

**Training Needs Analysis to Identify Primary
Care Skills and Prison Specific Competences for Doctors
Working in Prisons (NR 02/001/7)**

Final Report to Prison Health Group (Department of Health)

by

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CONTENTS

	Page
Acknowledgements	3
Summary	4
1. The Context, Objectives and Methodology of the Project	8
1.1 Context	8
1.2 Objectives	9
1.3 Method	11
2. What the Papers Say: documents relating to doctors working in prisons	13
2.1 General Practice in Prisons: heterogeneity and equivalence	13
2.2 Issues in Training Policy	15
2.3 Identifying Training Needs	16
2.4 Health Care Needs of Prisoners	17
2.5 Professional Guidance for Doctors Practising in Prisons	18
2.5.1 Confidentiality	
2.6 Current Training Courses	19
2.6.1 Diploma in Prison Medicine	
2.6.2 New South Wales Correction Service	
2.7 Documentation Indicating Training Needs	22
2.8 Conclusions	24
3. Practitioners Talking: interviews of doctors working in prisons and governor managers responsible for health care	26
3.1 Interviews of Doctors	27
3.1.1 Personnel	
3.1.2 Work of doctors in prisons	
3.1.3 Similarities with primary care in the community	
3.1.4 Challenges for doctors starting work in prisons	
3.1.5 Health care challenges in prisons	
3.1.6 Training implications of health care challenges in prisons	
3.1.7 Training implications: non clinical	
3.1.8 Ethical issues	
3.1.9 Providing care equivalent to that in the community	
3.2 Interviews of Health Care Governor Managers	38
3.2.1 Personnel and function	
3.2.2 Health care problems and training needs	
3.2.3 Involvement in critical incident analysis	
3.2.4 Confidentiality	
3.2.5 Changes needed	
3.3 Tensions and Contradictions	41
3.3.1 How much involvement?	
3.3.2 Use of health care centre	
3.3.3 Changing the culture	
3.3.4 Fragmentation of primary care	
3.3.5 Doctor-patient relationship	
3.4 Conclusions	42

4. Doctors Identifying Their Own Needs: an analysis of a national survey of doctors working in prisons	44
4.1 The Respondents	44
4.2 Potential Training Needs: Clinical Conditions	48
4.3 Potential Training Needs: Patient Contexts	50
4.4 Access to Training	53
4.5 Summary	54
5. The Training Needs of Doctors Working in Prisons: priorities and issues	56
5.1 Training Need Priorities	56
5.2 Training Policy Issues	59
Appendix A: Doctor Interviews: the questions	61
Appendix B: Prison Governor-Manager Interviews: the questions	64
Appendix C: Prison Doctor National Survey	67
Appendix D: References	75

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SUMMARY

Context, Objectives and Methodology

1. While the need for training for doctors working in prisons is not in question, ambiguities remain over the boundaries of specialised prison training and general practice, and therefore by whom such training should be provided and resourced. Questions also arise over the boundaries between professional training, generic prison-related information and local induction.
2. With the transfer of responsibility for prison health care from the prison service to the National Health Service comes an obligation to provide care at a standard equivalent to that in the community.
3. Within this general context the research team was commissioned by Prison Health (Department of Health and Prison Service) to identify primary care skills and prison specific competences for doctors working in prisons.
4. The project has comprised two stages. Stage 1 was designed to produce a set of statements about training needs that could be used in a national survey in Stage 2. These statements were formed by a triangulation of (a) a Documentary Analysis, (b) an Interview Programme of general practitioners and health care governors and managers in selected prisons, and (c) comments from members of an Expert Panel on (a) and (b). In Stage 2 a national survey of doctors working in prisons asked respondents to prioritise identified needs.

What the Papers Say

5. Documents relating to doctors working in prisons reveal a varying and changing context for general practice in prisons including the implications for providing care equivalent to that in the NHS, changing legal obligations and issues of training policy.
6. There are various documented approaches to identifying training needs for doctors working in prisons. On the basis of these approaches, health needs of prisoners (2.4), professional guidance (2.5), some current training provision (2.6) and training needs are identified:
 - (a) mental illness, drug misuse, and communicable disease as health conditions; and
 - (b) team work, health promotion, advocacy, clinical governance and aspects of medico-legal application as aspects of health care management.

Interviews of Doctors and Governor-Managers

7. The semi-structured interviews of a sample of doctors working in prisons compare their work with community-based primary care (Section 3.1.3), identify the challenges for doctors starting work in prisons (3.1.4), the continuing health care challenges (3.1.5), clinical (3.1.6) and non clinical (3.1.7) training implications, ethical issues (3.1.8) and barriers to providing primary care in prisons to an equivalent standard to that in the community (3.1.9).
8. Interviews of a sample of health care governor managers reveal perspectives on health care problems and training needs (3.2.2), critical incidents (3.2.3), confidentiality (3.2.4) and changes needed for doctors to work more effectively in prisons (3.2.5).

9. The interviews identify a number of tensions and contradictions in general practice in prison as seen by these two groups of practitioners (3.3) over the extent of doctor involvement, use of the health care centre, prison culture, fragmentation of primary care, and the doctor-patient relationship. But the considerable diversity of views makes it difficult to generalise them (3.4).

The National Survey

10. The survey instrument comprised statements derived from the foregoing analyses of documents and interviews, advice from the project Panel of Experts and Steering Group.
11. Of the responding doctors (Section 4.1), at least one in eight (12%) practised exclusively in prison without any external sessions. However, fewer than two fifths (38%) were employed directly by prisons. Although a majority (58%) cared for mentally ill in-patients, most doctors lacked training in psychiatry. The majority regard themselves positively as integral members of the prison healthcare team and recognised their leadership, change management, and advocacy roles. They were clear, however, that generic training in the community was not sufficient for prison practice.
12. Although from a variety of establishments, with differing patterns and length of experience, our respondents generally demonstrated a high degree of consistency in prioritising training needs relating to clinical conditions and patient contexts in custody (4.2 and 4.3).
13. Generally, as might be expected, they gave highest priority to conditions that are more prevalent or peculiar to the prison population. Similarly, they gave the lowest priority to generic conditions, i.e. those met commonly in generic general practice. Thus they prioritised conditions relating to substance abuse and violence, mental health and GUM above general chronic conditions such as asthma and heart disease (4.2).
14. Similarly, contexts more specific to prison were prioritised ahead of those generic to practice in the community. Thus aspects of custodial discipline that challenged professional medical ethics such as hunger strikes, dirty protests and the relationship with prison authority were prioritised ahead of inter-disciplinary and sector working, access to secondary and tertiary care and supervision of students.
15. Respondents had met barriers to accessing training including lack of funding, information and provision (4.4).
16. Although differences of experience, types of establishment and employment status are much less significant than the generally consistent agreement over the needs and priorities for training, some of the differences that emerge are nevertheless of interest.
17. Doctors with more than 10 years experience, for example, afforded lower priority to stress, schizophrenia and paranoia, to the criminal justice and prison system, and how dirty protests are managed and comparatively higher priority to professional ethics in prison, service planning, seeing prisoners before adjudication and assessing fitness to attend court. They found fewer difficulties in accessing training.
18. Prison employed doctors gave more training needs a high priority compared to their community employed colleagues. They attached more importance to training in prescribing, medico-legal reports, mental health legislation, consent, managing critical incidents, complaints, and relating with prisoner patients. But they gave lower priority to training needs in

human rights, custodial priorities for governors, and the role of the PCTs. They also found fewer difficulties in accessing training.

Priorities and Issues

19. There is a distinctive challenge in realising a standard of healthcare in prison equivalent to that in community general practice. The analysis of documents relating to prison health and our interviews of doctors and healthcare governor-managers identified a wide variety of clinical conditions and custodial contexts with which general practitioners should be trained to deal if this challenge is to be met.
20. The survey findings show a matrix of training priorities (high, medium and low) and conditions (clinical and contexts).
21. The highest training priorities are in **'exclusive' and 'special interest' competences** in clinical conditions and patient contexts.
22. Training in 'exclusive clinical competences' might be provided through a dedicated national programme and that in 'exclusive patient contexts' by and with the Prison Service.
23. Training in 'special interest clinical competences' might be provided through arrangements with postgraduate deaneries that ensure ready access to programmes and opportunities such as those available to GPs developing Special Interests. Training in 'special interest patient context competences' might require similar working with the Prison Service to ensure that there are appropriate programmes and that general practitioners have access to them.
24. Finally, many of these needs are shared by nurses and other medical practitioners. Reciprocally, members of the prison service staff have training needs in dealing with the effects of clinical conditions. The desire for multidisciplinary practice might be met in appropriate joint training.

Section 1: The Context, Objectives and Methodology of the Project

Some developments in prison health care are set out to provide a context for the study and its objective to identify primary care skills and prison specific competences for doctors working in prisons. The section also describes the methods adopted by the study.

1.1 Context

Prisoners present particular health problems.¹ Although they are a relatively young population (about 60% under 30 years old), they have greater than average need of care notably for mental health problems, communicable diseases and drug-related conditions. There are more than a quarter of a million prison receptions per annum for a prison population of over 70,000. They live in enclosed institutions where communicable disease can flourish and spread to the community at large if not contained and handled appropriately. Moreover, prisoners frequently fall through the NHS net thus aggravating problems arising from social deprivation, poor education, and unhealthy life styles.

Perhaps because an organised healthcare service for prisoners predated the National Health Service by about 100 years, healthcare professionals in prison have worked largely separately from mainstream healthcare. Furthermore, the culture found in prison health care centres is likely to be influenced as much by the custodial nature of the institution as by its function as a place of healing. These factors may well have contributed to some of the idiosyncrasies evident in prison healthcare today. Certainly for many it is a Cinderella service dogged by poor image, problematic recruitment and retention of staff, inadequate evidence on which to improve health care, professional isolation and inadequate training and development facilities. It is clear that if major improvement is to be achieved in prison health care considerable and imaginative investment will be needed especially through the training of its doctors.

Whilst there is undoubtedly a perception that health care in prisons differs from that in the community, there is little agreement as to the nature of the difference and what its implication might be for training. There is no national recognition of it from the British Medical Association (BMA) or any of the Royal Colleges. There is an association of nurses in Forensic Nursing but this originates from the special hospitals that in many respects are very different from prisons. Following the Hoffenberg report into the recruitment and training of doctors in the healthcare service for prisoners, the Prison Service in conjunction with the Royal Colleges of Physicians, General Practitioners and Psychiatrists, inaugurated a Diploma Course in Prison Medicine which is delivered by the Department of General Practice at Nottingham University. The key taught components of the course include General Practice, Psychiatry, Public Health, Substance Misuse and Blood Borne Virus Infection. In addition, elements of law and ethics are included.

A key recommendation of *The Future Organisation of Prison Healthcare* (1999) was that all doctors working in the role of Prison Medical Officer should possess the joint certificate in post-graduate training in General Practice. Although this and other documents (e.g. Marshall et al., *Health care in prisons: a health care needs assessment*, University of Birmingham 1999), recognised the general practice nature of prison medicine there has been very little research into

¹ This section draws on Pearce et al 2001.

primary care in prisons. The Prison Service itself has tended to place emphasis on topicality, highlighting issues such as HIV, sexually transmitted diseases, substance misuse and mental health. Thus, the psychiatric aspect of prison medicine has perhaps received the most widespread coverage. These emphases, however, have distracted attention away from the fact that most health care in prisons is primary care.

Prison Rules were translated into an operational code of working called Standing Order 13 which set out the parameters within which a doctor may practise. These have now been replaced but there remains a requirement to provide healthcare services of the same range and standard as that which is expected in the NHS (the principle of equivalence). This will become an operational reality as Primary Care Trusts take over from the Prison Service the responsibility for the health of their prison populations.

The process of gaining equivalence will have to acknowledge that primary care in prisons is delivered currently by a variety of arrangements of which the following models seem predominant:

1. One or more directly employed full time doctors supported by a mix of healthcare officers and nurses;
2. Primary care provided by NHS GPs who work a set number of sessions supported again by a mix of healthcare officers and nurses;
3. As in 1) with the support of local GPs and a variety of contractual arrangements providing secondary care services including pharmacy;
4. The entire Health Care Service contracted out to local practitioners;
5. Primary Care provided by clustering arrangements between several prisons.

That these delivery arrangements provide a considerable challenge to the provision of equivalence is beyond doubt. Moreover, they add to problems associated with a context of under investment in prison health care including in the dedicated training of its general practitioners.

