficult,we'll deal with that later"

4. How far has the procedure been developed?

Not applicable	15
Being worked on	2
Awaiting DoH guidance	1
Co-ordinating PCT comments on PSI	1
Agreed protocol approved by prison board	1
PALS promoted heavily	1
Near completion	1
In discussions	1
Documents for consultation ready	1
Received clearance	1
Working with other agencies	1

Steering groups	1
Project work plan	1
Embryonic	1
Commissioning group	1
Prison/PCT work together	1
Unsure	1
Prison using NHS complaint procedure	1

"There was a report due at end of Jan that was meant to clarify a lot of this, where is it?"

''I'm just concerned about the fallout following the continuing care fiasco and don't won't same thing to happen with this.''

''I am personally waiting for DH guidance. I 'phoned them in November and they said that a toolkit would be coming out but that they had no information at that time.''

''Everything is ready and in place to go live in April. Half day training courses take place in the complaints procedure and it is planned to train the PCT staff in the prison process and vice versa although the training will take place within the prison in order to cause the least disruption to services.''

5. What kind of feedback have you had? (Omit if not relevant)

Not applicable	20
None	7
PCT happy to go into prisons	2
Concerns re complaints process	1
Concerns re security	1
Staff not wanting to be part of NHS	1
Working well	1

<u>Prisoner support</u>

6. Are you aware of any support agencies available in your local prisons?

No	14
Independent Monitoring Board	6
Not applicable	5
Patient Advice and Liaison Service	3
Chaplain	3

ICAS	2
IPAC	1
Patient Forum	1
Samaritans	1
WRVS	1
Mental Health in-reach	1
Prison health	1
Unsure	1
Citizens Advice Bureau	1
Prisoner Groups	1

''..there are upwards of 10 organisations which input into prisons. Need to come to some agreement between all the organisations which system to use. For instance, the IMB can sometimes be seen as duplicating the role of PALS.''

Access

7. Telephone arrangements - have you put in place arrangements for prisoners to telephone you, if so, how does the process work?

Not applicable	12
Not in place	8
Discussion - PIN	2
No	2
In progress	1
No, thinking about it	1
Yes, during allocated hours	1
No objections to direct access	1
Not needed	1
Yes, made available	1
Unclear	1

8. Are you offering a face to face meeting option?

Not applicable	12
Yes	9
Not yet	3
Depend upon nature of complaint	2
No	2
PALS is, yes	1
Gate keeper procedure	1
May be helpful	1
Unsure	1
Prefer written	1

''There was concern from the prison staff from a security point of view – the approach to this is unclear on both sides.''

9. Have you created a special complaints form for NHS complaints, and if so, what arrangements are in place to protect confidentiality?

Not applicable	14
No/none	5
Use prison form (less confusing)	3
Verbal complaints form	1
Specific form	1
Separate form in development	1
Already in place	1
Developing NHS complaints form (similar to prison)	1
Accept any-even scrap of paper (is form available though!)	1
Unsure	1
No comment	1

Prisoner Profile

10. What interpreting and translation arrangements do you have in place?

Not applicable	6
PCT	3
PALS	2
Translating service	2
Via Regional officer	1
In train	1
Home Office	1
Literature	1
Tapestry Services	1
Contracts	1
None	1
Struggling	1

11. What arrangements are in place to assist those with low levels of literacy in making a complaint?

Not applicable	14
ICAS	3
Healthcare manager	3
PCT	2
Prison staff	2

PALS	1
IPAC	1
Complaints personnel (prisons)	1
Buddies	1
Social inclusion team	1
Local links	1
IMB	1
Advocacy/Voluntary Organisations	1
None	1
Complaint in any form (verbal etc)	1
Unsure	1

Healthcare specific questions

12. How many complaints have you received to date from prisoner? What percentage of these do you think would be appropriate for ICAS support?

a	Not applicable	14
	None	11
	Unsure	3
	One	2
	21	1
	63	1
b	Not applicable	29
	None	3

13. Do you think the introduction of ICAS in prisons will affect demand? If so, how?

Yes	9
Increased usage	6
Not applicable	5
No	4
Unsure	3
ICAS will be attractive (independence)	2
Initial increase	2
Slight increase	1

'(ICAS is) like everything – just another authority – another hoop to jump through, rather than someone who help and support them.'

'' There are 2 concerns – first the whole issue of confidentiality and second that the prisoners would use it as a tool for gaining advantage – apparently there are high levels of boredom – they might latch on to it because it's something interesting.''

''Like to think so as it should encourage people to air their complaints and the feedback can be very useful.''

32 wave two prisons returned questionnaires and of these 27 had done work on implementing the NHS complaints procedure within prisons. 9 considered there work to be well developed and 1 was awaiting guidance from the Department of Health. Only 3 PCT's in the second wave had telephone arrangements in place. 3 PCT's cited ICAS as the service to which they would turn to assist prisoners with literacy difficulties, which may be another inappropriate use of the service.

Again, in this section the number of complaints PCT's had received varied tremendously between none and in one case 63.

Comments included;

From what I've heard, ICAS would affect demand because it would be there and prisoners may see it as a valuable tool for the resolution of their concerns that may not necessarily be healthcare – for privileges.

This will raise awareness to prisoners but there would need to be clear guidance to individuals as to what the NHS complaints procedure covers and to ensure that prisoners are not referred inappropriately.

Hopefully ICAS might restrict the number of complaints coming through solicitors

Like to think it should encourage people to air their complaints and the feedback can be very useful.

Some prisoners will complain about things, due to being in a place they don't want to be, it's a survival strategy. They would be likely to access a system if in place; it will be used freely at that time. The main concern is that prisoners may duplicate their complaints – this will increase work loads – rather than one complaint, sharing.

We have explained the role of ICAS and have said this service can be accessed via PALS.

The availability of independent advocacy is likely to be attractive to the less articulate prisoners.

Prisons 'Wave 1'

Work undertaken

1. Have you done any work around implementing the NHS Complaints Procedure in your prison?

Yes	11
No	7
Unsure	1

If so, what?

Meetings and discussions with Trusts and the DoH	11
Unsure	5
Already implemented	3

2. Who have you worked with? (e.g. Local PCT, PALS)

PCT	14
PALS	13
Prison staff	4
PPI	4
N/A	3
ICAS	2
StHA	1
Prison Healthcare	1
MACA	1

How have you found it? (Omit if answer is no to previous two questions)

N/A	5
Difficulties (Differing systems)	5
Working well/formed good relationships	3
Slow	2
No feedback yet	1
Interesting (different systems)	1
No change	1
Difficulties (too many organisations)	1

Prisoner Support

4. What support agencies are available in your prison?

IMB	14
Samaritans	9
Chaplaincy	5
CARAT	4
PALS	4
Alcoholics Anonymous	3
Narcotics Anonymous/Drug Support	3
Counselling	3
CAB	3
Job Club	2
Healthcare Staff	2
Personal Officer	2
Independent Visitors Board	2
Listeners	2
MIND	2
Gamblers Anonymous	1
Resettlement	1
IMAN	1
St Giles/NVQ	1
Solicitors	1
Anxiety Management	1
Diversity Group	1
MACA	1
Commission Advisory Panel	1
Mental Health Act Commission	1
Mental Health In Reach	1
Housing Advice	1
CBT	1
Parentcraft	1

5. What prisoner peer support is available in your prison?

Listeners Scheme	10
Buddies	4
Insiders	4
None	3
Self Help Focus Groups	2
Diversity Group	1
Healthcare Group	1
Education Department	1
Peer Support	1

Samaritans	1
Prisoners Forum	1
Suicide Prevention	1

6. Is there a body or mechanism within prison for prisoner consultation? If so, please give details.

Monthly Committees	7
Healthcare scheme/Forum	4
None	3
Self harm forum	1
Canteen Committee	1
Prisoners Fund	1
Welfare/Probation	1
Prisoner Complaints	1
Prisoner Council	1
Prison Staff	1
Unsure	1
Rape Crisis	1
Mental Health Inreach programme	1
Suicide prevention	1
Counselling	1

<u>Access</u>

7. Telephone arrangements - when do the prisoners have access to make outgoing telephone calls?

Association hours	4
Lunch & Hours	4
Any unlock hours	3
Unsure	2
8.30am-8pm	2
Work hours & Weekends	1
Flexible	1
Varies	1

8. Implementation of 0845 line - what would be the procedure for adding a new number to the prisoners, list?

Prisoners apply	9
Through senior management	5

Through security	2
General administration	2
Through finance	1

9. Inbound telephone calls - is there any procedure in place for prisoners to receive inbound telephone calls?

None allowed	12
Unsure	3
Pre arranged only/special circumstances	2
No restrictions	1
At staff discretion	1

10. What are the procedures for physical access by outside support agencies into your prison?

Pre-booking/interview	13
CRB/Security Check	6

'Very cautious – I'm reluctant to have untrained and unqualified people coming in and doing more damage.'