1.2 Objectives

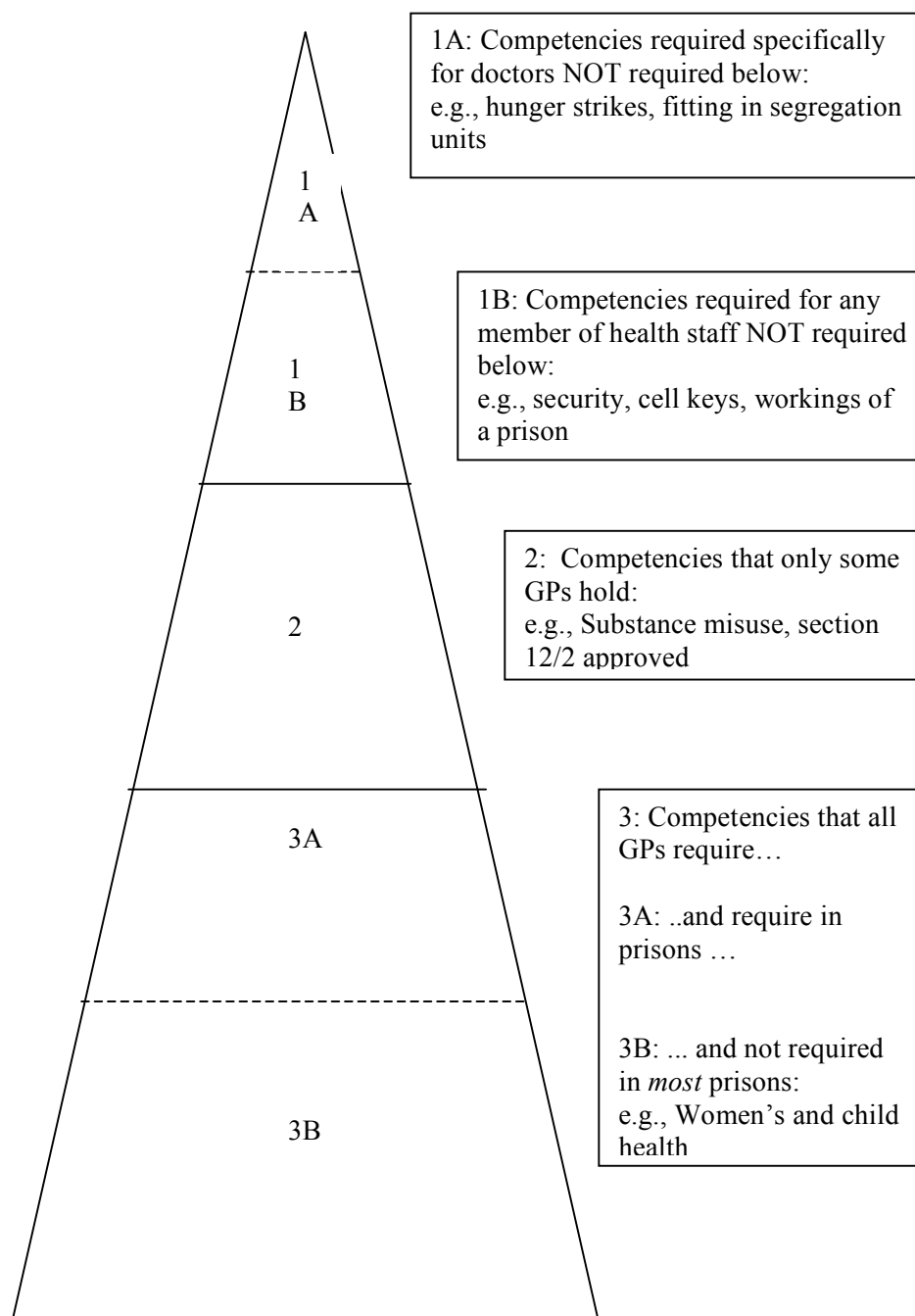
In the light of this context, the Prison Health Group of the Department of Health and Prison Service thus commissioned this investigation **to identify primary care skills and prison specific competences for doctors working in prisons**. In the early Steering Group discussions that shaped this project, Dr Cliff Howells expressed the competences required of doctors working in prisons in terms of a competency triangle (See Figure 1.1). At its base are those generic competences required by all general practitioners whether or not they are required for prison practice (Level 3). Above these are special interest competences that as a result of experience or particular interest only some general practitioners possess (Level 2). And beyond these are competences which general practitioners require by virtue of the uniqueness of prisons but will not have acquired in general practice (Level 1).

The research team drew on this conceptualisation to guide its investigation. It was interested specifically in the:

- (1) validity of distinguishing conceptually and operationally between:
 - (a) *exclusive competences* required only for doctors working in prisons, i.e., in Howell's terms, the Level 1 competences not required in Levels 2 (special interests) and 3 (generic practice); and
 - (b) *special interest competences* (i.e., at Level 2) that, although applicable to practice in the community, are particular strengths of doctors working in

- prisons because of the prevalence of conditions they were required address; and
- (2) implications of any such distinctions for the provision of training.

Figure 1.1: Howells' Triangle of Competences of Doctors Working in Prisons (Source: paper provided by Dr Howells)



1.3 Method

The project has comprised two stages. Stage 1 aimed to provide a set of statements of the principal training needs of doctors working in prisons. These statements formed the basis of Stage 2, a national survey of training needs that was administered to all prison establishments.

Stage 1:

This stage was designed to produce a set of statements about training needs that could be used in the national survey in Stage 2. These statements had to be based on the specific context of prison general practice and the imperative to move towards providing a standard of care equivalent to that provided in the rest of the NHS. The approach in this stage was a triangulation of:

1. **Documentary Analysis** of:

- a) Documents relating to the primary care areas, roles and functions of doctors working in prisons;
- b) Health Needs Assessments of Prisons insofar as they related to prison specific area, functions and contexts of doctors working in prison;
- c) Education and training programmes for general practitioners including the Nottingham University postgraduate Diploma for doctors working in prisons.

2. **Interview Programme** designed to provide qualitative information about the key areas, functions and contexts of general practitioners in prisons. Interviews were conducted with:

- a) Two general practitioners (including the lead clinician) in selected prisons in the County Durham and Tees Valley Strategic Health Authority area (see Figure 1.2);
- b) One health care governor or manager in each of the selected prisons.

**Figure 1.2: County Durham and Tees Valley
Selected Prison Establishments**

The prisons were selected as a regional group to reflect a range of security categories for female, male and young offenders.

Prison	Sex	Remand	Convicted	Special Features	Health Focus
Deerbolt	Male		Young Offender	Rehabilitation emphasis	Primary
Durham	Male	Adult	Adult	Local prison Special control units	Primary, Psychiatry
	Female		Adult	High Security (A) only	Primary, Psychiatry
Frankland	Male		Adult	High Security (A) only	Primary, Forensic
Holme House	Male	Adult	Adult	Local Prison	Primary, Drug therapy
Low Newton	Female	Adult	Adult		Primary, Drug therapy
		Young Offender	Young Offender		

3. An **Expert Panel** that commented on:

- a) general validity of the findings and issues raised by (1) and (2);
- b) differences and similarities between generic general practice and prison general practice and the implications for training needs;
- c) implications of equivalence for prison and community general practice.

Stage 2:

Stage 2 used the Stage 1 statements as the basis of a survey administered to all doctors in the Service. Respondents were asked to prioritise identified needs. Their responses were analysed in terms of the Stage 1 findings to identify general training needs. Preliminary findings were presented to a dedicated session of the Third Durham Prison Health Symposium in September 2003. These needs have been further analysed for this Report.

Our findings are presented in the following sections. Section 2 discusses documents relating to doctors working in prisons, Section 3 reports the main themes arising in a pilot set of interviews of doctors working in prisons and the governors and managers responsible for health care in their prisons. Section 4 presents the main findings from a national survey in which doctors working in prisons identified their own needs. Finally in Section 5 we conclude and discuss some of the issues that this research has raised about the training needs of doctors working in prisons.

Section 2

What the Papers Say: documents relating to doctors working in prisons

This section sets out the documentary analysis and its identification of training needs. The analysis contextualises the analysis of training needs rather than provides a comprehensive literature review of prison health care. It first addresses the context for general practice in prisons including the implications for providing care equivalent to that in the NHS (Section 2.1) and issues of training policy (2.2). It then describes approaches to identifying training needs for doctors working in prisons (2.3). Consistent with these approaches the Section then considers documented health needs of prisoners (2.4), GMC guidance (2.5) and some current training provision (2.6). The Section concludes with a summary of potential training needs identified from a variety of documentary sources (2.7).

2.1 General Practice in Prisons: heterogeneity and equivalence

In its paper on *Developing and Modernising Primary Care in Prisons*, the Department of Health and HM Prison Service (2002) observed that:

Good primary care is the essential foundation on which any good health care system is built and this is especially the case in prison settings. A well trained and effectively managed primary health care team can make a tremendous contribution to improving the overall quality of health and health care services for prisoners.

The effective training of the primary care team requires an analysis of training needs of doctors working in prisons that includes questions about the levels of training of individual doctors, the adequacy of specialist general practitioner training for providing care within a prison context, and the extent to which policy and legislative changes, in particular the principle of providing health care in prisons which is equivalent to that in the community, creates new training needs.

Doctors working in prisons are not a homogenous group with respect to qualifications, ways of working or modes of employment. In line with the view that most health care in prisons is primary health care, since 1999 all new and existing medical officers who provide primary care in prisons need a certificate from the Joint Committee on Post Graduate Training in General Practice (JCPTGP), or have an 'Acquired Right to Practise'. A survey of all 713 doctors working in the prison service, carried out to inform the report of the Working Group on Doctors Working in Prisons (Department of Health, 2001), showed that a small number did not hold a qualification in general practice and recommendations were made accordingly (para. 11.8). Only seven per cent of doctors working in prisons have formal psychiatric qualifications (House of Lords, written answer, 22 January 2003).

Moreover, prisons differ in their populations, in the health needs of their prisoners and in the ways that healthcare is provided. Marshall et al. (1999) point out that local prisons (with a high turnover) have the highest incidence of physical and mental ill health, training prisons and high security prisons have more physical disorders and the need for health education and health promotion, and women's prisons raise different issues and also have higher consultation rates. Finally, in young offenders' institutions, 'temperamental,

emotional and behavioural problems that manifest as self harm and suicidal behaviour' are more common. Thus different kinds of prisons may have different implications for training.

The principle that prisoners are entitled to the same level of medical care as people living in the community is recognised in most European countries (Council of Europe, 1999). Prison health care in the UK is changing in response to the principle of equivalence with NHS care, the case for which has been argued for at least 40 years (Reed and Lyne, 1997). More recently, it was recommended in *Patient or Prisoner?* (HM Chief Inspector of Prisons, 1996), expressed in the *Future Organisation of Prison Health Care* (HM Prison Service and National Health Service Executive 1999) as a formal partnership to secure better health care in prisons, and finally accepted following the *Report of the Working Group on Doctors Working in Prisons* (Department of Health, 2001).

The *Health Services for Prisoners (July 2002) Standard* (Department of Health 2002) provides prisoners with access to the same range and quality of services as the general public receives from the National Health Service (NHS). From April 2003, funding responsibility for the prison health services was transferred from the Home Office to the Department of Health and between 2004 and 2008 the responsibility for prison healthcare will be transferred to primary care trusts. Moreover, the principle of equivalence is promoted through Prison Health, an amalgamation of the Prison Health Policy Unit and the Prison Health Task Force.

The realisation of equivalence will open up the same processes of clinical governance and continuing professional development which are the norm within the NHS. They will also expose differences of culture and definition. For example, a study of significant event analysis in prisons (Fox et al. 2001) showed differences in the ways this activity is understood and in attitudes towards it in both the NHS and prison service. In the latter, for example, it is largely related to security and deaths in custody. Integration with critical incident analysis as part of clinical governance culture within the NHS, and as a means for improving quality of services will therefore require new processes to be set up and training across health care staff to narrow the gap between these two definitions.

Training needs for doctors working in prisons will also be influenced by how far a model of primary care which is provided by multidisciplinary teams with easy access to specialist care can, in practice, be replicated across the prison health service. The principle of equivalence implies that referral practices mirror those in the community, although there would be more frequent referrals given the greater health care needs of the prison population. Training needs will be influenced by the extent to which there is true 'referral equivalence'.

Equivalence of care and the centrality of primary health care both in prisons and in the community are thus now accepted principles. However, there is some dispute about the implications for training of the differences between providing routine primary care in prisons and routine primary care in the community. There are differences, for example, between a practice population and a prison population in relation to health needs, notably co-morbidity, mental health needs and problems deriving from substance misuse, and in the intensity of health problems in a population which is typically multiply deprived. Added to this are health care needs which result from the stressors of the prison environment which may include self harm, suicide and neurotic disorders. Marshall et al (1999) point out, for example, that primary health care needs are often 'overshadowed by health care needs related to offending behaviour such as substance misuse and mental health problems'.

The provision of health care within prisons also gives rise to specific organisational and ethical challenges in relation to the doctor-patient relationship, access to care, management arrangements and referral procedures. For example, a doctor should not be asked to certify that a prisoner is fit to undergo punishment and a failure to remove seriously mentally ill people from prison breaches article three of the Human Rights Act 1998. Providing health care in prisons gives rise, therefore, to numerous ethical tensions which are rare in community general practice.

Routine primary care in prisons clearly differs from routine primary care in the community, which raises the question of whether these differences require professional training which is specific to prisons, in addition to that reflected by the JCPTGP, and if so what forms it should take. There are different views on this question. For example, the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT) (Council of Europe, 1999) considered that 'specific features of the provision of health care in a prison environment may justify the introduction of a recognised professional specialty, both for doctors and for nurses, on the basis of postgraduate training and regular in service training' (para. 77). In a similar vein, in 1998, the Council recommended that:

prison doctors should be well versed in both general medical and psychiatric disorders. Their training should comprise the acquisition of initial theoretical knowledge, an understanding of the prison environment and its effects on medical practice in prison, an assessment of their skills and a traineeship under the supervision of a more senior colleague. They should also be provided with regular in service training'.

(1998, Recommendation No R (98)7).

Others, however, including some of the doctors working in prisons interviewed as part of this project, consider specialist training in primary care to be sufficient.

Thus the context of prison health care is changing. Equivalence with the NHS has implications for training needs in relation to service priorities and policy imperatives. For example, equivalence involves implementation of the National Service Frameworks and the national strategy for the prevention of suicide. Likewise, doctors need to be kept up to date with legal obligations and broader international agreements and policies on prison health care, including those of the World Health Organisation.

2.2 Issues in Training Policy

The temptation to recast wider problems in providing health care in prisons as the training needs of practitioners has been recognised. For example, the Working Group on Doctors Working in Prison (Department of Health 2001) noted that the expansion of mental health care in prisons would help avoid primary care doctors taking on secondary care needs in this area (para. 6.15), that clinical audit could not be carried out in the absence of computer facilities and that some performance problems emanated from the system in which doctors operated (para. 10.3). The extent of training required partly depends, therefore, on the nature of improvements in place locally.

There are also different attitudes towards what additional training is needed, who should carry it out, how it should be funded and whether there should be a specialised and validated prison-specific training programme. How

these questions are answered will influence the nature and extent of additional training considered important for doctors working in prisons.

Moreover, there are distinctions between training, induction and information. There are already worked examples of the kinds of information that should be routinely available for new entrants to health care in prisons (see, for example, Department of Health 2001, Appendix G), and a recognition of the need for induction programmes tailored for more experienced doctors working in prisons or for visiting consultants. Induction-related information can be divided into several categories:

- Routine information common to all prisons (and for all health care staff);
- Routine information relevant to the prison in question: local conditions and procedures;
- Prison-specific administrative duties for doctors (such as medical assessment on reception and transfer and before release, parole reports, custody reports, psychiatric reports and court orders).

Perhaps more complex, however, are areas where there is not only information to absorb but also room for interpretation and the potential for tension between professional and custodial demands. This includes a wide range of medico-legal and ethical issues including those arising from the Human Rights Act, 1998. The question arises whether these are to be considered areas for professional training or for induction. The answer to this will influence decisions on how this is to be provided and funded.

2.3 Identifying Training Needs

Training needs for doctors working in prisons can be identified through a number of different routes.

- *Interviewing doctors working in prisons* in order to identify challenges in their work and their views on how training could support them in their role. While doctors working in prisons are increasingly involved in framing and informing policy (as in the working group for *Doctors Working in Prisons* and in the report on *Good Medical Practice for Doctors Providing Primary Care in Prisons*), there have been few attempts to research their views (but see, for example Smith (1984) and Pettinari (1996)). To this end, a sample of doctors working in the Durham prison cluster was interviewed in March 2003 (see Section 3 below).
- *Identifying the health care challenges of the prison population*. Health needs assessments have been carried out in each prison for each of the last two years. Section 2.4 below summarises some of the findings from the health care needs assessment of the national prison population.
- *Professional guidance* over good medical practice in prisons (see 2.5 below).
- *Analysis of issues covered through specialist courses for doctors working in prisons* (see 2.6 below).
- *Documentation which indicates a training deficit*. Our focus is on national policy documents (2.7). Although the reports of HM Chief Inspector of Prisons, Confidential Enquiries into deaths in custody, critical incident analyses and reports from the Prison Ombudsman are also relevant they are not included as part of this documentary analysis as they are prison specific. However, prison specific research has highlighted specific areas such as the nature of the initial screening

programme (now revised) and poor levels of counselling before and after testing to establish HIV or hepatitis. Thus they might be appropriate for inclusion in any future more in depth considerations of training for doctors working in prisons.

A training programme needs to anticipate short and longer term changes which are likely to affect an organisation. Key forces for change in the organisation and policy context of prison health care are the concepts of equivalence between the NHS and prison health care, the statutory framework of prison general practice, the concept of health promoting prisons and of prison as an opportunity for addressing health needs which have been neglected, health promotion for a group by definition socially excluded, prisons as whole systems and working in partnerships with other organisations, and national policy priorities such as the prevention of suicide.

By definition, training is a dynamic process and is partly a response to continuing processes of audit and review. There are increasing numbers of GPs providing care in prisons on a sessional basis and the number of doctors working full time in prisons is declining. These changes will contribute to breaking down the barriers between prison health care and health care provided in the community, help reduce the isolation of doctors working in prisons, provide a framework for activities ranging from clinical governance to opportunities for research and will help build up medical networks around prison health care. (Arrangements for clinical governance and designated clinical lead details are in place following PO 3100, 2003). These issues are discussed in more detail below.

2.4 Health Care Needs of Prisoners

The prevalence and incidence of health problems in prisoners are well documented nationally and also now emerging from the two rounds of local Health Needs Assessments carried out in prisons, latterly in conjunction with PCTs. Marshall et al. (1999) have comprehensively documented health needs of prisoners as a whole:

- a) Suicide is eight times more common in the prison population (and higher among remand prisoners) and 42 per cent of suicides happen in the first 28 days of custody;
- b) Almost half of all prisoners suffer from a neurotic disorder (in any one week);
- c) Over half of young prisoners on remand have a diagnosable mental disorder;
- d) One in ten prisoners has suffered from a psychotic disorder in one year;
- e) Self harm is reported in one in 60 prisoners a year with greater frequency in the remand population;
- f) Half of all prisoners are heavy alcohol users and hazardous drinking seems to be twice as common in male prisoners and about three times as common in female prisoners compared with the general population;
- g) Half of remand prisoners and 40 per cent of sentenced prisoners have been dependent on drugs prior to imprisonment, and about one quarter of prisoners have injected drugs at some time;
- h) Almost half have no educational qualifications;
- i) Thirty three per cent of male prisoners and 29 per cent of females on remand were in local authority care;

- j) The majority have experienced three or more stressful life events at some time;
- k) Physical health of prisoners is worse than that of people of equivalent age in the general population;
- l) One in four adult prisoners was at risk of HIV infection and about one in ten prisoners had antibodies to Hepatitis B and Hepatitis C (1997 figures);
- m) Tuberculosis is more common in the prison population than in the wider community and it is possible that all cases are not detected;
- n) Six per cent of prisoners were known to have a disability (1997 figures);
- o) Prisoners have low levels of social support.
- p) Over half of male prisoners and almost a third of female prisoners have an anti social personality disorder;
- q) Ten per cent of men on remand had suffered from functional psychosis in the last year;
- r) Prisoners have more frequent consultations for less important medical problems than in the community (partly due to lack of informal care); and
- s) Admission rates for health care centre beds are very high.

In summary, Marshall et al. conclude that 'the greatest health care needs among prisoners are for services for mental health, whereas the greatest health care demands are for the treatment of minor illness' (p. 125). A survey of mental ill health in the prison population of England and Wales (ONS, 1997, quoted in Marshall et al., 1999) estimated that around 90 per cent of prisoners suffered from at least one of the following conditions: personality disorder, psychosis, neurosis, alcohol misuse and drug dependence.

2.5 Professional Guidance for Doctors Practising in Prisons

For the purposes of validation, the GMC has produced guidance on expectations of doctors as a profession, and of general practitioners. All doctors have a professional responsibility to comply with these principles. *Good Medical Practice* was recently expanded (Department of Health 2003) to include issues relevant for doctors working in prisons. Under the same seven key headings (good clinical care, maintaining good medical practice, relationships with patients, working with colleagues, teaching and training, assessment and appraisal, probity, health and the performance of other doctors), issues of particular relevance to doctors working in prisons were highlighted. Many of these underline the primacy of the medical role, the duty to speak out against inadequate premises or equipment for providing medical care and to 'facilitate, monitor and be an advocate for appropriate access to continuing secondary care for prisoners'.

This guidance makes it very clear, however, that while doctors working in prison may encounter many ethical challenges, they are also to act as advocates, to change traditions which work against effective medical care, whether this applies to equipment, access, arrangements for secondary care or for flows of information between the community and the prison. For example, in relation to the poor flow of information between prisoners' GPs and their doctors in prison, the GMC update states 'doctors working in prisons have a responsibility to change this tradition'. In relation to access, they comment 'any structural and organisational blocks to access should be identified by the doctor and efforts

made to resolve any issues in partnership with Prison Service Management'. In relation to emergencies they must be 'satisfied that delays are minimised'. This emphasis suggests a proactive, change management and leadership role for doctors in prisons and, therefore a possible training need.

2.5.1 Confidentiality

International and national medical associations have long recognised the many potential ethical tensions for doctors working in prisons and issued declarations by which doctors are bound. However, it has been argued that the United Nations' Declaration on the Principles of Medical Ethics (1981), the World Medical Association's Declaration of Tokyo in 1975, and the World Psychiatric Association's Declaration of Hawaii in 1983 are not commonly available to doctors working in prisons 'who face difficult ethical decisions daily' (Reed and Lyne 1997). Principles of confidentiality and of consent within the prison setting are key areas where guidance has been produced (General Medical Council, 2000). Detailed guidance on hunger strikes for doctors is provided in the World Medication Association's Declaration on Hunger Strikers (1991).

In principle, patient confidentiality in prisons is equivalent to that in the community. Bar exceptional circumstances, information on a patients' health is restricted to those with a genuine need to know, confidential consultation is to be maintained subject to a risk assessment, and free consent obtained. However, there are exemptions and exceptions and the scope for compromise, misconception and interpretation is large. Guidance on the use of confidential health information states that 'information can be shared without consent if it is required by statute or a court order'. Disclosure without consent can also be made in exceptional circumstances if it is considered essential to protect the individual or anyone else from risk of death or serious harm, or for the prevention, detection or prosecution of serious crime. In such circumstances, the benefits of disclosing the information must be considered to outweigh the patient's or the public interest in keeping the information confidential. The GMC points out that 'there is a fine line of judgement to be made here between respecting patients' rights to a confidential consultation and safeguarding the health care team and the security of the prison'.

Medical confidentiality may thus be adversely influenced by the conflicts of interests in a prison setting. The International Committee of the Red Cross remarked that 'prison governors sometimes tend to think that there is 'no such thing as confidentiality in a prison'. This is certainly not justified' (1996). It may be that governors, discipline officers and others take the view that they are entitled to unimpeded access to, for example, a prisoner's health records. However, it has been pointed out by the Royal College of Psychiatrists (2002), in its response to the *Thematic Review on Suicide in Prisons*, that some doctors used medical confidentiality 'as a device to avoid passing on important, perhaps life saving information about particular prisoners' mental states'. This suggests that this is a complex area and one in which doctors working in prisons may require additional training and guidance.

2.6 Current Training Courses

There are few examples of training programmes which attempt to encompass all dimensions of prison health care, although there are numerous separate training programmes for aspects of care, such as drug misuse, which are particularly relevant for doctors working in prisons. This section outlines the

Diploma in Prison Medicine developed at the University of Nottingham as one of the few examples of the former and an RCGP Certificate which has also attracted doctors working in prisons as an example of the latter. Also included is a brief outline of what is considered relevant for training doctors working in prisons from the viewpoint of the New South Wales Correction Service in Australia.

2.6.1 Diploma in Prison Medicine

Described as a world first, the Diploma in Prison Medicine, a conjoint Diploma of the Royal College of Physicians, Psychiatrists and General Practitioners was launched in 1996. Funded by the prison service and provided by the University of Nottingham, it is a two year Diploma with ten taught modules, each of three days duration. Delegates are encouraged to carry out an assessment of their own learning needs at the beginning of the course.

The course is a combination of material related to primary care in general, material which would often be subject for referral (such as genito-urinary medicine) and prison specific issues, including medico-legal aspects, special groups in prisons and practical sessions in prisons. A great deal is covered in a short space of time. For example, in the handbook for 2002-3, for Module one, the needs of eight special groups of prisoners and eight special cases (such as self harm and food refusal) are all covered within a single 90 minute session in the first module with a 90 minute session on suicide/para-suicide in module six.

Details of the programme's modules can be found in the Diploma Handbook (2002-3). In summary, they are organised around the following themes:

1. *Primary care and audit* including medicine and society; primary care teams, case conferencing, appropriate referral, needs of special groups of offenders, chronic diseases; principles and practice of audit and clinical governance including significant event audit; causes and effects of personality disorders, learning difficulties and offending behaviour; the module includes a practical prison-based session and one of the days is devoted to delivery of primary care within the prison environment;
2. *Public health* including relevant partnerships, health data and health needs assessment, health and health promotion, evidence-based practice, screening and communicable disease (in association with occupational health and Genitourinary medicine);
3. *Genitourinary medicine* including diagnosis, investigation and management of all common STIs, issues related to HIV including palliative and terminal care, vaccination for hepatitis A and B, patient confidentiality, health education and notification, safety of residents and staff;
4. *Health Service Management and IT* including organisation and management theory, management of change, negotiating strategies, team roles and leadership styles, role play and dealing with conflict;
5. *Primary care and audit (second module)* including managing chronic disease, problems of women and infants in prisons and clinical issues in relation to 'problematical medical disorders in prisons';
6. *Psychiatry* including the relationships between prison and wider psychiatric services, mental disorders and their management, substance misuse and its effects on offending behaviour, legal and ethical dilemmas;
7. *Medico-legal aspects* including a critical understanding of the legal and ethical framework, standards required for patient care, rights of prisoners with

- respect to medical treatment, Mental Health legislation and Parole Board procedures, Human Rights Act;
8. *Psychiatry/medico legal* including law of prison medicine including case studies, doctor skills in a legal context, Coroners Court, Prison Ombudsman and Parole Board (plus overlaps with previous two modules);
 9. *Psychiatry* covers issue of security, homicide and defences to murder, women and ethnic minorities in secure settings, sexual offenders, fitness to plead, psychiatric reports and institutionalisation;
 10. *Occupational health* covers key issues for occupational health in prisons including workplace hazards, fire safety, radiation, infectious diseases, Health and Safety responsibilities, environmental health and prisons and ethics of occupational health.