11. Do you think there are any safety/security issues relating to the implementation of ICAS in prisons? If so, what are these?

Agency vetted/CRB	4
Face to face meetings	4
None	3
Only usual letters	3
Not sure	2
Info not given	2
Abusive calls	1
Confidentiality	1
Meetings in view of staff	1

12. Postal arrangements - what is the standard format for addressing post to prisoners?

Prisoner name, number and wing	18
Unsure	1

13. Are letters opened, and if so do you have a system whereby some letters may be kept confidential (i.e. solicitors) If so, could this arrangement be used for ICAS?

All opened except 'Private & Confidential	14
Governor's Discretion	3
Only opened in extreme circumstances	1
Unsure	1

'There is a prison service order which allows for letters to not be opened but the NHS and Department of Health aren't contracted to that.'

'Procedures are in place for certain post to remain confidential but there would have to be a directive to the prison to have this arrangement for ICAS'

Prisoner Profile

14. What interpreting and translation arrangements are in place at your prison?

Language Line	10
List of translators	7
Foreign Nationals within prison	4
Unsure	2
Prison staff	1
University staff	1
None	1

15. Please tell us about the levels of literacy in your prison, are there arrangements in place to assist those with low levels of literacy in making complaints?

Not given	10
Various	5
Reading age 11	2
Well educated	1
Low level	1

'Unaware of help available to prisoners with low levels of literacy. Probably peer support.'

'Reading age of 10 on average. If assistance is required the prisoner could ask an officer or someone in education. Also a buddy.'

Prison staff	10
Education departments/Learning skills	7
Peers	4
PALS	2
Learning disabilities nurse	1
Healthcare Department	1
Unsure	1

(We) use advocacy and voluntary organisations where appropriate.'

9. What is the average length of stay in your prison?

No average	7
Long stay	1
18 months-2 years	2
2-3 years	1
12 months	1
3 months – 4 years	1
3-6 months	1
6 weeks – 3 months	1
4-5 months	1
3 – 6 months	1
1 week – 1 year	1

<u>Healthcare specific questions</u>

10. How many people currently require advocacy to help them make a health complaint per year?

Unsure	10
10-15 people	3
None	2
120 people	1
4 people	1
2-3 people	1
Not many	1

11. Do you think the introduction of ICAS in prisons will affect demand? If so, how?

Initial rise	10
Yes	4
No difference	2
Massive rise	1
Slow uptake	1
Unsure	1

'If the complaints are genuine it may be that bad systems will be recognised and something might get done about them. At present complaints aren't acted on in a way that requires system changes to be implemented.'

'So far so good but problems may arise with the prisoners when they have to get used to a new system'

'If the vexatious complaints can be whittled out then any remaining complaints will highlight areas that need improvement and these improvements can then be implemented so that a better overall service is in place.'

'Yes (ICAS will increase demand) but only to be used to try to make a better case for compensation.'

19 of the 34 first wave prisons responded to our requests for interviews, only 11 of these had done any work on implementing the NHS complaints procedure. Only 3 of these had implemented the procedure.

Only 3 prisons reported that procedures were working well with good relationships formed. 5 reported difficulties operating different systems, and 1 found working with lots of different organisations was problematic.

Of relevance to ICAS and PCT/PALS, is the feedback that of the 19, only 1 prison allowed unrestricted incoming phone calls, and 12 did not allow any at all. This makes arrangements to return calls left on answer phones very problematic, and raises further issues for those services only proposing remote support with no option for face to face meetings.

Literacy was again an area which had appeared to have received little attention. 10 of the 19 offered no assistance at all. 10 also predicted an initial rise in the level of complaints when ICAS is introduced into the prisons.

Comments included;

"There are upwards of 10 organisations which input into the prisons. Need to come up with some agreement between all the organisations which system to use. For instance, the IMB can sometimes be seen as duplicating the role of PALS"

"I don't see any safety/security issues – ICAS is another tool to aid increasing standards. My only concern is that so many are likely to complain. I am a little concerned that it may become a means for making staff feel more vulnerable. Prisons are unique places – it's tough to manage the tension between health and security – the only way to learn (we recruit lots of good staff with ambitious opinions about how things should work in prison). The only way to learn is to experience it. There is a naivety at the outset that all prison staff are negative/aggressive. This lack of understanding about prison dynamics leads to misperception. Anyone coming in needs good training and good understanding of the system, the IMB are a good example of this – they have a good understanding of the different roles within the prison".

"I think the introduction of ICAS will clearly affect the number of complaints over all. I would think that there would be a massive rise in complaints but this is not necessarily a bad thing, it does not mean that incidents/grievances would increase but that the expression of these would increase. I hope that, as the Head of Healthcare this would help other members of staff to improve".

When asked 'How many people currently require advocacy to help them make a health complaint per year?' One respondent answered

'Not sure'. There are instances when an officer will ring healthcare about a prisoner complaint. This may be a form of advocacy as the prisoner perhaps doesn't feel confident to come to them directly. Or alternatively may not have the literacy skills to put the complaints in writing. Not thought about it before."

"Long term I feel ICAS will help and support."

"A new initiative always brings with it increased interest. When posters and leaflets are displayed you will find prisoners will take a lot of interest in what is being advertised. There will be an initial peak and then it will die down. We always noticed an increased interest in services offered whenever we replenish our stock of leaflets and posters throughout both prisons."

"We have been working closely with the PCT and are in the process of developing our 5th draft""

Prisons 'Wave 2'

Work undertaken

1. Have you done any work around implementing the NHS Complaints Procedure in your prison?

Yes	No
16	10

2. Who have you worked with? (e.g. Local PCT, PALS)

Primary Care Trust	21
Patient Advice and Liaison Service	13
Not applicable	4
Prison Healthcare	2
Prison staff	2
Patient and Public Involvement Forums	1
Mental Health Trust	1
Acute Trust	1
Independent Monitoring Board	1
Strategic Health Authority	0

3. How have you found it? (Omit if answer is no to previous two questions)

Working well/good relationships formed	12
Not applicable	5
No feedback yet	1
Foresee problems	1
Difficult	1
Slow	1
Few complaints	1
Too early to say	1
No problems	1
Useful	1

Prisoner Support

4. What support agencies are available in your prison?

Independent Monitoring Board	17
Samaritans	11

CARAT	8
Healthcare staff	5
Alcoholics Anonymous	4
Forensic mental health nurse	3
Prisoner Advisory Service	3
Counselling	3
Chaplaincy	3
Mental Health In reach	3
Citizens Advice Bureau	2
Peers	2
Personal Officer	2
Prison complaints	2
RAPT	2
Healthcare Forum	1
NVQ qualification	1
St Mungos	1
Race Relations	1
Listeners	1
Patient Advice and Liaison Service	1
Primary Care Trust	1
Crisis Support	1
ADOPT	1
Caseworkers	1
Teachers	1
Age Concern	1
Revolving Doors	1
Turning Point	1
Prison staff	1
Surgery	1
Gamblers Anonymous	1

Governor - "One crucial thing missing where – where do the prison staff become involved in any of this? Prison officer has complete control over access to phones etc. If prison officers do not understand why a prisoner would need to access ICAS they won't allow them to do so"

5. What prisoner peer support is available in your prison?

Listeners scheme	15
Peer support	8
Wing group	4
Buddies	4
Samaritans	4
Insiders	3

Personal officer	2
Chaplaincy	1
Drug support	1
Expert Patients	1
McKenzie Friends	1
Consultative Committee	1
Foreign National Support	1
Outsiders	1
Prison staff	1

6. Is there a body or mechanism within prison for prisoner consultation? If so, please give details.

Monthly committees	15
Healthcare scheme/staff forum	8
Race relations	6
Suicide prevention	4
No	2
Self harm forum	1
Prisoner Council	1
Prison staff	1
Chaplaincy	1
Unsure	1
Do not understand question	1
Patient Advice and liaison	1
Violence reduction	1
Suggestion box	1

Access

7. Telephone arrangements - when do the prisoners have access to make outgoing telephone calls?

Unsure	4
Association hours	4
Any unlock hours	3
No restrictions	2
Work hours and weekends	1
Lunch and evenings	1
Evenings only	1
7.30 am to 9 pm	1
8.15 am to 8.30 pm	1
No response	1
All day	1

Book calls	1
Routine access	1
Lunch	1

'Telephone access raises issues of confidentiality as telephone calls are monitored.'