2.6.2 New South Wales Correction Service

The New South Wales Correction Service is also working along similar lines. Its Director, Dr Richard Matthews, a member of our Expert Panel, outlined for us the elements of medical training for prisons:

- i) the philosophy and aims of incarceration, including a section on prisoners' rights or prisoners as citizens and a brief history of prisons. Socioeconomic and health status to include their relationship to offending;
- ii) mental health issues: prevalence, assessment and treatment, including a section on the law and an understanding of forensic status;
- iii) drugs and alcohol: an understanding of the pharmacology and effect of all licit and illicit mood-altering drugs, assessment skills in intoxication and withdrawal states, a thorough understanding of the treatment of withdrawal and a knowledge of all the treatment modalities including the prescribing of pharmacotherapies such as methadone and buprenorphine;
- iv) public health: prevalence of communicable disease, an understanding of prisons as "vectors" in the spread of infection to inmates, staff and the broader community. Understanding of the concept of "healthy prisons" and all the environmental factors that contribute to this;
- v) primary health in general but with a real emphasis on the multiple morbidity of this population and the array of socioeconomic and health deficit;
- vi) women in custody, special needs, children in with them;
- vii) medical ethics in the prison environment to encompass a debate as to how the service ought to be constituted, i.e., as part of the general health system or funded and directed by the justice arm; this module should explore the relationship between health care provider and correctional staff, looking at the mission of correctional staff and their legitimate need for information and covering the difficult nexus between confidentiality of health information and the responsibilities of prison authorities;
- viii) the challenge of quality improvement in this environment;
- ix) juveniles, the disabled, end of life care, release before death and other issues.

2.6.3 Specialty Courses Relevant for Doctors Working in Prisons

In addition to the diploma for doctors working in prisons, there are specific courses in the UK which are relevant to particular needs. As one example of this, the Royal College of General Practitioners Certificate in the Management of

Drug Misuse was launched in October 2001. Its aims were 'to develop a core of GPs in the field of management of drug misuse with the aim of enabling GPs to fulfil the aims of treatment as outlined in Department of Health (1999), *Drug Misuse and Dependence - Guidelines on Clinical Management*, develop the role of GPs in local strategic planning and commissioning, and improve standards in primary and secondary care' (RCGP Press Release, 2002). This is a certificate course, which takes place over five days, but is not designed to produce specialists in addiction. The 2002-03 course had an intake of 150 GPs, 50 nurses, 50 pharmacists, 50 general psychiatrists and 30 doctors working in prisons. The Department of Health provided £3 million over two years to fund it.

There is a paucity of general training programmes specifically designed for providing health care in prisons or guidance on the range of accredited training opportunities which could be considered relevant to providing medical care in prisons. For example, there is a lack of clarity over whether providing primary care in prisons is a specialist task, given the nature of the population, a generalist task, or suitable for a generalist with special interests. There is also some confusion of terms. There are intermediate practitioners (where the government has piloted training initiatives through modernisation monies), GP Specialists, Primary Care Specialists, GPs with Special Interests and different levels of training initiatives for GPs with Special Interests (at both Diploma and Certificate level) with different levels of commitment and forms of assessment.

2.7 Documentation Indicating Training Needs

There has long been concern over the quality of health care in prisons, including over-medicalised care, with little attention to audit, prevention and health promotion or continuing professional development. A series of influential reports between the publication of *Patient or Prisoner* (HM Inspector of Prisons 1996) and *Health Promoting Prisons, A Shared Approach* (Department of Health 2002) served, through their analysis of the state of play in issues related to prison health or in their vision for the future, to highlight potential training issues. These are set out in Table 2.1.

Table 2.1: Training Needs of Doctors Working in Prisons: main themes from official reports

Potential Training need	Source	How should it be met
To be related to assessed health care needs of prison populations	<i>Report of the Working Group on Doctors Working in Prisons</i> (2001) (DWiP)	Mainstream training
Carry out surveys of patient satisfaction	DWiP	
Understanding differences between health care and health promotion/whole prisons approach	<i>Health Promoting Prisons: a shared approach</i> (2002) (HPP)	
Meeting health promotion needs; providing evidence-based health promotion; fostering health promotion understanding; Prison as an opportunity to meet health promotion needs of socially excluded groups.	HPP; Marshall et al (1999); <i>Good medical practice for doctors providing primary care services in prison</i> (2003) (GMP); <i>Prison Health Handbook</i>	

	(2003)	
Use of tools for identification of prisoners with alcohol problems	Marshall et al (1999)	
Assessment and management of self-harm patients	Marshall et al (1999)	
Patients with serious mental illness should be managed using a care programme approach. If necessary, staff should undergo training in the care programme approach to mental health care	Marshall et al (1999)	
Identification and management of neurotic disorder should be given high priority for all prison health care staff	Marshall et al (1999)	
Core skills	DWiP	General practice sessions
Working in primary care teams	DWiP	General practice sessions
Initial screening inadequate for identifying important health problems	Marshall et al (1999)	
Comprehensive primary care services	DWiP	JCPTGP or Acquired right to practise
Strengthen links with outside bodies offering Training	DWiP	
Substance abuse problems	DWiP	GP specialists/ career grade consultant post/ plus session in secondary care
Diversity awareness training	GMP	
Health problems of Immigration Act detainees	DWiP	
Mental health problems And substance misuse	DWiP HNA <i>Suicide in Prisons. Response to Her Majesty's Chief Inspector of Prisons for England and Wales (1999) RCP (2002)</i>	GP specialists (specialist generalist role) i.e. with special interest or as non consultant career grade working in psychiatry plus session in secondary care facility
Working in teams	DWiP	
Security awareness training needed	Critical incident analyses show a number of cases	
Overstepping boundaries of competence especially in mental health to be addressed	DWiP	
Clinical audit and IT support	DWiP	Participation in Significant event analyses, national inquiries and PCT audit activities
Mental health needs and substance abuse of young offenders	DWiP	
Significant event analysis; learning from complaints and serious incidents. Risk management	<i>Clinical Governance - Quality in Prison Healthcare. Prison Service Order No 3100. (PO 3100);</i> GMP	
Clinical governance leadership	PO 3100	
Managing risk and security issues while not compromising clinical care	GMP	
Coordinated approach to clinical care packages given co-morbidity and mental health problems	GMP	
Prisoners have same rights to confidentiality	GMP	
Leadership and advocacy role	GMP	

Avoiding discrimination and prejudice against patients	GMP	
Leadership for significant audit analysis		
Issues around informed consent	GMP; <i>Seeking Consent: Working with People in Prison</i> PSI 38/2002	
All prison doctors should receive specific training in psychiatric and drug misuse medicine	RCP (2002)	
Multi disciplinary audit for any unexpected death to be initiated by senior doctor	RCP (2002)	
Training (all) prison staff in relation to suicide and self harm should be carried out by the NHS	RCP (2002)	NHS
Prison doctors failing to recognise psychiatric disorder in about a third of cases identified by a research team	Gunn et al 1991, (quoted in RCP,2002)	
Training to include interviewing skills, counselling techniques, attitudinal issues, basic psychology and psychiatry	RCP (2002)	
Assessment of suicide risk should include individual clinical assessment by staff trained and supervised by mental health professionals	RCP (2002)	
Identification of prisoners at risk of suicide needs special training	RCP (2002)	
Personal safety issues	GMP	
Prison specific competencies required by visiting specialists to be determined locally	DwiP	
Advocacy and leadership	GMP DWiP	Model contracts set time aside for training
Recognition and management of neurotic disorder using effective pharmacological and psychological treatments	Marshall et al (1999)	
Initial screening not adequate for assessing mental illness	Marshall et al (1999)	
Workforce development	DWiP GMP	Links between Post Graduate Deaneries and prison health. Post graduate deaneries to include doctors working in prisons in their training activities Prison health to work with Workforce Development Confederations to ensure current and future training needs of prison health care staff
Training on human rights	BMA	Training should start at undergraduate level and be supplemented on appointment to a prison post

2.8 Conclusions

While the need for training for doctors working in prisons is not in question, ambiguities remain over the boundaries of specialised prison training and general practice, and therefore by whom such training should be provided and

how it should be resourced. Questions also remain over the boundaries between professional training, generic prison-related information and local induction. There is a wide range of possible training responses, from the use of existing resources for post-graduate training to the development of generic and validated specialist prison training or of modular, day release, distance learning or network-based training programmes. As the GMC emphasised in *Good Medical Practice*, it will also be important to specify in contracts how much time should be set aside for training and continuing professional development activities. It will also be necessary to ensure cover and protected learning time so that doctors working in prisons can avail themselves of training opportunities which become available.

Section 3

Practitioners Talking: interviews of doctors working in prisons and the governor managers responsible for health care

Semi-structured interviews of doctors and health care governor managers are analysed to inform the content of a national survey of doctors working in prisons. The sample of ten doctors and five health care governor managers worked in five prisons in County Durham and Tees Valley selected to incorporate different levels of security, health care needs and regime. The analysis first compares the work of doctors to community-based primary care (3.2.1 -3. 2.3). It then, identifies the challenges for doctors new to prison practice, the continuing health care demands and their ethical implications (3.2.4 -2.8), and the barriers to providing primary care in prisons at a standard equivalent to that in the community (3.2.9). The analysis of the interviews of health care governor managers considers the respondent perspectives on health care problems and training needs (3.3.2), critical incidents (3.3.3), confidentiality (3.3.4) and changes needed for doctors to work more effectively in prisons (3.3.5). Finally, the analysis reflects (3.4) on the tensions and contradictions in general practice in prison as seen by these two groups of practitioners but concludes (3.5) that the considerable diversity of views makes it difficult to generalise them.

In order to inform the content of the national survey and also to provide a qualitative analysis of key issues related to the training of doctors working in prisons, a series of semi-structured interviews was carried out with a sample of ten doctors and five health care governor managers working in five prisons within County Durham and Tees Valley. The interviews with doctors were carried out by Dr Sarah Pearce. Each interview lasted for about an hour and all except one were successfully recorded. The interviews with the five health care governor managers were carried out by Professor Andrew Gray and all were successfully recorded. Detailed notes were made from interview recordings but interviews were not transcribed. In the qualitative analysis which follows, all comments are non attributable. Both interview schedules are attached in the Appendices.

As the documentary analysis (Section 2) has indicated, training needs are partly framed by the resources which are routinely available within specific prisons, the ease of access to specialist care, and the length of doctors' experience in prisons. However, the interviews demonstrate great diversity in the self assessment of training needs, not just between prisons within the compact geographical area of this study but also between doctors within the same prison. This diversity was evident in relation to perceptions of training needs, to the importance attached to policy imperatives in primary care such as National Service Frameworks, arrangements for clinical governance and health promotion, and to ethical difficulties inherent in prison medicine.

3.1 Interviews of Doctors

3.1.1 Personnel

The interviewees reflected a wide range of occupational arrangements and different levels of training and of experience in prisons. Hours worked ranged from three per week to (more than) full time and occupational arrangements comprised locums who were learning 'on the job', members of GP consortia and full-time doctors carrying out a range of strategic, change management and leadership functions, including the development of primary care in prisons equivalent to that in the community.

Training varied. Three had not completed the RCGP vocational training scheme, two had completed the Diploma in Prison Medicine offered through the University of Nottingham, four had attended courses in substance abuse and two had psychiatric experience outside the prison setting. Those with longer than five years' experience in the prison service commented on improvements that had occurred over this time, notably in the provision of organised substance misuse services and easy access to psychiatric expertise. There was great variation in how doctors viewed their jobs. For example, one interviewee considered his prison to be 'a good environment' while another commented that the environment and the packages involved meant that 'you won't get doctors working in prisons; who would work here if we weren't here?'

The interviews can therefore be considered as reflecting a range of possible responses to training needs by doctors with different levels of training and experience, but given the small numbers involved they are neither representative nor definitive. The national survey places these findings in context but also needs to be interpreted in the light of the likelihood of similar levels of variation at a national level. Some of the similarities and differences between the interview analysis and the national survey are discussed later in this report.

3.1.2 Work of doctors in prisons

Although the work of doctors in prisons varies according to the level of responsibility, the main tasks mentioned by interviewees as a group are as follows:

1. provision of general medical services for the morning 'sick parade' and on-call arrangements;
2. referral within and outside the prison;
3. managing health care centres;
4. supporting nursing staff;
5. in-patient care for the hospital wing;
6. strategic and management roles;
7. supervisory roles in relation to registrars; and
8. filing, sorting out post and distributing letters.