8. Implementation of 0845 line - what would be the procedure for adding a new number to the prisoners, list?

Through security	11
Prisoners apply/PIN	6
Unsure	4
Through Senior Management	2
Through finance	1
Not prevented from ringing any number	1
EDS	1

9. Inbound telephone calls - is there any procedure in place for prisoners to receive inbound telephone calls?

None allowed	14
Pre arranged/special circumstances	8
Healthcare only	3
Unsure	1

''Inbound calls are allowed but they need to be booked which is done by the wings as there are 40+ prisoners on each wing''

10. What are the procedures for physical access by outside support agencies into your prison?

CRB security check	20
Pre-booking/Interview	5
Management discretion	1
With identification	1
Not given	1

'Biggest concern is requirement for agencies to have CRB checks. If there are none in place the timescales for setting up these meetings is phenomenal'

'Prisoners can access support agencies by letter or telephone in our prison. We have certain approved agency numbers that prisoners can call.'

11. Do you think there are any safety/security issues relating to the implementation of ICAS in prisons? If so, what are these?

None	19
Only usual issues	5
Agency vetted/CRB	3
Security issue	1
Child protection	1
Not sure	1
Information not given	1
Third party enquiries	1
Telephone access	1
Physical access	1

12. Postal arrangements - what is the standard format for addressing post to prisoners?

Prisoner name, number, wing	26

13. Are letters opened, and if so do you have a system whereby some letters may be kept confidential (i.e. solicitors) If so, could this arrangement be used for ICAS?

All opened except	
Private and confidential	25
Unsure	1

<u>Prisoner Profile</u>

14. What interpreting and translation arrangements are in place at your prison?

Language Line	12
List of translators	8
Foreign nationals within prison	6
Prison staff	4
None	2
Primary Care Trust	2
Unsure	1
Chaplaincy	1
University staff	1
Signer	1
Prison Intranet	1
Embassy	1

15. Please tell us about the levels of literacy in your prison, are there arrangements in place to assist those with low levels of literacy in making complaints?

a)

Not given	11
Low levels	3
Reading age 8	3
Unsure	3
Good	2
Reading age 10	1
5-10% literacy	1
Poor	1
60% problems	1

'6000 prisoners a year with various literacy skills.'

'The availability of an independent service is likely to be attractive to the less articulate prisoners.'

b)

Education department	12
Prison staff	14
Peers	8
Healthcare Department	6
Independent Monitoring Board	4
Chaplaincy	2
Unsure	2
Translators/Language Line	1
Resettlement	1
Visitors	1

16. What is the average length of stay in your prison?

Not given	7
6 months	2
2 years	2
4 years	2

1 day - few months	1
1 day - four years	1
6 weeks - four years	1
Few weeks - 2 years	1
26 weeks	1
3 months	1
6 months - 2 years	1
9 months	1
18 months - 2 years	1
3 - 4 years	1
2-3 years	1
1-3 years	1
Few months - life	1

Healthcare specific questions

17. How many people currently require advocacy to help them make a health complaint per year?

Unsure	12
None	4
1 person	3
2 people	2
6 people	1
12 people	1
20 people	1
36 people	1

18. Do you think the introduction of ICAS in prisons will affect demand? If so, how?

Initial rise	8
No difference	7
Yes	7
Unsure	2
Eventual rise	2

''Yes – there would be an increase in complaints which may better reflect prisoners concerns. The IMB and other groups at the Prison could be encouraged to take on a greater advocacy role to address these concerns in a more proactive way.''

''I can compare (ICAS) to the Prison Advocacy Service, which is a legal

voluntary, free service that has been running for about 3 years. There was great demand for this service initially – about 2 complaints a week. However, this has petered out and there has been nothing received for the last 3 months.''

'It raises the question of why prisoners who already have care through the NHS i.e. an operation at a hospital or services which are commissioned in at present by the prison but are supplied by NHS staff don't already have access to the NHS Complaints Procedure and ICAS. There needs to be some standardisation of the process nationally and at present each PCT and prison seems to be working in isolation.'

'Some prisoners may see it as another way of manipulating the system to their own agenda.'

Twenty-six questionnaires were completed by wave 2 prisons, and 16 of these had done some work on implementing the NHS Complaints procedure. Similarly to wave one prisons, very few prisons allow incoming phone calls, which reinforces earlier comments about how difficult it will be to offer remote assistance. This is compounded further by the low levels of literacy, and wide range of first languages within the prison population which makes correspondence difficult also without the support of appropriate services.

Comments included;

'After a while it will settle down and it will be used by people who have a genuine complaint.'

'YOI – Most of the boys left school after primary and before secondary school'

'Some prisoners will see it as another way of manipulating the system to their own agenda'

'I think there will be an increase in complaints initially. The service will be perceived as another instrument with which to have a go at prison staff and the system. (Not necessarily in this prison but perhaps in other prisons which are not open). The vast majority of cases where a prisoner has brought a complaint have been proven to be false. However, no action has been taken against the prisoners who are malicious or vindictive which are some of the reasons why they are there in the first place. I have been personally threatened by legal action when I have refused something a prisoner wants, which they are not entitled to.'

'There would be a rise in complaints, which is fine – I would like to see facilitation for this and an increase of a voice for those who find it difficult to express their concerns. We tend to find that the able make the complaints and we don't tend

to hear from the less able'.

'I would like to see ICAS preventing escalation – I would hope that ICAS could mop up some of the generalised anxieties. '

Fourteen prisons sent us back data regarding the number of complaints they had received over the past 12 months. We have combined these fourteen responses below to give an indication of the potential demand for ICAS.

Complaint Type	Number of Complaints Received	No. of complaints in previous column that would be suitable for ICAS support?
Change of medication	28	3
Unable to access medication	58	5
Concern that treatment is incorrect	42	2
Concern with nurse triage system and inability to access Doctor	33	2
Objection being passed fit to work	7	
Breach of confidentiality	1	
Staff attitude	28	2
Unable to access special equipment and hygiene products	6	
Length of time accessing hospital treatment	34	8
Request to access external GP	3	
Delay in access to dentist	43	
Request to access	5	

Complaint Type	Number of Complaints Received	No. of complaints in previous column that would be suitable for ICAS support?
external dentist		
Refusal of dental/cosmetic treatment		
Unhappy with dental treatment given	8	
Other, please detail		
Unhappy with Waiting times for smoking cessation clinic	2	
Unhappy with waiting time for an optician appointment	5	
Unable to access food supplements	1	
Unhappy with healthcare at previous prison	3	
Unhappy with waiting time for chiropody appointment	2	
Health needs prevented transfer	1	
Unknown	1	
Healthcare staff not willing to rub cream in	1	
Reordering (Items not ready for collection)	10	
Attending Late at Health Centre	5	
Dressing	4	
Epilepsy Nursing	1	

PRISONER RESPONSES

1. Do you know what ICAS stands for and what it is about? (Please explain ICAS after the participant has given his/her answer)

Yes	No
21	6

2. Do you know what advocacy is? If yes then please explain/give an example.

Person who speaks on behalf of someone else	16
Person who gives support	5
Person who provides advice	3
Person who looks into complaints	1
Person to go to if you need help	1

3. At the moment, if you wanted to complain about the NHS while you are in prison who would you speak to?

Healthcare staff	6
No-one	6
Unsure	5
IMB	3
Prison officer	2
Governor	2
Solicitor	1
Fill in form	1
Complaints Department	1

4. Would you prefer to speak to someone who knows about the NHS complaints process or would you prefer to speak to someone you already know?

Someone who knows NHS Complaints Procedure	16
Either	4
Both	4
Someone I already know	3

5. Would you be happy to have other prisoners supporting you with a complaint?

Yes	22
No	2
Depends	2
Only if they have a vested interest	1

6. Would you access the service even if all the details might not be confidential due to prison rules/ regulations?

Yes	16
No	4
Difficult to maintain confidentiality with prison staff present	3
Unsure	2

7. Would you prefer to speak to someone on the telephone or in person about a complaint? Please tell us the reasons for your choice.

Face to face	27
Telephone	0

8. Do you have any ideas on how we could make sure that more prisoners know about ICAS?

Advertising	20
Induction	2
Word of mouth	2
None	2
By post	1

9. Do you think you would use the services of ICAS if they were available?

Yes	24
No	1
Possibly	1
Depends upon confidentiality	1

10. Are there any further comments you would like to make?

None	8
Would like ICAS assistance	6
Difficult to get healthcare	4
Difficult to complain	3
Would like more info	2
Would like medication access to be quicker	1
Sooner ICAS in place the better	1
Great filing in the questionnaire	1
Hard to distinguish genuine complaints	1

28 prisoners completed structured interview forms, the overwhelming majority of these were aware of advocacy services to a greater or lesser degree. 100% of respondents felt that they would prefer to speak to an advocate in person when making a complaint

"In person. It's easier to deal with all the issues and provide a comprehensive account in a relaxed manner".

"In person, talking on the phone is like talking to a machine".

The majority felt comfortable with the suggestion that other prisoners might assist them in making their complaint. Some, however questioned the motives of prisoners willing to do so. Information is currency within a prison, and access to it places individuals in a position of considerable power. Comments ranged from

"only if they were doing it because they too had similar problems and were therefore, wanting a common aim or goal in wishing to achieve an objective common to all".

"Yes if done for the right reasons".

"No as it might be confidential".

A number of prisoners expressed a belief that the prison service was designed to

"block complaints reaching their intended source"

Prisoners expressed their belief that prison healthcare was poor and comments included:

"Healthcare is very often low down on the list of priorities of prison management teams. Being seen to be giving a good service and actually giving it are two very different things in a prison. Outside we can change doctors, hospitals etc. In

here we cannot, many prisoners have died because of this. One in this prison not too long ago".

"Prison healthcare is so devious and underhand, they act as their own judge and jury which is against all principles of natural justice. If I were to have access to the NHS (as of April 05) I would contact the NHS Ombudsman or local PCT first".

'Trying to get treatment here, is like asking the Queen for her jewels.'

"The staff in healthcare don't seem to bother it's just come to work and get out as soon as they can, you cannot get a straight answer from any of them and when you do it seems as though they twist the truth they ask us to be honest but lie to us and treat us like children".

The way prison healthcare is run these days, they should close them down, or let people run them who understand what helping people means instead of pumping people with all types of medication. This is not helping people, it's shutting them off form other human beings.

'Would you make sure the medication doctors issue is given to inmates a.s.a.p. At the minute it's a wait of 2 to 4 days.'

"We've gone to great risk to fill in these forms, which will be viewed as complaining by the back door!! Viewed by a lot of inmates with reservations!!".

'Could I have more information about what you do?'

'The sooner this is off the ground the better for all.'

ICAS PROVIDERS

These questionnaires were completed by the Service Directors for each provider with the exception of the Carers Federation Ltd, where it was felt that the involvement of the Service Director in the writing of this report would provide a conflict of interests. The ICAS Team Leader, who has no involvement in this pilot, has therefore completed it on behalf on the Carers Federation Ltd.

1. Have you done any work around implementing ICAS in prisons within your area?

Yes	No
2	2

2. Who have you worked with? (e.g. SHA, local prison)

N/A	3
All stakeholders	1

3. Are any plans in place to begin the process?

Yes	No
1	3

4. How far has the procedure been developed?

Refer to pilot	2
N/A	2

5. What kind of feedback have you had? (Omit if not relevant)

N/A	3
Refer to pilot	1

<u>Prisoner Support</u>

6. Are you aware of any support agencies available in your local prisons?

Yes	No
1	3

7. If so, are you working with them?

Yes	No
1	3

Ways of working

8. Telephone arrangements – when are your telephone lines open?

9-5 Mon to Fri	2
9-5 Mon to Thursday, 9-4.30 Fri	1
All the time	1

9. What facilities do you currently have in place for face to face meetings?

Home visits	4
Offices	4
Neutral venues	3

10. Do your advocates/caseworkers travel to visit clients in their homes or other venues? Are all advocates/caseworkers able to drive?

Yes, all drive and can visit external venues	4

11. Are all staff CRB checked?

Yes	4

Prisoner Profile

12. What interpreting and translation arrangements do you have in place in your region?

Local translation and interpretation services	4
Language Line	1

Healthcare specific questions

13. How many complaints have you received to date from prisons? What % of these do you think are appropriate for ICAS support?

None	2
Unable to pull data together	1
22 of which 8% are relevant to ICAS	1

14. Do you think the introduction of ICAS in prisons will affect demand on your service? If so, how?

Yes	4

"Need extra resource""
"Yes, will put more pressure on already stretched resource""
"It will increase demand on the caseworker/advocate time per case"
"Travel for visits"

"Specialist training"
"Cost of CRB checks"
"Increase in telephone enquiries"

Only two of the current ICAS Service Providers have worked in prisons to date, and of these only one has worked specifically on ICAS provision in prisons with other stakeholders.

One provider only, has any plans in place to begin the process of service delivery, and two providers are looking to the ICAS Prison Pilot to develop procedures. Three providers are unaware of support agencies already established in prisons.

At the time of analysing the data, the one ICAS provider currently working with prisoners has to date received 22 complaints, of these 8% were considered appropriate for ICAS support.

All four ICAS providers felt that the introduction of ICAS into prisons will affect demand on the service, and specific comments included

"Yes it will put more pressure on already stretched resources which may then have a knock on effect on service quality".

"Yes, increase in demand on caseworker time per case, travel for visits, specialist training. Likely cost of CRB checks".

"Yes, increase in telephone enquiries about the service available and if the complaint is relevant to ICAS".

"Yes, will need extra resources to undertake"

"In spite of comments about resources I think it is essential that the ICAS service is offered to prisons, as part of our remit to support the disadvantaged and vulnerable. It is therefore, important that we receive the appropriate funding to enable us to offer such a service along with appropriate training for advocates".

The Prison Pilot work has identified the very time consuming nature of visiting clients in a prison setting. Clearing prison security can take anything up to an hour, and visitors can then be faced with considerable delays waiting for a prison official to become available to escort them around the prison. There is the further complication of prisoner meal times, or lock-down situations during which visitors will have to leave the prison premises. Any unfinished work, may then require a further visit to complete. It has been strongly recommended by prison staff and the IMB that ICAS visit prisoners at the Visitor Centres instead, although these are not yet available in every prison.

The providers commented on a number of issues they considered important which included:

Recruitment, particularly staff with prison experience.

This could be an issue, as advocate questionnaire feedback indicated clearly that advocates with experience of working in prisons were less willing to consider doing so again. Work in prisons is considered particularly stressful, and a high percentage of staff turnover could materialise, this would require careful monitoring.

Providing training

Training for ICAS advocates is urgently required, tailored to the specific model of; service delivery, chosen for implementation by the Department of Health. Please refer to the training section of this report.

Non-disclosure of personal information is essential, and we would strongly advise the use of a false name. Many experienced advocates already do this and it could be something to consider for the generic ICAS service also. There is further information on the proposal to use false names in the legal section of this report also.

Obtaining prison clearance for staff involved

This can be a very lengthy business and can take many months to complete. This clearly needs to be planned in well in advance to ensure sufficient numbers of cleared staff are available to support prisoners. Prisons have continually told research staff that they exist within a 'top down' system, if they receive an order telling them to do things in a certain way they will do so. It would be useful if the forthcoming Prison Service Instruction/Order could address this matter, and consider also the needs of PCT and PALS staff members.

Gender issues

Of considerable concern is the vulnerability many female workers within prisons express, and their particular fears for the safety of their children. One forensic lead informed us that on a recent visit to prison, the prisoner had said;

"I've got your number plate, and a mate on the outside. I'm going to do you then I'm going to do your children".

Threats to visitors are not uncommon, and not everyone will be willing to work in such an environment. Another issue raised from a wide variety of stakeholders, including prison governors, IMB, advocacy services is the fact that women are

currency within a male establishment. Prisoners having access to an hours time with a female worker can 'sell' this experience to other prisoners over a series of weeks to come. It will be necessary to ensure male advocates are available to visit prisoners as appropriate, although we should make no assumptions that they will always be willing to do so.

Organising meetings with advocates/NHS & prisoners

Organising any meetings within the prison setting is complicated and time consuming. Partners will need to be flexible to ensure arrangements work as smoothly as possible for prisoner complainants.

Rapidity with which prisoners move around and out of the prison system

This is a serious challenge to delivering the ICAS service into prisons. The speed, through which prisoners travel, particularly through remand establishments, is extremely rapid. This we are informed, is going to speed up even further with the proposed changes in the prison and probation services.

Other stakeholders:

It is important to note that only 4 stakeholder questionnaires were completed in the course of this research, the information below must therefore, be read in the knowledge that this is not a representative sample. It is recommended that caution be taken when attempting to draw any conclusions from this section of the report. Questionnaires were completed by

MACA (Mental Health Aftercare Association)
Milton Keynes Children and Young People's Rights Service
Mind in Bristol
Oxfordshire Short Term Advocacy Scheme

1. Are you familiar with ICAS?

Yes	No
4	0

Comments:

"I'm becoming more familiar and it's becoming clearer. I would like to be able to consolidate a bit more how we can best make use of it for us with working with patients. We have systems and processes established for raising issues here."

"Yes because I was on the steering group for one in this area a couple of years ago"

"Yes , used to run the mental health pilot when they were ongoing".

"Moderately though I wasn't sure how it fitted in/worked with PALS".