There is a wide range of administrative tasks which are specific to a prison context, although not all of these tasks are carried out by all doctors working in prisons. Indeed, one doctor commented that it was the administrative tasks and not the clinical challenges that distinguished prison medical care. Administrative tasks included the following:

- (a) statutory assessment (and filling in a pro forma) for new or transferred prisoners within 24 hours of their arrival and for prisoners about to be discharged;
- (b) reviewing inmates on '2052';
- (c) signing forms for fitness for restraint and transfer under restraint;
- (d) deciding mental and physical fitness for work;

- (e) assessing fitness for adjudication (through a pro forma);
- (f) assessing fitness for segregation;
- (g) visiting prisoners in segregation;
- (h) signing for a range of issues such as wide fitting shoes, rice diets and double mattresses, minor administrative tasks;
- (i) linking with the PCT over prison health care;
- (j) supervising detoxification programmes;
- (k) routine reports, including court reports;
- (l) dealing with complaints;
- (m) replying to solicitors' letters;
- (n) attending court;
- (o) parole reports;
- (p) biannual reports on life sentenced prisoners;
- (q) fitness to be repatriated;
- (r) suitability for temporary release under escort for compassionate reasons;
- (s) involvement in substance misuse and other programmes within the prison; and
- (t) liaison with prison management.

Forms were considered to be simple and not generally time consuming. However, one doctor also felt that proformas were not adequately completed and that more information was often required. Certain minor administrative duties, such as approving wide fitting shoes or double mattresses, were considered both archaic and inappropriate by many of the doctors interviewed.

3.1.3 Similarities with primary care in the community

There were many areas of general agreement over the behaviour and management of patients within prison, and on the similarities between prison health care and general practice. As one interviewee commented, 'most of what I do is what I do in general practice.' Indeed, there was agreement that the bulk of the work of the prison doctor was ordinary general practice and most interviewees saw little difference between providing general practice in prisons and general practice in the community. It was pointed out that practices were dealing with the same people when they were not in prison and that experience in general practice in an inner city area meant familiarity with many of the problems seen in prisons. As one respondent remarked, 'most of my patients are like the patients in here, except they're free'.

A number of doctors emphasised to their patients in prison that they were not reflecting the disciplinary side, and where relevant, would emphasise that they were also GPs in the community. One respondent suggested this was recognised: 'prisoners regard doctors as a friend not like a guard'. Doctors sought often to differentiate themselves from the prison system:

Myself and my colleagues, we make a point of not going into the criminal history of patients, not finding out why or how long unless it is of clinical significance.

And, to a large extent, interviewees were happy with the relationship with patients in prison, although inevitably high security prisons presented prisoners with more challenging behaviour.

3.1.4 Challenges for doctors starting work in prisons

When questioned over the challenges they first encountered in taking up their post in a prison, interviewees presented a wide range of problems (see below). Very few claimed to have received adequate induction programmes and many suggestions were made over the possible content of induction packages and

programmes (Box one). The boundaries between induction and training were often blurred.

Prison culture and regime

For some 'prison culture is the first shock... health care is the lowest priority' and they reported low expectations of medical staff. More directly, doctors spoke of the difficulties in 'meshing' with the prison system', 'learning the ropes', 'vertical networking' or of the shock of having to lock doors behind them. In the face of this, maintaining identity as an 'ordinary GP' was itself a challenge:

Remind yourself you're just being an ordinary GP and try and react as an ordinary GP in exceptional circumstances. Use ordinary language and try and demilitarise.

Interviewees also commented on differences in the degree of initiative taken by nursing staff in prisons compared to those in the community, the amount of decision-making left to the doctor (although this varied from prison to prison), lack of training amongst nurses in chronic disease management and a poor grasp of clinical governance. There is, for example, 'little concept of nurses taking clinical responsibility in prison service. There is a cultural tendency not to accept responsibility but pass it on.' Moreover, some of the rules and regulations were considered archaic and there was little attempt to help doctors place their work in the context of the prison: 'We weren't given and have never been given a list of rules and regulations that pertained to the prison and medical care'. These are the properties of a command culture for which many doctors are not specifically trained.

Prisoners as patients

Some interviewees expressed their shock when they first became aware of the backgrounds of prisoners and one interviewee felt that 'most of these people shouldn't be in prison'. They commented on the high incidence of mental health and drug-related problems and of their need to adjust to the sometimes manipulative and demanding behaviour of prisoners as patients. These characteristics could challenge the traditional doctor-patient relationship. Patients who continually 'cried wolf', for example, were more easily subject to errors in clinical decision-making and some might be bullied into demanding analgesics to be passed on as barter ('I never knew what was happening to my prescription drugs'). With one exception, doctors felt that patients' expectations of them were high and often unrealistic ('they expect you to take their side against the prison and against the system'). Demands ranged from tranquillisers to double mattresses and trainer shoes. Moreover, prisoners were more litigious as patients than their counterparts in the community, a tendency that all practitioners should be aware of not least to avoid over defensive medicine, including more investigations.

There were different views over the difficulties of managing prisoners. Some described the confrontational and sometimes aggressive nature of prisoners, with two doctors commenting on the challenges of witnessing extreme behaviour and having to examine violent prisoners. However, aggression was at worst seen as an occasional problem. One interviewee had encountered only one aggressive patient in a five-year period, less than in his own practice in the community. Moreover, any sign of aggression was 'quickly cracked down on'. Indeed, one doctor commented that he felt more comfortable inside prison than

outside it. The view was also expressed that any initial mistrust could usually be dissolved and most interviewees described good doctor-patient relationships.

One interviewee stressed the importance of recognising the implications of the fact that prisoners had little scope to manage their own lives. As they were unable to take holidays, buy over the counter medicines, or rely on family support and had additional pressures to people outside prison, diagnosis and prescription had to recognise that 'coping mechanisms and strategies are going to be different'.

Providing medical care

Interviewees described disorganised systems for providing medical care, shortages of medical and nursing staff and the lack of an administrative infrastructure for providing health care, although in some prisons changes had occurred since their arrival. A shortage of manpower tended to limit public health programmes such as smoking cessation and problems were raised in relation to prescribing, possession of medication, access to prisoners, continuity of care, referral and moving people out of prison for hospital appointments. Moreover, prison transfers led to fragmented care, compounded by the lack of information technology. Medical records in particular were described as poor. In general 'the administrative system in the prison is not geared up to providing the sort of back up that you'd expect in general practice'.

Induction or the lack of it

Despite the many difficulties facing doctors taking up posts in prison, few examples of induction programmes were given, and this was also the case for doctors who had recently taken up their post. Six of the ten interviewees had not received any induction apart from information about keys and security. One received information about drugs and detoxification, shadowed a doctor for two weeks, had a tour of the prison and received guidelines, another received files of prison instructions, was able to refer to a doctor who had been brought in and received a week's induction course a week later, a third just received a 'five minute talk about keys', how to restrain and pull away and a fourth had a talk on security, breakaway techniques and suicide prevention. One new doctor who had recently joined a prison commented that an induction had been offered 'but it hadn't materialised'. Thus, most would identify with the respondent who was 'a first time medical practitioner in prison and no one gave me any instruction on problems I'll be dealing with... I just walked around... I believe there are things I haven't seen yet'. This indicates that with the exception of security arrangements, induction programmes are variable, and not a priority.

Although one doctor was sceptical about induction ('how can you train someone about how they will feel being in a prison?'), most identified a strong need for induction and offered a host of suggestions for induction (see Box one). While recognising that it needed to be profiled to the particular establishment as problems differed, it also needed to be sensitive to the individual doctor's experience of working in prisons. Proposed methods for induction included shadowing a doctor for a few weeks, a week's intensive induction, daily lectures and prison visits for a week. One doctor felt that rules and regulations as applied to medical care should be given to those new to prisons in both verbal and written form. All this needed to be backed up by ongoing peer support and mentoring to help deal with the clinical, legal and ethical dilemmas 'which are not always easy to predict'.

Box 3.1: Suggestions for Induction for Doctors Working in Prisons

Prison regime and culture

1. security issues – keys and dogs
2. rules and regulations; these should be explicit – e.g., categories of prisoner to be shackled when outside the prison
3. how violent and severely disturbed patients are managed
4. policies on barricading, fights, bullying
5. transfer of high security prisoners
6. how prisons prioritise their work and reasons for the regime
7. prison-related procedures such as assessment for adjudication
8. the use of segregation and the kinds of punishments used in prison
9. prison jargon

Prison environment

10. tour of the prison
11. opportunity to meet those in charge of workshops and segregation units
12. the environment in which prisoners live (as this may be relevant for clinical reasons - e.g., number of flights of stairs)
13. responsibilities of governors

Health care

14. a list of services and how these could be accessed
15. information on referral to secondary care
16. access to prisoners
17. information on prescribing to include restrictions and dosage schedules
18. restrictions on possession of drugs
19. restrictions on the delivery of health care
20. indication of the work to be carried out and the standard expected
21. protocols
22. treatment regimens

Occupational issues

23. clarity over contractual obligations and pension rights was mentioned by one of the doctors

Prisoners

24. illness behaviour in prisoners
25. the kinds of complaints that occur
26. drug culture in prisons: to include the kinds of drugs available in prisons, the drugs which prisoners are likely to ask doctors to provide and the ones to which they attach importance
27. manipulative skills of prisoners
28. challenging behaviour
29. what to expect in dirty protests

Personal security

30. self defence (obligatory in certain prisons) although there was some disagreement about this (one doctor felt this was unnecessary as he had 'never felt physically intimidated' and claimed that none of the prison doctors had felt they needed to defend themselves)

Contextual information

31. explanation of the criminal justice system and what sentences mean
32. information on the Mental Health Act and how to access information on it
33. how human rights legislation affected the work of the prison doctor
34. definition of an ethical issue.

3.1.5 Health care challenges in prisons

Interviewees were invited to describe the major health care challenges they faced. These varied according to the type of prison and age range of the prisoners. In addition, it was pointed out that the nature of health care challenges facing doctors had changed as separate detoxification services had been introduced and many prisons had introduced nurse-led services for diabetes and asthma.

Although the range of conditions is wide 'most of the medical conditions I see and treat would be those that other GPs see and treat except that I would

see them at a higher incidence'. However, a number commented on the poor general, nutritional and dental health of prisoners, on the high numbers of smokers and on the evidence that prisoners had neglected their health and had had little access to ordinary services. 'My first impression', observed one doctor, 'was that the majority of prisoners that I saw could not or did not attend any general practice surgery routinely'. This doctor also described uncontrolled hypertension, diabetes, poor compliance with medication and a lack of antenatal care. There was therefore more pathology than might be expected in people of the same age in the community and prisoners were often in need of consistent general practitioner and dental services and health promotion advice.

The following specific conditions were highlighted:

1. Substance misuse and problems with injection sites;
2. Psychiatric morbidity including depression and personality disorder;
3. Minor psychological problems;
4. Ischaemic heart disease, stroke and associated risk factors;
5. Respiratory illnesses;
6. Asthma, diabetes, hypertension;
7. Hepatitis B and C;
8. HIV (although this was considered less of a problem than had been anticipated by some doctors);
9. Sexual and other abuse in childhood;
10. Multiple pathology;
11. Head injury;
12. Asplenism due to fights and road traffic accidents; and
13. Poor uptake of vaccines.

Interviewees were subsequently asked to rank as high, medium or low priority nine conditions. High priority did not necessarily imply high incidence or a high priority for the doctor. For example, psychosis was ranked as high priority by most interviewees, but was not generally perceived as a problem as there was ready access to psychiatric services. Learning disability was ranked as high priority by the majority of doctors, but was not an area that interviewees felt they could easily address.

In this exercise all interviewees ranked suicide and self harm as a high priority, followed by substance misuse and psychosis. Drug dependency was considered an important issue in high security prisons. Half of all interviewees ranked depression as high and half as medium priority. Detoxification was important but generally carried out by others. Four ranked communicable diseases as a low priority and three as high priority. Learning disability was ranked as high priority by eight and low priority by two (with two doctors in the same prison classifying its importance differently). It was seen by one doctor as an area that was more important than had been assumed and which required further assessment. One interviewee noted that, in relation to serious learning disability 'we cannot manage them but don't know where to send them'. In the same way, one doctor claimed to have referred on a case of learning disability only to have it 'batted straight back at me'. A further doctor commented that learning disability 'is a big issue, there isn't a proper structure and some officers are very sharp'. Genitourinary medicine in contrast, was ranked high priority by only three doctors and medium or low by six.

Although health needs assessments have been carried out in prisons over the last two years, none of the interviewees referred to these assessments when asked about health care needs of their patients.

3.1.6 Training implications of health care challenges in prisons

The needs for training were diverse as were views on the necessity for training. Although the emphasis in this study is on the training needs of doctors working in prisons, it is also the case that skills acquired within a prison setting are of value to GPs working in the community. For example, a number of doctors felt their skills had been enhanced through their experience of working in prison. Drug misuse (3 doctors) and psychiatry including self harm (3) were most often raised while other topics included suicide prevention, awareness of security, dealing with difficult patients, communication and decision-making skills, ethnic minority issues and management of blood borne viruses.

The areas where a training need was identified below were raised by interviewees both in relation to initial questions on perceptions of health care needs and to the subsequent ranking of named conditions. Section 3.2.7 outlines areas where training was felt to be required which are not strictly clinical but are relevant to providing health care in a prison context.

Psychiatric training and assessing suicide risk

A number commented on difficulties in assessing suicide risk and the unpredictability of suicides in prison:

As an ordinary GP, I felt very ill equipped to carry out those sorts of psychiatric assessments ...you (assess suicide risk) to some extent as a GP but the circumstances of prisoners are so different and the pressures are so different on your patientsI wouldn't have been surprised if any of them had committed suicide.

But there was also an opposing view that the 2052 system was 'exceptionally well done' and that there was not a problem in this area. Another felt that the suicide prevention format was being devalued 'by the frequency with which the notification mechanism is used. 2052 can be opened by anyone, and the more they are opened the less seriously they are taken'.