"Yes because I was on the steering group a couple of years ago"

2. Do you or your organisation work with prisons? If so please give details of your activities

Yes	No
3	1

"Providing free, impartial advocacy including information and support to patients of the Trust ‘’

"No".

3. Do you offer a telephone service? If so please give details

Yes	No
4	0

"Yes. The service is free, private and confidential and the line/calls don't go through the hospital censors. Confidentiality is broken if patients inform advocates of any of the following:

child protection issues
threats of suicide and/or self-harm
threats to commit a security threat
We tell the patients that we will need to break the confidentiality and we've found that sometimes we are used for preventative reasons, for example to stop self-harm occurring".

"Yes we offer an enquiry service and can also offer telephone support directly to young people".

"This is offered but it's very difficult for prisoners to call because their number would need to be added to the prisons' system. Prisoners very rarely phone".

"Yes:

We will often talk through issues with people when they phone and then discover that it is dealt with and so there is no need to take it further
We do not offer a telephone helpline and we are not in the office 9-5, nor are we a 24 hour service
However, we do monitor the phones and if a message is left you should get a call back within about 3 hours"

4. Do you offer face to face support? If so please give details

Yes	No
4	0

"We don't ask patients to sign consent forms or letters of authority unless they are asking us to give copies of our diaries to their solicitor, for example. In that instant we would ask the patient to sign to give consent for us to do that"

"Yes we will visit people in prison. We will book a professionals visit and listen to them and enable them to address any rights, issues they may have".

"Yes. I go into two prisons and run drop-in sessions on those areas of the two prisons. These are held set days and times".

5. Do you currently assist prisoners with healthcare complaints? Is so, what are the main healthcare complaints by prisoners at present in your opinion?

Yes	No
2	2

"No

Not generally but we do assist some
There are one or two advocates regularly dealing with complaints
Healthcare complaints here are mainly on extreme issues: Self-injurious behaviour (SIB), life-threatening illness"

"Yes. Depression, suicidal feeling, self harming".

"Yes:

We have with one or two in the past and we would do again. None of the complaints have been made on a formalised basis.
complaints are usually about the absence of a service or the tardiness in provision

6. What knowledge do you currently have of the NHS Complaints Procedure?

Good	Average	None
1	2	1

"Pretty good working knowledge"

""Not a lot, we do have a manual".

"Without looking it up, a reasonable knowledge".

"Slightly limited, I should know more about it".

7. Would you be interested in receiving NHS Complaints Procedure training?

Yes	No
3	1

"Depends on the slant of the training. We always need to be up-to-date and have the correct knowledge. We would be interested if it was new and appropriate to us".

"No, we don't have time. We are a very small service only 2 full-time workers".

"Maybe but I'm not clear how it would fit in as I am an independent advocate".

8. Would you prefer to offer this service yourself or should it be provided by ICAS?

Yourself	ICAS
2	2

"Offered by ICAS but we would want to understand the role of ICAS in relation to the patients in Rampton. We would like to hand over complaints if local resolution isn't possible. We would be happy for a reactive service to be provided by ICAS. If there is someone else who is more appropriate to do a piece of work then that's fine by us".

"Ideally it should be provided by ICAS because they have had the opportunity to:

build up the expertise in that field and are, therefore, used to doing it
We wouldn't look to extend the service beyond where we work
We would extend what we are offering now - a complaints service rather than just complaints".

"ICAS are better placed to offer the service".

"In theory;

I would be happy to do but it would need to be properly resourced
We have the capacity to do more but extra resources would be needed".

9. Any other comments?

"No we don't have the time (to learn about the NHS Complaints Procedure). We are a very small service only 2 fulltime workers".

"ICAS are better placed to offer the service"

"I think it would be useful to have ICAS available in prisons; it would need a lot of work setting it up so that it meshed in with what's already available in prisons
A lot of work would have to be done with prisoners to inform them of the different roles etc"

"Some additional difficulties: not being told of then a hospital appointment is until the day of the appointment. This is for security reasons. On one occasion the appointment was mistakenly sent to the prisoner rather than the prison and consequently had to be cancelled and re-scheduled, ICAS would need to be aware of things like that"

"One of the largest obstacles will be the prison walls, access is limited as is the amount of time you can spend in there"

"Mealtimes are absolute. At 11.30 a.m. the prison shuts down for prisoners to be fed and prisoners are sent back to their wing, there is no leeway. So if you are on the wing at 9.00 a.m. you will have to leave at 11.15 a.m. This happens to everyone, including solicitors."

"There are a lot of differences between working in prisons and working elsewhere. Prison is a very different set-up. The primary concern of the staff is control and security, not rehabilitation and care"

"Even in healthcare, prisoners are routinely called by their surname. This is very

strange as it is a therapeutic relationship."

"There are other cultural things such as the belief that prisoners are swinging the lead and they're not really ill, they're just trying to extract an advantage out of the situation"

"I don't yet have keys so I need an escort to go beyond the gate and between different areas. Additional security clearance is needed to become a key holder, then you need to apply for keys. It's a very long process."

"I would be interested in looking at getting involved in this and would like to discuss it more if the opportunity arises"

Of the four stakeholder questionnaires returned three requested training on ICAS. This was a request heard throughout the research during focus groups and from comments posted to the discussion boards. These requests are for general information about what ICAS does, and the difference between the service and in particular the PALS service.

Although two of the stakeholder who submitted detailed questionnaires said that they were willing to provide ICAS support themselves in prisons which relate to models 3 & 4. This, however, was not a generally supported view, it is also important to note that the IMB also did not support these models. An approach in which partner agencies provide advocacy on the ground in prisons is complex. All stakeholders felt that if they were to do this they would require detailed training about the NHS complaints process and the ICAS approach. This would require considerable investment and support on the part of ICAS service providers, and the need to create a Bespoke Training Programme specifically for this purpose. It also poses the difficulty of how stakeholder agencies would be selected to the service, and who if any would be considered unsuitable. The legal section of this document also raises the issue of liability should there be problems in this area.

The research identified several hundred stakeholders already well established within prisons, many of whom are key holders. There is clearly a need for comprehensive information to these key partners who are well placed to signpost prisoners with complaints and issues, not just to ICAS but PALS and Patient and Public Involvement Forums also.

<u>Morton Hall</u>

Morton Hall is a semi-open women's prison near Newark in Lincolnshire. Previously an RAF base, Morton Hall was re-opened as an open prison in 1985. New accommodation was opened in 1996 and has been re-fitted in 2001 to

provide dedicated facilities for women offenders. Two ready to use units opened in 2002 increasing the capacity of the prison.

The Carers Federation Ltd became involved in the original Morton Hall pilot scheme as part of the Prison Health report before we had been commissioned to write this report.

Initial meetings between Prison staff, PCT complaints staff, local IMB representatives and the then project leader took place in September 2004. It transpired that no work had taken place to set up an NHS complaints procedure prior to this date, and the local PALS were not aware of the scheme either.

Complaints staff provided the Pilot Team with copies of all healthcare complaints received over the previous six months. These were analysed by the report authors to give some baseline data and identify the pertinent issues. Upon analysis of this data the authors found that only a small percentage of the complaints were issues that ICAS would become involved in, although there would be a signposting role for many more of these complaints. Under our analysis PALS would be the body to which we would refer a large proportion of these.

Subsequent monthly meetings took place and PALS were also invited on our request. It is important to note that the IMB declined to join further meetings following the second of these meetings. Reasons include the fact that the IMB were also called upon to participate in a Patient and Public Involvement Forum (PPIF) trial running at the same time, and felt that the demands being placed upon them were too great for the volunteers. Additionally, the IMB felt that they had not been consulted regarding this second trial.

The Carers Federation Ltd considered the best way to trial ICAS at this stage was to work to offer a fully equitable service offering face to face advocacy within the prison. With this aim in mind, recruitment in the Lincolnshire area had taken place in July 2004 and an advocate with relevant work experience was taken on to join the ICAS team.

As soon as the advocate had joined ICAS and received the relevant training, she was asked to join the regular meetings and to commence the work of getting the pilot underway.

Staff at Morton Hall worked closely with our advocate to make the necessary arrangements for security checks and access to clients for the advocate. A tour of the health facilities also took place.

A meeting place with prisoner representatives at an early stage to identify key issues and concerns for the prison population within Morton Hall. This meeting was in addition to the regular meetings which identified and found solutions to all practical issues such as physical access and access to telephones.