A number mentioned the importance of general psychiatric training with specific mention of adolescent psychiatry, self-harm, including swallowing foreign objects and different kinds of cutting, personality disorder and depression, and diagnosing psychosis. Screening tools for personality disorder were seen as useful by one interviewee. Another mentioned that self-harm should be considered a challenge to the whole of the prison system rather than as a medical problem. One doctor felt it would have been useful to have sat in on sessions with the forensic psychiatrist as 'that was the only bit really that was different from general practice'.

There was also scepticism about the effectiveness of treatment, particularly in borderline personality disorder, which one doctor considered both under researched and a difficult area in which to carry out research. He considered treatment available through forensic psychiatry had severe limitations.

Blood borne viruses

Training in the management of blood borne viruses was mentioned by some doctors although the majority was confident in this area.

Chronic disease management

Diabetes, epilepsy and the management of asthma were mentioned by a few of the doctors.

Drug dependency (and drug use in adolescents)

While training in this area was considered useful, in practice, this was largely taken out of doctors' hands. The point was also made by one interviewee that it could be a disadvantage for GPs working in prisons to become experts in drug dependency as this could also influence the nature of their practice outside prisons.

Minor surgery

This was important in order to reduce numbers of prisoners having to attend hospital, with all the costs and security risks implied.

3.1.7 Training implications: non clinical

The following areas were raised by interviewees:

1. training in protocol development (and development of protocols jointly with the PCT);
2. challenging behaviour;
3. communication and negotiation skills with prisoners and with adolescent prisoners;
4. basic research techniques and the ability to spot areas which are under researched;
5. medico-legal issues;
6. segregation duty as '*you don't even know what you're looking for*'
7. leadership: although not all doctors felt they had a leadership role and one emphasised the importance of developing a team approach, training for leadership was felt to be useful by most of the doctors, even if not all felt it would be relevant for them given their experience.

However, opportunities to access training for doctors who were not also GPs were varied. While some had found no problems in accessing training courses others were constrained by their environment and the shortage of staff.

3.1.8 Ethical issues

Interviewees were asked about a range of ethical issues including confidentiality, compliance, consent, dirty protests, hunger strikes, segregation and restraints. In relation to hunger strikes, refusal to accept treatment or dirty protests, it was argued that human rights legislation was applied strictly and these areas appeared to pose few ethical concerns for doctors in the sense that the prisoners' decisions were respected. Moreover, in relation to hunger strikes, for example, many others were involved apart from the doctor working in the prison.

Compliance was not generally perceived as a problem. It was described by one doctor as no greater a problem than in general practice and by another as less of a problem because it was easier to monitor compliance in the prison environment. Consent was also not generally perceived as a problem although one doctor insisted that prisoners read through consent forms properly at reception and another that the importance of getting patient consent needed to be more widely emphasised.

Confidentiality posed more problems as there was little privacy in prisons. Although doctors emphasised that confidentiality was respected as far as possible, security and disciplinary concerns were prioritised. It could be difficult to maintain confidentiality in relation to participation of prisoners in offending behaviour or substance misuse programmes. In relation to assessing fitness for adjudication, there were others present and one doctor considered that inmates could find this intimidating. He had therefore started asking inmates at

adjudication if there were any medical issues that they wanted to discuss in private. Prison Officers were often aware of prisoners' health problems and while attempts were made to provide only minimal information, this could be difficult. Non-medical staff needed to know if people were being sent outside the prison, as outside visits had to be justified.

The presence of nurses throughout the doctor-patient consultation was generally welcomed. As one interviewee commented, 'I am protected physically and in terms of allegations'.

There was concern by one of the interviewees over whether information was communicated to prisoners as 'the amount of sharing of information with prisoners is distinctly and decidedly limited'. Letters were opened unless clearly from a solicitor.

Some doctors considered the laboriousness of procedures (and the delays to which this led) and restrictions on the numbers of prisoners who could be allowed out each day to be of ethical concern. Similarly, delays during the screening process could mean that prisoners were too tired and stressed to communicate.

Segregation was seen as a disciplinary issue and one doctor commented 'I defer to people who have experience'. It was not generally considered as an ethical problem in this sample, although it was mentioned that the assessment could be done by a nurse rather than a doctor. Only one doctor pointed out that it was unethical for doctors to assess prisoners' fitness for punishment.

Thus, although some doctors expressed concern about ethical issues, the majority did not. Prisoner conditions were not generally criticised, with the exception of lack of ventilation. No problems were raised over use of restraints or doctors' roles in deciding fitness to travel. One doctor was concerned at the shackling of prisoners in hospitals, but this concern was not shared by all doctors who felt that security issues should take precedence. While some mentioned the importance of training in medico-legal issues, others felt that no training was required in areas of potential ethical concern.

3.1.9 Providing care equivalent to that in the community

Doctors working in prisons need, according to our interviewees, to be aware of the barriers to providing care in prisons which is equivalent to primary care in a community setting. These can arise from a number of sources. There may be a lack of familiarity with developments in primary care arising from developments in clinical governance, for example, or barriers in providing care in the prison environment due to staff shortages, the ways that staff are deployed or the tension between custodial and clinical imperatives. All these aspects were reflected in the interview sample. For example, one doctor was not familiar with national service frameworks (NSFs), while in another prison, all protocols included NSFs. The bulk of problems, however related to providing health care in a prison context, and as such these constitute important barriers to achieving equivalence with community-based primary care. These barriers are summarised below. While these are not directly training needs, they are relevant to defining the leadership tasks which doctors working in prisons may need to undertake to move towards equivalence of care.

Referral and accessing secondary care

There was a range of difficulties in referring to secondary care, in communications with the outside world, keeping appointments and ensuring appropriate treatment. It was difficult to get visits from outside specialists established, even though this was preferred from a security perspective and

because of the costs of escorting prisoners. Yet, 'certain consultants I think are either frightened to come into prison or don't want to have to deal with prisoners.' Three interviewees commented that there was a tendency to treat prisoner referrals differently from other referrals. This created the risk of referrals going astray, which one doctor described as happening every few weeks. Moreover, some doctors felt that hospitals took less care over discharge notes with prisoners.

While doctors could insist on referral to secondary care, many doctors felt pressure not to refer until absolutely necessary because of security issues and costs. One doctor described a limit to the number of prisoners who could leave the prison each week for hospital care. Another doctor commented that the prison could refuse to send a prisoner for a hospital appointment for security reasons or because of a lack of staff. There were also particular security risks where regular outpatient appointments were involved: 'I've never been stopped sending anyone out but there is a pressure to keep them in'.

Accessing prisoners

One doctor reported the lack of access to prisoners after 7 pm and a number observed how surgery times have to fit into the prison regime. This could mean rushed surgeries.

Nursing in prisons

A number spoke of a different culture within nursing in prisons, although it was also pointed out that this had improved. Health care officers could be 'nurses first and prison officers second' or the reverse, and this varied from prison to prison. There were not enough nurse-led services and not enough emphasis on nurse training in prisons. One doctor claimed that nurses were refused admission to attend courses outside the prison.

As nurses undertook a range of tasks and worked shifts it was difficult for them to run clinics or carry out health promotion activities. Nurse rotas worked against the continuity required to provide screening services. Some doctors who were trying to implement clinics for managing chronic diseases or health promotion found it difficult due to a 'shift system mentality' which worked against the continuity of care. Moreover, there was an overall shortage of nursing staff which meant that, in some cases, doctors were running clinics more appropriately run by nurses. In other prisons, however, nurse-led clinics were up and running.

Team approaches

A number of doctors commented on a lack of team working: 'It's a problem. We don't all meet together and discuss common problems like we do in the practice.' This could affect the quality of relationships within the prison. One doctor commented that it was difficult to get 'people to recognise we are not just there to sign people in and out'. It also posed problems for managing risk. Although there were a number of protocols, these were not interdisciplinary.

Peer support

There was less peer support in prisons than in general practice.

Continuity of care

No attempt made to track prisoners and it was not possible to write discharge notes for every prisoner who left as 'many of them disappear after court':

There is no continuity of care with the GP, partly because not all have GPs and others don't want GPs to know... we have to find some way of communicating what we have done in the prison medical service to the outside world.

Critical incidents and clinical governance

Interviewees gave a variety of responses to questions about critical incidents and significant events. One doctor pointed out that critical incidents were defined in a different way in the prison service with the emphasis on cost and security issues. GPs working in prisons defined critical incidents in the same way as in general practice, but some seemed unaware of its significance for routine clinical governance arrangements. Interviewees made it clear that discussion of critical incidents in prison is rare - one doctor could recall one five years ago, another could not think of any examples and a third thought they did not present a problem ('I have not seen any critical incident forms in the prison'.) Definitions of a 'critical incident' were unclear and there was little evidence of routine and open discussion of critical incidents among the health care teams. One doctor claimed, for example, that there were 'loads of critical incidents and no discussion of it in house.'

When asked about examples of critical incidents doctors mentioned suicides, problems with overdoses, (which would then lead to changes in prescribing arrangements), failures to provide escorts leading to investigations being postponed, or drugs which belonged to one prisoner being found in another prisoner's cell. It was argued that the tension between security issues and risk management needed to be 'supported through the administrative infrastructure'.

Although all doctors were asked about clinical governance, only one mentioned PSO 3100 which formalises arrangements for clinical governance in prisons, including the need to identify a clinical governance lead, a strategy and arrangements for review.

Prescribing issues

Doctors described a number of differences between prescribing in prisons and in the community which affected the quality of care. First were prescribing restrictions (such as for codeine and opiate based drugs and topical treatments for acne) and for drugs which were dangerous in overdose. Needles (such as for insulin injection) were forbidden and bed boards and crutches would be considered a security risk. Doctors were generally advised by the nursing staff on restrictions of this kind and nurses also provided relevant information on the background of prisoners. Second were decisions over whether a prisoner was allowed to be in possession of drugs. While policies seemed to vary from prison to prison, there would always be restrictions for some prisoners. One doctor noted that a prisoner would not be allowed any drugs at all if they had previously taken an overdose. Third was the prescription of drugs which were not generally prescribed in general practice and with which GPs would be unfamiliar.

Research

Carrying out research within a prison context was difficult due to a lack of time and of mechanisms to support it. However, one doctor was trying to encourage prison staff to carry out 'lots of small audits' and develop an action research approach.

Infrastructure

The lack of computers in most of the prisons meant the ability to carry out routine administrative tasks and chronic disease management tasks effectively was limited, as was research capability. The lack of IT made it difficult to avoid the fragmentation of care due to prison transfers. This meant the duplication of investigations and was both a resource and an ethical issue.

Continuing Professional Development

Doctors working in prison who also worked in general practice had ample opportunities for Continuing Professional Development (CPD). However, locums had no opportunities and, with the exception of one interviewee, few opportunities were made available through prisons. Prison-based meetings were described as largely focused on security issues. There were, however, attempts to involve nursing staff in these issues and to develop a more team-based approach.

This summary of barriers to achieving equivalence demonstrates the importance of developing through training the appropriate team approaches to achieving a balance between custodial and clinical imperatives and between individual training needs and an infrastructure which promotes primary care in a prison context.

3.2 Interviews of Health Care Governor Managers

3.2.1 Personnel and function

As their roles span health care and custodial responsibilities, health care governor managers provide an additional perspective on the training needs of doctors working in prisons. As in the analysis of doctors working in prisons, health care governor managers expressed different views and tensions are revealed in how the role of the doctor working in prisons is perceived. Moreover, differences emerge between health care governor managers and doctors in relation to the nature of the doctor-patient relationship.

The health care governor managers were not all clinically qualified and came from a variety of backgrounds, mostly from other prisons. They had overall responsibility for the management of health care and the deployment of health care staff. Their tasks included:

- meeting the health care standard for prisons;
- case work with clinical directors;
- running in-patient services and arranging out-patient appointments;
- setting up new services; and
- partnership arrangements including those with PCTs.

3.2.2 Health care problems and training needs

Interviewees were asked about health care problems of prisoners in their establishments and their views on the training needs of doctors working in prisons. Health care problems which they identified varied with the nature of the prison and included previous general neglect, mental health problems including suicide risk and self harm, drug abuse, sexual abuse, untreatable personality disorders, dental problems and the needs of women prisoners. The further development of health promotion services was seen as important. In general, however, health care governor managers did not comment on the clinical training needs of doctors. It was noted that sentenced prisoners would have already

been through a detoxification process and psychiatric services were readily available. However it was also pointed out that:

- doctors needed to be aware of the drug scene and whether prisoners were under the influence of illicit drugs in custody;
- mental health knowledge was important and in particular training in the management of self-harm; and
- there was a problem with over prescription outside prison which could lead to unrealistic expectations inside prison.

Induction offered to medical staff was minimal and mainly concerned with security and sometimes the paperwork that would be unfamiliar to them. Instead there was an emphasis on learning on the job: 'Use the people around you to help you find your feet.' One interviewee suggested that a set of policies and action plans for different circumstances that could arise during surgery should be made available: 'We do have instructions but not to the depth I think we should have, talking this through now.'

While tensions between the custodial and clinical roles were recognised as inevitable, health care governor managers made specific suggestions both in relation to induction, the importance of understanding the expectations of prison staff and the ways in which doctors could support the work of health care staff within the prison. These are described in turn.