In Morton Hall, inmates have access to the telephone in the morning after breakfast and over the lunch period of 11.30am – 1.30pm and again in the evening from 6.30am – 9.00pm. There are no standard facilities available to enable ICAS staff to return calls to clients, although an arrangement was agreed with a prison officer that calls could be placed to her department and clients could be escorted to use the telephone. To enable the telephone system to work at all, first it was necessary that the ICAS '0845' number was added to the prisoners PIN list. It was felt that it was very important that this number was in addition to the inmates allowed 10 numbers as we did not want the service to replace any existing privileges. The staff at Morton Hall did assure us that this addition would happen swiftly – unfortunately this was not the case and it took many more weeks before the number was actually available for clients to call us.

Publicising the service within Morton Hall was a key concern. Posters and leaflets detailing the service were provided to the Prison and we requested that at least one poster and leaflet be available in every wing and in every communal area – usually to be included alongside the current complaints material. It has been difficult to verify if this has happened in practice.

We also requested that this information could be included in every prisoner induction pack. Once again it has been difficult to verify if this has happened.

Our advocate worked closely with PALS to create a presentation to be given to all staff detailing the services that both offer. These presentations were written with two audiences in mind – prison staff and prisoner representative groups who we hoped would cascade the information through to the rest of the prison population. Unfortunately it took some time to arrange this, and the staff presentation did not take place until February. Due to varying difficulties within the prison, this presentation has still not taken place at the time of writing.

It has been brought to our attention that the prison staff felt somewhat under siege having two trials taking place within the prison at the same time, and anecdotal evidence suggests that the Forum trial did not go well, and could actually have set back the ICAS Prison Pilot, as prison staff goodwill was eroded. Whilst mentioning this issue it is important to stress that prison staff were always very welcoming and accommodating to the ICAS Prison Pilot Team, but some reticence was evident.

Diversity issues

Illiteracy is a serious issue in prisons. There is a diverse population with a wide range of languages, not all of which have a written format. The IMB has expressed a preference for publicity in pictorial format for young people, and indeed this is something that we have recognised during the pilot, and we are currently working with a group of prisoners to achieve this goal for ICAS.

''There are 9,000 foreign national prisoners spread across nearly every Prison Service establishment in England and Wales. Their number has increased at three times the rate of British prisoners: they now represent 2% of the prison population, and more that 20% of the female prison population. Only eight out of 38 prisons in full inspections had foreign national policies, and of these only two London prisons (Brixton and Wormwood Scrubs) could be described as making reasonable progress in implementing them.

The distinct issues facing foreign national prisoners are now well established. They include: immigration-related difficulties, lack of communication with distant families, which means a greater reliance on phone contact and visits; discrimination connected with national and cultural identify, a lack of preparation for release, particularly for deportees; and language difficulties, which exacerbate all other problems.

Of these, communication difficulties, the expense of international telephone calls and poor access to telephones were consistent themes in our inspections. There was under-use of translation services; few establishments made adequate use of the Language Line telephone interpreting service."

Annual Report of HM Chief Inspector of Prisons for England and Wales 2003-2004

There is a need for improved health services, different types of housing and the provision of a variety of aids for when women become disabled as they get older (Wahidin 2003). As women become older there is an increased risk they will suffer from: an impairment of sight, hearing, memory and reflexes and a general slowing of movement and mental responsiveness. The majority of women in this study chose to stay in their cells therefore reducing their physical activity and reinforcing their sense of isolation. The study suggests that in order to allow older women control over their immediate physical environment, the following could occur:

> Installing doors and windows that could be easily opened
> Radiators that older women can adjust themselves
> Staff members specifically trained to meet their needs.
> (Wahidin 2003)

The Howard League for Penal reform also highlights the added problems within an elderly prison population which jails do not cater for, including 'infirmities, complex health problems, lack of mobility, incontinence and even terminal illnesses' (Batty & other Agencies 2005). Mobility issues can be exacerbated by the fact that prisons are not very accessible and the problems are not helped by the refusal of some staff to push wheelchairs due to the fact that they are not trained to do that. Mobility problems can also cause problems in the showers:

either with feelings of being unsafe or with needing extra help when taking a shower (Batty & other Agencies 2005).

Whilst this study addressed the issue of provision for older women in prison, much of the issues raised are just as relevant for older men in prison. Currently, though, the prison service 'only has four male prisons with small wings offering specialist services' (Batty & other Agencies 2005).

UK Law on Equality and Discrimination

The United Kingdom has specific legislation on equality that outlaws discrimination and provides a mechanism for individuals to lodge complaints when they experience unlawful discrimination. Currently, there is direct legislation dealing with discrimination on the grounds of sex, race and disability that applied in a number of fields, including employment, education, housing and the provision of goods and services.

Currently, there is no direct legislation dealing with discrimination on the grounds of religion or sexual orientation. However, with effect from December 2003, new regulations came into force which makes specific provision outlawing discrimination on grounds of religion and sexual orientation in the employment and education fields. Draft regulations on age discrimination were introduced in 2003. The regulations are expected to come into force on 1 October 2006.

The Human Rights Act 1998, which incorporates the rights contained in the European Convention of Human Rights (The Convention) into UK law, is also relevant challenging discrimination. However, unlike UK equality legislation, the Human Rights Act can only be enforced directly against public bodies such as the police or a local authority and private bodies exercising public functions. Courts and tribunals are themselves public bodies must interpret and apply legislation in a way that is compatible with the Convention. Moreover, it is possible to rely on the Convention in any court or tribunal proceeding including for example proceedings in an Employment Tribunal. Article 14 of the Convention prohibits discrimination on many grounds including sex, religion, political opinion as well as any other status. Other status has been interpreted broadly to cover for example, marital status, sexuality, prisoners and would more than likely cover disability.

(The Liberty Guide to Human Rights)

Prisoners' Complaints

Complaints are an important source of information on health of an organisation. Both internal and external studies (Baskerville, 2001, Tabreham & Whiteside, 2005) have concluded that complaints from prisoners are under reported. Reasons for failing to report a complaint can include:

Having to put up with those things outside prison so continue to do so inside

They are about to be released so they do not want any trouble

Complaining won't make a difference and may even result in adverse factors such as an unwanted transfer

They do not know how to complain, this may be particularly true of foreign nationals

They just want to get through their sentence with the minimum of fuss

At Rye Hill Prison a prisoner had submitted a complaint in Arabic as he could not express himself adequately in English. The complaint had been translated but the reply was sent to him in English.

As the Prison Service begins to implement the action plan agreed with the Commission for Racial Equality, inspections continue to show that practice in prisons is variable. Black and minority ethnic prisoners consistently report worse treatment than white prisoners.

(Annual Report of HM Chief Inspector of Prisons for England and Wales 2003-2004)

"The attitudes and approach of staff are key. "Many prisons holding significant numbers of black and minority ethnic prisoners are in almost exclusively white areas. Training and support are vital, with no requirement for mandatory or off-site training, this is often either not a priority, or delivered by staff who themselves have an imperfect understanding of the issues. The percentage of staff trained in race and diversity varied from 87% at Wakefield to 7% at Hindley."

(Annual Report of HM Chief Inspector of Prisons for England and Wales 2003-2004)

Training

Training on the NHS complaints procedure would be required as part of any induction programme for new ICAS advocates. In the instance where advocates going into prisons are existing ICAS advocates then the following are key training needs:

1. Personal Safety
2. Policies and Procedures of the prison service
3. Policies and Procedures of the ICAS provider
4. Basic principles of issue based Advocacy including consent and working practices
5. Confidentiality

6. Managing difficult situations and understanding of mental health problems/ disorders
7. Maintaining Independence
8. Communication
9. Prison terminology
10. Overview of the relationships between prisons and health

1 Personal safety

It is important that advocates are trained in basic breakaway techniques and that following training they feel confident and safe enough to be able to work in a prison environment. Basic breakaway training is different from control and restraint (CNR) and SKIP training. Both CNR and SKIP training are more appropriate for staff that have a duty of care and may therefore be required to restrain someone in order to manage a situation. As advocates do not have a duty of care it is important that the safety training they receive is designed for their safety as opposed to managing/restraining clients.

Basic safety issues should include the following:

Ensuring that you are sat nearest to the exit and that the client is not between you and the exit

Being aware of body language which may indicate agitation

Ensuring that you are dressed in an appropriate manner, this means ensuring that you are covered up and could not, therefore, be construed as encouraging the prisoners in any way

Ensuring that the relationship is professional and one of advocate-client, not befriender

Ensuring that the client clearly understands the role of advocacy and what the advocate can and cannot do

Ensuring that none of your personal details are given by you to the client

Ensuring that advocates are aware that they cannot work with anybody they may know and/or be related to

Ensuring that the staff communicate any possible problems to you in a way which is understood by you but which cannot be misunderstood by the client. This is particularly relevant in situations where staff may consider the client to be agitated and therefore more of a risk. As advocates we should respect the knowledge and experience of the prison staff. If the clients are aware from the very beginning of the working relationship and that on occasions advocates may follow the advice of staff for their own safety then this should alleviate any concerns the clients may feel.