Medical decision- making in context

There was some concern that doctors adopted a narrowly medical model of decision- making which did not always take account of staff needs for support or for making decisions where the boundaries between the social and the medical were blurred. It was suggested doctors could see their role as 'supporting the staff who are managing the prisoner as well as caring for the prisoner'.

One manager suggested that health care staff would find it helpful if medical staff could enlarge on their reasons for taking particular decisions, especially where members of staff were managing a difficult situation. In the same way, it was also argued that prison staff would welcome more involvement of medical staff in decision-making in relation to disruptive patients, patients who self harmed, or when to use force or special accommodation. Doctors could also participate in risk assessment in relation to suitability for sharing cells, for example. A number mentioned the importance of doctors clarifying the time it would take them to come into the prison when called and a reluctance of doctors to visit the segregation unit was mentioned by one interviewee.

Conversely, health care staff could provide doctors with information on the background of prisoners and, by helping them 'understand how some of the game is played provide them with more of the defence mechanisms to make the right decisions in the end'.

Training in dealing with prisoners on the segregation unit

One interviewee commented that some doctors found the 'punitive role' difficult: 'they see a patient. I see a prisoner'. It was important that doctors understood what was expected of them in the segregation unit and one interviewee considered that doctors needed training for this. They should be prepared to document events if unable to make a medical diagnosis when faced with a difficult and threatening prisoner.

Understanding the regime, resource and security issues

There was agreement that doctors should be made familiar with prisons and be provided with training in security awareness. They should be clear about the security implications and difficulties for the prison regime in sending prisoners out, especially at night, as well as the resource implications. Likewise, they should recognise restrictions on the availability of prisoners for routine health care and inevitable tensions between 'control and care'. This should form part of their induction.

Doctors working in prisons who were not familiar with the custodial side and 'held up the regime' were described as not popular with prison officers.

3.2.3 Involvement in critical incident analysis

While a number of governor manager interviewees described the culture of blame that surrounded critical incident analysis in prisons, there was also an awareness that the two different cultures of the prison and the NHS might require different approaches given that, as one interviewee put it, 'we've got so many different elements of risk'. One interviewee considered that the analysis of critical incidents in the NHS was 'too soft' and would create problems where two members of staff could be treated differently for the same misdemeanour. It was suggested that there should be 'something between the two' for prison health care reflecting both a disciplinary and a nurse focus.

Deaths in custody appeared to be treated as part of a 'no blame' culture. One interviewee considered that they were caused by 'lack of a care' that was organisational rather than individual and due to prison procedures. Deaths in custody were thus not routinely treated as critical incidents, in the way the term is understood in the NHS. It was considered by the same interviewee that the escape of a Category A prisoner would have greater political consequences than a death in custody.

Two interviewees considered that GPs should be more closely involved with the analysis of critical incidents. One considered that Clinical Directors should be trained in investigations so that they could help in analysis of deaths in custody, while another commented that doctors were not involved in critical incident analysis 'because when things happen they're not here'.

3.2.4 Confidentiality

In general, 'there needs to be clear advice to both parties about what is acceptable and what isn't'. Specifically, health care governors and managers did not wish to be informed whether a prisoner had medical conditions such as HIV 'because there are great dangers in giving that sort of information'. However, in other areas, the situation was less clear cut. It was recognised that there were difficulties in deciding how much information to share with members of the residential team over the effects of medication for example. In the same way, for prisoners in the segregation unit, information could influence the way they were cared for. In the absence of clear guidance 'unofficial mechanisms take over'. One manager considered that not enough information was given to prisoners about their condition.

In relation to transfer of prisoners, this could be delayed for medical reasons but clear justification would need to be provided.

3.2.5 Changes needed

A number of managers commented on the superficiality of a number of the roles doctors were asked to perform: 'GPs should be working as GPs, not deciding if someone can work in the kitchen' and 'signing things takes the Mickey out of the

job they do'. The nature of assessment in the segregation unit was perfunctory, just asking a question through a hatch, and tasks such as assessing fitness for work seemed unnecessary. However, as they were still obliged to carry out these tasks they needed to understand what was expected of them within the prison service.

Some felt that for most cases doctors did not need to be involved in reception screening, which was in any case often unnecessary as many prisoners were just returning to the prison after court appearances, for example. It was considered that the bulk of reception screening could be carried out by nurses as could fitness for adjudication. It was also argued that many issues brought to the GP in prison would not be brought to GPs outside prison and that alternatives, such as drop in centres and nurse triage, could be provided on the wings.

3.3 Tensions and Contradictions

There was evidence of differences of opinion between and within our groups of doctors and governor managers about the desired extent of involvement of doctors working in prisons in prison health care, about how far in-patient wings could be used for non medical problems and problems of fragmentation of health care in prisons. There were also differences in perception of the prison population. These are discussed in turn.

3.3.1 How much involvement?

There were different views over the degree of influence that was welcomed from GPs. One interviewee felt that doctors were 'overstepping the mark in influencing health care services' but at the same time wished for more involvement from doctors in protocol development, how to run services and the discussion of critical incidents: 'They don't have time to sit with me and talk about why someone tried to hang themselves or what we're going to do about it'.

In the same way, the level of involvement in shaping care regimes that could be expected of GPs for those on the hospital wing but who were also under the care of the mental health team seemed unclear to one manager.

3.3.2 Use of the health care centre

It was recognised that the health care centre could be a place of safety and provide a respite from bullying and drug dealing. One manager was happy for the health care centre to be used for such 'non-copers' - those who are not ill but not well - as they could self-harm and become withdrawn if not helped. Another manager in an attempt to deal with the same issue aimed to create drop in clinics and mental health nursing on the main wing. However, one manager had 'fought against' what was seen as the inappropriate use of health care facilities, contrasting the situation on taking up the post 'beds full of non-copers, attempted self-harmers and bullies' to the present situation where 'I rarely have anyone in them'. Another thought, in relation to this issue, that 'most prison doctors know when someone's pulling the wool over their eyes'.

3.3.3 Changing the culture

A number of health care governor managers commented on the difficulty in changing routine ways of working, such as ways of distributing medication, and resistance to change on the part of nursing staff who were described as not

clinically confident by some interviewees. Conversely, one manager considered that doctors did not recognise the skills of the nursing staff, treating them as subservient.

3.3.4 Fragmentation of primary care

There was evidence that changes in the organisation of health care worked against a team approach. For example, medical staff no longer managed health care, and had no responsibility for staff. Nurses in prisons reported to the health care manager and there was the potential for confusion between different streams of management between clinical directors and health care governor managers. Moreover, it was pointed out that when PCTs funded the services they would not also be managing the delivery of care.

There was also fragmentation of information as prisoners transferred were transferred without medical histories. One manager argued that all transfers should be considered by health care staff. Continuity of care was also difficult when a number of GPs visited one prison and there was no choice of doctor in these circumstances.

3.3.5 Doctor-patient relationship

The major difference in the perspectives of health care governor managers and doctors was in the assessment of the doctor-patient relationship. Although two health care governor managers emphasised the non-aggressive nature of their populations, two emphasised the demanding, manipulative, unreasonable and sometimes aggressive nature of many prisoners. It was considered important to make doctors aware of aggression, although it was difficult to give everyone an idea of what they might come across.

This concern was far more evident than in the interviews with doctors suggesting that health care governor managers saw more difficulties in the doctor-patient relationship than did the doctors themselves.

3.4 Conclusions

As we have already noted, the diversity of views makes it difficult to generalise on issues raised through the interviews. However, the responses, especially of the doctors, do provide clear qualitative information about the nature of the not always warmly regarded experience of working as a medical practitioner in a prison, including the custodial culture and the barriers to providing primary care equivalent to that in the community, and the potential fields in which training (and induction) might be needed. The views of health care governor managers specifically underline the need for dialogue between this group and doctors working in prisons in order to clarify boundaries of involvement in key areas of risk management and of reporting and responding to critical incidents. If this need for team training has not been met when for the most part the practitioners have been employed by the same service, it may yet be more difficult when in the future they are to be employed by different services as health care per se is transferred to the NHS. That, of course, does not lessen the need.

While the content of training will take its cue from a body of knowledge considered relevant to the tasks of doctors working in prisons, a degree of flexibility will be required in order to reflect substantial variation in the perceived training needs of doctors working in prisons. Moreover, little research has been carried out on prisoners' perceptions of health care needs (although see

Pettinari, 1996) or on the nature and extent of critical incidents in prisons. These neglected areas of research would furnish a critical perspective on the views expressed by professionals working in prisons and could further inform training and induction needs of doctors working in prisons.

The inferences about training need that may be inferred from these interviews may now be synthesised into a set of statements of need that can be tested in the general population of doctors working in prisons. The findings of this survey are discussed in the next Section.

Section 4

Doctors Identifying their own Needs: a national survey of doctors working in prisons

This section presents the responses to the national survey of doctors working in prisons. Respondents come from the wide range of custodial establishments, serving their populations from a basis in community. They regard themselves as integral members of the healthcare team and leaders of change and advocates for prisoners. Despite high levels of experience of practising in prisons, few have accredited training or a qualification in general psychiatry and generally they regard training in the community as inadequate for practice in prisons. The clinical conditions they identify as high priority for training are principally those unusually prevalent in the prison population: mental ill-health, substance abuse and communicable diseases. Similarly, they award the highest training priorities in prisoner contexts to those peculiarly challenging to professional ethics in prison practice: hunger strikes, dirty protests and other characteristics of the prison population and their custody. However, they identify barriers to accessing training including lack of funding, information and provision.

On the basis of the analysis of documents and the interviews of doctors and managers, a draft survey instrument was drawn up by the research team and discussed with members of the Expert Panel and Steering Group. It was at this stage agreed to omit statements about induction programmes. Although these had been identified in the analysis of documents and interviews, the Training Group of Prison Health in the Department of Health was already addressing such programmes through another exercise. The final agreed instrument (Appendix C) began with questions about respondent position, experience and qualifications. There followed three sections of statements about the role of general practitioners in prison healthcare (Part B), the need for training in specified clinical conditions of prison patients (Part C), the need for training in specified aspects of the patient context in custody (Part D). In each of these sections respondents were requested to use their experience to indicate how strongly they agreed or disagreed with each statement of need. Finally, they were asked some general questions about their access to training (Part E) and invited to make any other observations (Part F).

4.1 The Respondents

The survey was distributed to the 138 prisons establishments in the United Kingdom and 99 responses were received. As shown in Table 4.1, the respondents represented a wide range of establishments. Their relatively high levels of experience (almost a third having worked in a prison for more than ten years) may reflect the fact that perhaps the first practitioner to receive the survey form would have been the most senior. This may also explain in part the relatively high percentage (12%) still working exclusively for the prison (i.e. without external sessions), although the majority of doctors serving prisons now do so from community practices. Despite the known perception of prisoner mental illness and the numbers of respondents with mentally ill in-patients

(Table 4.2), relatively few doctors reported accredited training or a recognised qualification in general psychiatry (Table 4.3).

Table 4.4 shows that the respondents regard themselves as integral members of the prison healthcare team, recognising their leadership and change management roles, acting as advocates for prisoners and reporting that clinical decisions in prisons are influenced by the custodial dimension.

They also keep up with general practice in a variety of ways (Table 4.5). However, importantly for this study, our respondents deny that training in the community is sufficient for effective general practice in prisons. This denial is worth further investigation (Table 4.6). Prison employed doctors are more likely to deny this than their NHS community colleagues and those with least experience are twice more likely to deny it than their most experienced colleagues. That those working in local prisons (and those in remand centres – although the numbers are too small to be significant) are the most likely to deny the sufficiency of community training may indicate the influence of the size and high turnover of their populations and their associated difficulties on the sufficiency of community training. On the other hand, the stability of high security prisons and the relatively unchallenging populations of open training prisons may present fewer distinctive problems.

Table 4.1 Respondents by Prison Type and Experience (n=99)

This table shows the types of prisons in which respondents practice, their length of experience in prison practice and the basis of their employment.

(a) Type of prison establishments currently provided for

Male	Female	YOI	High security	Local	Closed training	Open training	Remand centres	Total
50	19	27	12	39	24	15	11	197

(b) Respondent Experience as Doctor Working in Prison

Less than 3 years	3-10 years	More than 10 years
23%	44%	33 %

(c) Employment basis

Prison employed; no external sessions	Prison employed; some external sessions	Community GP some prison sessions	Salaried GP some prison sessions	Prison medical lead	Other
12 %	15 %	47%	6 %	9%	11%

Table 4.2 Respondents by Characteristics of Service

This table shows selected aspects of the service provided by respondents.

(a) No. of sessions per week in prison practice

1-3	4-6	7-9	10 or full time
38.1%	26.8%	17.5%	17.5%

(b) Providing out of hours cover

No	Yes
25.3%	74.7%

(c) No. of primary care prison patients seen per week

<10	11-20	21-30	31-40	41-50	51-60	>60
2.0%	16.3%	15.3%	10.2%	12.2%	12.2%	31.6%

(d) Mentally ill inpatients within prison

No	Yes
41.2%	58.8%

Table 4.3 Respondents by Accreditation

This table shows the percentages of respondents with designated medical accreditations.

	Yes	No
Certificate of prescribed experience in general practice issued by the Joint Committee	87	13
Exemption from need for experience in Vocational Training Regulations (n=46)	15	85
Acquired rights to practise without certificate (n=44)	25	75
At least six months at SHO level or higher in general psychiatry	33	67
Approved under S12/2 of Mental Health Act as having specialist experience in Psychiatry	15	85

Table 4.4 Roles of General Practitioners Working in Prisons

This table shows the percentages of respondents identifying designated roles for doctors working in prison.