Advocates may require a talk about keys and will require training in the handling of keys should it become a possibility that they will be able to hold keys when at the prison.

2 Policies and Procedures of the Prison Service and ICAS provider

A good working knowledge of the prison services policies and procedures, in conjunction with that of the ICAS provider are essential to facilitate effective working practices.

Basic principles of issue based advocacy

Training should be provided to ensure that advocates are familiar with the role of the Advocate. This could include the role of an advocate and what they can and cannot do.

Consent

It is important that any work undertaken is done so with consent. Consent can either be written or verbal but would need to be in accordance with the policies and procedures of the ICAS provider. Written consent facilitates potential problem situations which may arise if a client feels that an advocate has acted outside the realm of their role and the specific instructions given. Written consent also acts as a guide for the advocate and can keep them focused on the task in hand.

Working Practices

Written records of work undertaken are essential and should clearly show what has been achieved. All communication between the client and the advocate must be recorded as should all communication between the advocate and any third parties. This will facilitate the review process by both line managers and the client and advocate. It is important that any deadlines are met and that both client and advocate are aware of the deadlines. The client must be kept informed at all stages of progress in their complaint. The advocate should aim to offer informed choice. This will involve undertaking research to facilitate an informed discussion about what options are available.

Advocates will need to be aware of any restrictions regarding bringing things into the prison. Whilst this may be of more relevance to “contraband” items (cigarettes etc) there may also be issues regarding the bringing in of information. In such cases it is important that the advocate is aware of any policies and procedures which would govern the passing on of information. In being aware, the advocate can act accordingly and without causing further possible problems. For example, if a client requests information on new or proposed legislation which can be obtained freely from the internet as it is considered to be in the public domain then the advocate would need to be aware if they would be any objections from prison staff in bringing this information in. Where the request is refused by staff the only possible course of action open to the advocate may be

to facilitate a meeting with staff and the client so that reasons for the decision can be explained to the client.

3 Confidentiality

It is important that advocates are clear about the rules and boundaries of confidentiality as defined by both the prison service and the ICAS provider. Confidentiality between advocate and client is of paramount importance to an effective working relationship. Good working relationships and a clear understanding of the role of an advocate for prison staff will facilitate the confidentiality aspect.

It is important that the client is also clear about when the advocate will break confidentiality. It is perhaps also advisable that should an advocate find themselves in any circumstance where they may have to break confidentiality that they reinforce the fact that they will need to break confidentiality as this will facilitate any future working relationships with that client.

4 Managing difficult situations and understanding of mental health problems/ disorders

Due to the statistics which indicate that there are a very high number of clients with mental health problems/illnesses it is important that advocates have basic training in some of the more frequently diagnosed mental health problems (and possibly learning disabilities). One of the aims of such training could be to add to any training in personal safety which will build upon the advocate's confidence.

5 Maintaining independence

It is important that the advocate is both confident and competent at informing staff what their role is and that they stress the important of independence.

6 Communication

Advocates should be trained in basic communication skills and be able to identify the different methods of communication needed for different situations and clients. Communication needs to be in a format which is accessible to the client. Advocates should therefore be able to identify how they can work with a particular client's needs. Advocates should also be familiar with what is available in prisons to facilitate communication. Once aware, advocates will be able to offer informed choice about how the client can be supported to complain. Advocates should therefore be aware of the role of services such as language line in order that any use of these services is appropriate.

7 Prison terminology/jargon

Prisons have their own terminology and it is important that advocates are aware of what that terminology is. It is possible that this might be learnt by participating in a prison induction or alternatively from asking the prison staff when the Advocate first begins work in the prison.

8 Overview of the relationship between prisons and health

Advocates will need to be aware of the history behind the decision to pass responsibility for prison healthcare over to the NHS. They will need to know who the best person is to contact when a client wishes to make a complaint. Advocates will also need to know who is who within the prison set-up and the PCT set-up. As research has shown the differences in the way things will work across the country it is important that advocates are clear whether or not they approach the PCT directly or the prison healthcare unit.

9 Proposed Induction

In prisons which are low category/open it may be possible for advocates to join the induction given to all new prison officers. Permission to do this will need to be gained from the prison governor. This induction includes the following:

A talk about keys
A tour of all the units within the prison
Information about different prison terminology/ jargon

Advocates will need to be CRB checked and may also need to be PNC (police national computer) checked. Advocates will also need to ensure that they have had the required vaccinations; details of which vaccinations are needed will be provided by the prison. For the more high security prisons advocates will almost certainly be escorted around the prison by staff. In the absence of being able to shadow current prison advocates, I suggest that ICAS prison advocates shadow advocates who are currently working in acute mental health units.

Wish List

Although this section falls outside the remit for this report, we consider it highlights key issues for stakeholders which were captured at Focus Group sessions in Nottingham, Leeds and London and is useful to include for further consideration by the Department of Health.

At each Focus Group session, stakeholders expressed their urgent requirements for further information, and posed a number of key questions for the Department of Health which we recorded on flip chart. These appear below in list format.

Nottingham Wish List

How can we be faced with a statutory requirement in the absence of guidance?
How can we decide how an independent body will operate when we haven't got official ones yet?
Advice to stakeholders/IMB required about expectations
When is the consultation paper going to be finished? Will PCT's be copied in?
What interim measures does the Department want prisons to adopt?
We need something to give to prisoners on April 1st explaining how it works
Helpline with medical people for staff – who, where? If there is a helpline people need to know the number
Whatever goes on in the NHS must go on in HMP system also
Volunteer groups have no access to the intranets
Can NHS Prison Health Service access GP health records cost free?
Communication- once a decision on ICAS has been made, will ICAS send out detail to every prison?
Diversity agenda is very high in prisons (20ish languages in my prison alone)
My priority is healthcare not security
Name badge, what should go on it?
Fear that forensic may be missed, PCT is high on clinical governance but missing the forensic bit
Jail craft courses?
Can staff shadow?
ICAS should visit prisons also to understand perspectives and limitations
Lay conciliator, how will this work?

Leeds Wish List

Haven't got official statutory requirements ironed out yet, let alone ICAS Repercussions?
The NHS Complaints Procedure is still not finished
Who do we ask, who is in charge?
Need for advice
What are the proposals for interim measures?
We need something to give to prisoners on April 1st
Staff support?
Communication!!?
How will confidentiality work?
Need for information across organisations
Prisoners need to know
Self Help pack needs to include details about this
Things need to be published from the Centre and on the intranet
Clarity of purpose?
Prisoner friendly notices and correspondence necessary
Communication issues between stakeholders
There was supposed to be a report due out about all this, where is it?

London Wish List

Standardised procedure pathways
Proper training required
Prison process
Policy/procedures
Infrastructure
Support
Uniformity
National lead?
Where do we access support for issues when they arise?
Counselling may be required
Mental Health!!!
In the NHS not one person would feel comfortable going into prisons on 1st April 05
Understanding is it ours or another PCT's? Who's commissioning the service?
If GP/Dentist goes in, normally the practice would deal with it, but will they in prison? – depends on Service Level Agreement
Communication with prisoners so they know what it's about
Uniformity in prison setting
Whose responsibility?
Even within prison, staff only know about their own sections/wings etc

Board (Governor, PCT Lead StHA etc) Service Level Agreements who will make the decisions?

StHA's will not look at partnerships. Each has its own StHA lead, what about interaction with PCT's and staff?

Staff on the ground, delivering the service – very unsure of what's required

Healthcare lead within prisons, how will their role change? Where will they get advice?

Need to understand prisoner's rights i.e. access to paracetamol, creams – to be able to advise appropriately

IMB just explain to prisoners, you can't have that (sanitary protection, paracetamol etc) prison officer will be there to protect them

Guidance such as NICE guidance – How will they know it's appropriate?

Publicity/Literature – national/standardised. Checked by Crystal Clear English, prisoner checked also, don't recreate the wheel

Sharing good practice – StHA could step in. Something similar to PPI network required

Prison service – National Framework, need something similar to identify individual prison needs

We need regular events like today – bi-monthly events. I've learnt so much! There's been nothing else like it!

I'm concerned, expecting people to advise prisoners without any knowledge of environment and issues

Two systems coming together – they don't understand each other!

Legal Rights Issues. What's applicable to prisons – equity of service

How does it fit with the National Programme for IT? (NHS), is it compatible with NOMS?

Prison Service is a paper based system

If it's a lifer record it would cover this table

Prisoners have the same rights of access to information held about them as everyone else. It takes 10-15 man hours to prepare a lifer record to take the parts out they can't see

What happens to complaints, do they go to the Ombudsman or Prison Ombudsman?

IMB's can investigate, ICAS cannot, if IMB's take the lead how will this work?

Shipman Report – investigation teams? How will these function?

PCT – Private providers issues, with their own procedures. Inherited private contract made between prison and private provider

Time frame is a key issue. Awaiting loads of National decisions but the NHS Complaints Process will apply 1st April 05!

Confidentiality? Data Protection? Consent? And informed consent? Communication?

Information – how do you provide information to prisoners that there are 2 systems they can go through? Do prison health timescales apply

within prisons? Or do we work to 2 different timescales? Joint complaints how will this work? Escort/hospital visit?

How will prisoners access the Healthcare Commission? How will they be informed about the Healthcare Commission?

How will the Ombudsman offices work together? Need for clear agreed process including IMB and prison sign up and PALS involved

Information needs to go to all relevant people within the prison. Patients Forums still very new and still finding feet in the NHS without having to take on this as well. Need for review and prisoner involvement

Remand speed! We will need a quick turnaround within 4-6 weeks!

Huge number of solicitors coming through – at what point are they acting legally or as advocates? Will they be evasive?

Being looked at under litigation now whether 2 systems can work together up to a certain level

Touch screen money for the East Midlands on induction wings that can be loaded up on National and Local (ICONS on screen) can be regularly updated nationally (Legal Services have commissioned them).

Free Legal Aid is available to prisoners

StHA's need to be signed up for April 1st 05, if it's not right because we've rushed it are we stuck with it? Lots of issues arise after it will be written, complaints guidance is still in draft, when will it arrive?

Conclusion Table Highlighting Support for 5 Proposed Models

Support Key GREEN = high AMBER = moderate RED = weak/none

Model	Pros	Cons
Model 1	Equitable with generic ICAS	High cost/labour intensive
	Supports diverse needs of prisoners, literacy & language needs met	Security difficulties in accessing clients in prison
		Not all staff happy to visit prisoners
		ICAS capacity issues
Model 2	Less labour intensive/more cost effective	Prisoner limited time for access to telephone and lack of privacy on wing for sensitive calls
	Impact on capacity issues less marked	Literacy levels prohibit many prisoners ability to read Self Help Pack, write/read letters. Danger complaint will not be made
	Lower security issues	Not equitable with external ICAS service
		Breaks ICAS Core Principles of accessibility and inclusion
		Threat of Judicial review
Model 3	Partners have existing knowledge of system and security clearance	Partners unwilling to take on ICAS work, seen as specialist knowledge, majority of their staff volunteers
	Already trusted by inmates	High demand on ICAS for training and support
Model 4	As model 3 above	As model 3 above
	Higher level of knowledge required for Independent Review Panels	ICAS advocates feel taking client on at complex stage, unworkable
		Confusing for client
Model 5	Listeners already running in every prison with exception of YOIs	Prisoners would have access to confidential health information about their peers, potential to cause harm
	Evidence of reduction in recidivism	Training and supervision of peer workers time consuming, difficult to ensure consistency and access issues
	Availability of support 24 hours a day	Workload for peer support worker could be high
		Unlikely to work in YOI's & remand where the average length of stay extremely short

Discussion

Model 1

Model 1 received overwhelming support from key stakeholders, this is also the preferred model of the IMB. The model embodies all ICAS Core Principles and would meet the need of the diverse prison population particularly in relation to literacy and language.

This is also the preferred model for prisoners, 100% of whom stated that they would prefer a face-to-face meeting with an advocate to construct their complaint.

Prison governors felt that everything the service would require to become operational, such as security clearance, contact details for booking clerks, visiting procedures, would easily fit in with existing procedures. Governors also suggested that ICAS advocates could book visits within Visitor Centres which would simplify the process further.

The introduction of an 0845 number could be added to the prisoner pin list Nationally, and this procedure is extremely straightforward. It was stressed that a section on health and how to complain, understanding the difference between ICAS and PALs and how to contact them needed to be inserted into the prisoner induction pack which they all receive on arrival.

There are key security issues associated with this model such as: what areas of the prison would ICAS advocates have access to, how would their work complement the IMB and not get in the way, CRB checks will be costly, who will do the visit risk assessment and be responsible for the security of the advocate once on prison grounds.

Model 2

Model 2 was supported by a number of stakeholders and this was rated second to model one in the most preferred model option. Advocates unwilling to visit prisoners preferred this model also. The model is less labour intensive, and the ICAS capacity issues are less marked. The model cuts out many of the security issues, and the high travel and visit time each complaint would demand with the face-to-face model.

The model is, however, not equitable with the generic ICAS service, and legal advice suggests prisoners could pursue judicial review for discrimination against the Secretary of State for Health.

Major concerns with this model, was that prisoners have limited time available to make telephone calls, and often the telephone is not available until the evening.

Telephones are on the wing, and there is little opportunity for privacy when discussing confidential/sensitive information. Literacy levels are very low in prisons, and a wide range of languages are spoken, not all of which have a written format. It was felt that the lack of a face-to-face option may put some people off complaining.

Model 3

Model 3 received some positive support from stakeholders, particularly a Strategic Health Authority who commented

"I think the model proposing the use of a partner agency has a lot of merit. I assume this would/could be the IMB…"

It is important to note, however, that the IMB are unwilling to undertake this work on behalf of ICAS, and feel it would cause them considerable difficulties at their volunteers are unpaid and ICAS employs paid staff. Other stakeholders who participated in the research, particularly prisoner representative bodies felt the service required specialist knowledge and preferred to refer prisoners direct to ICAS rather than trying to undertake the work themselves. Stakeholders also spoke of the high demands on their time at the moment, and none other than two who returned completed questionnaires considered they had the time to take on this work.

Model 4

Model 4 was not supported. Advocates were particularly concerned at the thought of being asked to take over complex complaints at the stage of Independent Review Panel, without having built a working knowledge of the complaint or gathered an understanding of what outcome the prisoner is looking for. One ICAS advocate only felt supporting clients over the telephone or via correspondence could be useful, but lacked awareness of time constraints on telephone use in prisons.

There were particular concerns about recruitment and support of partner agencies to this model, who would screen them and supervision it was felt, could be extremely time consuming.

Everyone expressed concern that the model could be confusing for all parties, and the selection, training and supervision demand on ICAS time was considered very high.

Model 5

This model was considered unworkable in a YOI or remand setting. There was a suggestion that it could be considered in long stay establishments, but here also

support for this model was weak. The main areas of concern were, some prisoners may feel uncomfortable discussing personal matters with a peer. Training and supervision of peer support workers is time consuming and extremely difficult for an agency working on the outside. Confidentiality and abuse of information given in trust was a major concern. Fears of peer support workers becoming 'over burdened' was also a worry to many.

One suggestion was that 'Listeners' may be willing to take this on, however when consulted they felt this would compromise their role which was there to listen only. They also felt the skills would not necessarily transferable.

Another concern related to peer advocates needing to move around the prison to support complainants, and governors expressed concern about the potential movement of drugs in particular.

Regardless of the model/s chosen literature must be prisoner friendly, not everyone will understand what the NHS is and does particularly a population such as prisoners who have traditionally been very poor users of health services. The model must work with the prison regime in order to be accessible, and it must be able to cope with the rapidity with which people most around and in and out of the prison service. It may not be possible to have one model for implementation only, particularly in a remand setting where length of stay may only be days, and robust arrangements with external ICAS will be essential.

Communication with partners will be key to the success of implementation of ICAS into prisons. One governor made the point that all prisons are different, and commented *"where do the prison staff become involved in any of this? Prison officers have complete control over access to phones etc. If prison officers do not understand why a prisoner would need to access ICAS they won't allow them to do so."*

It became clear very early on in this work that two very different cultures within the prisons and PCTs are coming together rapidly, with little or no understanding of each other. There is an urgent need for National Guidance and support and for the issues raised in the wish lists contained in the report to be addressed.

GLOSSARY OF TERMS

CAB	Citizen's Advice Bureaux
CPS	Crown Prosecution Service
CRB	Criminal Records Bureau
DH/DoH	Department of Health
HMP	Her Majesty's Prison
IAO	Information Access Officer
ICAS	Independent Complaints Advocacy Service
IMB	Independent Monitoring Board
IND	Immigration and National Directorate
IRC	Immigration Removal Centre
IRP	Independent Review Panel
NOMS	National Offender Management Service
PALS	Patients Advice and Liaison Service
PCT	Primary Care Trust
POhWER	ICAS Provider in the East of England
PPI	Patient Public Involvement
SEAP	SouthEast Advocacy Projects
SHA/StHA	Strategic Health Authority
SIB	Self Injurious Behaviour
VO's	Visiting Orders
YOI	Young Offenders Institution

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