	Disagree/ Strongly disagree %	Neither agree nor disagree %	Strongly agree/ Agree %
GPs working in prison are integral members of the prison healthcare team	3.1	5.1	91.8
General practice includes a leadership role in promoting healthy prisons	4.1	13.3	82.7
Providing general practice in prisons to an equivalent standard to that in the community requires me to lead change	6.2	15.5	78.4
General practice in prisons includes acting as an advocate for prisoners	6.1	17.3	76.5
Clinical decisions in prisons are influenced by the custodial dimension of prisons	18.4	14.3	67.3

Table 4.5 Keeping Up with General Practice

This table shows the percentages of respondents reporting that they used the designated way of keeping in touch with general practice.

Accredited educational events	Personal development plan	Reading journals	Working in NHS general practice
85%	60%	95%	68%

Table 4.6 Sufficiency of Training in the Community for Prison Practice

This table shows the percentages of respondents agreeing or disagreeing that training in the community is sufficient for general practice in prison classified by type of employment, length of experience and types of prison.

	Disagree & Strongly Disagree % row	Neither % row	Agree or Strongly Agree % row
All respondents	58	17	25
Prison employed GP	74	10	16
Non prison employed	47	22	31
Experience 1-2 years	78	13	9
Experience 3-10 years	62	19	19
Experience >10 years	36	19	45
High Security Prison	33	42	25
Local Prison	71	16	13
Closed Training	67	11	22
Open training	30	10	60
YOI	50	0	50
Remand	*	*	*

* indicates that too few respondents (2) answered to be material

4.2 Potential Training Needs: Clinical Conditions

Respondents were presented with statements relating to the need for training in specific clinical conditions and asked to express their strength of agreement or disagreement with them. Table 4.7 sets out the identified clinical needs ranked statistically by strength of view. The general pattern emerging is that the more specific the condition to the prison population the more likely respondents were to agree with the need for training in it. Similarly, the more likely they were to meet the condition in generic general practice, the less they agreed with the need for training. Thus they prioritised conditions relating to substance abuse and violence, mental health and GUM above general chronic conditions such as asthma and heart disease.

We tested for the effect of length of practice experience in prison and the different types of establishment and practitioner employment. We found no significant variations in their priorities. One or two differences, however, may be of interest. Those, for example, with the least experience of practice in prisons (i.e., less than five years) placed a marginally higher priority on training for violent and self-harming conditions and vulnerable prisoners than those with the greatest experience (more than ten years). These more experienced GPs also placed a comparatively lower priority on stress, schizophrenia and paranoia. Doctors practising in local prisons prioritised training in schizophrenia and paranoia, genito-urinary and communicable diseases more highly than their colleagues practising in YOIs. Doctors practising in YOIs gave higher priorities to training in adolescent mental health and learning disabilities. Prison employed doctors gave a high priority to a twice as many conditions as their community employed colleagues. They were also more likely to award even higher priorities to training in conditions related to violence, self-harm, suicide, substance abuse and detoxification.

Further, we explored associations between respondents' prioritisation of clusters of related clinical training needs and their views of the sufficiency of their community based training for their practice in prisons. Table 4.8 summarises this analysis. As we observed earlier, a majority of respondents denied that community training was sufficient. But the minority who took the contrary view were as to be expected less likely to agree with the need for training in a range of conditions. Most significant, statistically speaking, was their low prioritisation of disorders related, first, to schizophrenia, stress and neurosis and, second, to violence, suicide and vulnerable patients. This implies that this admittedly minority group of doctors (about a quarter of our respondents) believe that training in the community is sufficient even for treating conditions that are unusually prevalent in prisons.

Table 4.7 Need for Training in Clinical Conditions

This table shows the percentages of respondents agreeing or strongly agreeing with need for training in specified clinical conditions found in prison patients.

Condition	All Respondents n=99	Experience		Prison Type		Employment	
		>10 years n=32	< 5 years N=42	Local n=41	YOI N=27	HMP staff n=38	Community n=58
Detoxification regimes	91	88	88	95	89	100	84
Violence	90	81	91	100	89	100	83
Self-harm	88	78	90	98	85	100	79
Segregation unit prisoners	88	91	88	88	89	92	84
Suicide	86	75	88	95	82	100	76
Vulnerable prisoners	86	78	91	85	82	89	83
Substance abuse	84	78	79	93	78	100	72
Personality disorders	83	81	76	88	74	95	74
Schizophrenia and paranoia	73	56	76	85	59	92	60
Sexual abuse	70	66	67	73	74	81	61
Stress	65	50	69	76	63	78	57
Genito-urinary	61	53	64	81	59	76	52
Communicable diseases	57	44	55	71	52	70	47
Adolescent mental health	56	44	55	68	70	65	49
Referral criteria for psychiatry	55	53	48	61	52	70	43
Affective disorders	55	41	57	63	44	73	40
Learning disabilities	54	53	55	56	70	65	45
Neurosis	53	34	62	59	41	68	43
Transexuality	32	38	19	34	30	43	21
Epilepsy	36	41	33	42	30	41	32
Diabetes	28	34	21	24	26	32	24
Dermatology	26	31	17	22	22	38	18
Asthma	25	34	19	20	26	30	19
Ischaemic heart disease	25	31	21	20	22	30	19
COPD	23	31	19	17	26	27	19
Minor surgery	27	28	24	32	22	35	19
Palliative care	11	19	5	10	11	14	9

Note: the classification of 'All' responses into high, medium and low priority takes account statistically of the percentages neither agreeing nor disagreeing and those disagreeing.

High Priority	Medium priority	Low priority
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Table 4.8 Sufficiency for Prison Work of Training in the Community and Need for Training in Clinical Conditions (see end note 1)

This table shows correlations between views about the sufficiency of generic training in the community for prison practice and the specified need for training in clusters of conditions.

	GP training in the community is sufficient for general practice in prisons		
	Disagree or strongly disagree	Neither disagree nor agree	Agree or strongly agree
Schizophrenia, stress and neurosis (n1)	.268	-.075	-.591
Violence, suicide, vulnerable patients (n2)	.250	-.173	-.474
Chronic conditions	.163	-.100	-.371
Substance abuse and detoxification	.130	.084	-.347
Sexuality and disease	-.016	-.055	.030

Note: shading indicates statistically significant: n1: p=.002; n2: p=.009

4.3 Potential Training Needs: Patient Contexts

Respondents were next presented with statements relating to the need for training in specific patient contexts in prisons. Again they were asked to express their strength of agreement or disagreement with the statements. Table 4.9 sets out the identified training needs ranked statistically by strength of view. The pattern of priorities reflects that observed in relation to clinical conditions: respondents consistently prioritised those contexts more specific to prison ahead of those generic to practice in the community. Similarly, the more likely they were to meet the context in generic general practice, the less they agreed with the need for training in relation to prison patients. Thus aspects of custodial discipline that challenged professional medical ethics such as hunger strikes, dirty protests and the relationship with prison authority were prioritised ahead of inter-disciplinary and sector working, access to secondary and tertiary care and supervision of students.

As with the identification of needs for training in clinical conditions, we tested for the effect of length of practice experience in prison and the different types of establishment and practitioner employment. Again, we found no significant variations in their priorities but some differences of note. Professional ethics, for example, were generally a high priority among respondents but did not emerge as strongly in the interviews (except in relation to patient confidentiality). This contrast may have been a function of experience or type of prison. Yet, when we tested for these factors we found no significant differences between them.

In general, experience seems not to exert much difference on perceptions of priorities for training in these patient contexts. Those respondents with over ten years experience placed only a marginally higher priority (compared with their less experienced colleagues) on a group of contexts including professional ethics, service planning, seeing prisoners before adjudication and assessing fitness to attend court. And these experienced doctors placed a marginally lower priority on the criminal justice and prison system, how dirty protests are managed, women in prison, clinical governance in prisons, the role of PCTs in

prison health, advocacy in custodial environments, relating with prisoner patients and health and safety.

There are some differences between prison employed and non prison employed staff. The former place marginally higher priorities on prescribing issues, medico legal reports, mental health legislation, consent, managing critical incidents, complaints, relating with prisoner patients, and slightly less to human rights, custodial priorities for Governor, and the role of the primary care trusts (PCTs) in prison health.

Finally those doctors who believe that community training is sufficient for prison work are significantly less likely than their colleagues to award a high priority to training needs in patient management and different types of prisoner (Table 4.10).

Table 4.9 Need for Training in Patient Contexts

This table shows the percentages of respondents agreeing or strongly agreeing with need for training in specified clinical conditions found in prison patients.

Condition	All Respondents n=99	Experience		Prison Type		Employment	
		>10 years n=32	< 5 years n=42	Local n=41	YOI N=27	HMP staff n=38	Community n=58
Managing hunger strikes	94	91	93	95	85	95	95
Limit of medical authority	89	81	95	95	85	84	91
Professional ethics in prison	88	94	88	93	89	90	86
Managing dirty protests	88	75	93	90	78	87	91
Role of Governor	88	84	93	93	85	87	88
Criminal justice and prison system	87	77	91	93	85	90	84
Custodial priorities for governor	87	84	95	98	89	79	91
Human rights	85	84	86	93	85	79	90
Prescribing	84	81	81	90	82	92	77
Behaviour of prisoners	84	77	88	95	82	82	84
Immigration Act detainees	83	80	81	90	78	81	84
Young offenders	81	80	79	81	93	84	79
Confidentiality	80	75	86	85	70	82	77
Women in prison	75	67	74	81	78	81	70
Consent	75	78	79	81	82	82	68
Medico-legal reports	75	75	69	81	74	90	63
Role of PCTs in prison health	75	59	86	71	82	68	79
Mental health legislation	74	69	69	90	78	84	65
Compassionate release	74	72	76	81	70	71	77

Screening and reception	72	72	74	81	82	79	68
Clinical governance in prisons	71	66	76	78	78	74	70
Advocacy in custodial environments	70	65	79	78	78	61	77
Health and safety	65	59	74	68	74	66	65
Seeing prisoners before adjudication	64	72	60	71	70	71	58
Assessing fitness to attend court	64	72	62	68	70	68	60
Relating with prisoner patients	64	53	74	81	63	74	60
Complex case management & audit	61	59	60	71	63	63	60
Managing critical incidents	61	63	57	73	59	74	53
Service planning	61	84	71	66	70	58	63
Rehabilitation programme	60	50	69	66	56	55	63
Patient records and record keeping	59	53	67	66	44	66	54
Complaints	57	63	52	63	59	74	46
Avoiding discrimination and prejudice	50	53	43	54	48	55	46
Trans-cultural practice	50	44	45	51	44	58	44
Cross-sector working	44	41	41	59	52	50	40
Access to secondary and tertiary care	40	34	43	51	30	55	30
Multi-disciplinary team working	34	34	31	42	37	45	25
Supervision of students	32	31	29	34	41	37	28
Conditions	All Respondents	>10 years	< 5 years	Local	YOI	HMP staff	Community
		Experience		Prison Type		Employment	

Note: the classification of 'All' responses into high, medium and low priority takes account statistically of the percentages neither agreeing nor disagreeing and of those disagreeing.

High Priority	Medium priority	Low priority
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Table 4.10 Sufficiency for Prison Work of Training in the Community and Training Needs in Patient Contexts (see end note 1)

This table shows correlations between views about the sufficiency of generic training in the community for prison practice and the specified need for training in clusters of prisoner patient contexts,

	GP training in the community is sufficient for general practice in prisons		
	Disagree or strongly disagree	Neither disagree nor agree	Agree or strongly agree
Patient management and administration n1	.242	.061	-0.635
Different types of prisoner n2	.164	.103	-0.475
Ethics and consent	.199	-.530	-.094
Cross sector working and planning	.049	-.005	-.116
Rehabilitation and assessment	-.021	.229	-.116
Clinical governance	.054	.061	-.176
Governor and custodial priorities	.153	-.423	-.059
Hunger strikes & dirty protests	.087	-.428	.105

Note: shading indicates statistical significance: n1: p=.001; n2: p=.030

4.4 Access to Training

Finally, we sought information about respondents' experiences of gaining access to training. As Tables 4.11 and 4.12 show, about a fifth of respondents were in the process of applying for training (one third of doctors with the least experience and one seventh of those with the most experience). More than two fifths had experienced difficulties in accessing training (with the least experienced doctors and those employed in the community finding the most difficulties). The respondents proffered a range of difficulties including:

- Lack of information and coordination;
- Lack of funding;
- Disinterest of PCTs or Governors;
- Lack of cover;
- Lack of short term courses.

To improve matters respondents suggested:

- More on the job training with colleagues;
- More use of the buddy system;
- More formalised coordination of training by the PCTs;
- More short courses;
- More use of the national diploma.

Table 4.11 Access to Training

This table shows respondents in and not in the process of applying for training by length of experience and type of employment (n=91).

	All	Experience			Employment		
		1-2 year	3-10 year	>10 year	HMP staff	Community	NHS
Applying	22	35	18	14	23	20	50
Not applying	78	65	82	86	77	80	50

Table 4.12 Experience of Difficulties in Accessing Training

This table shows respondents finding and not finding difficulties in accessing training by length of experience and type of employment (n=60).

	All	Experience			Employment		
		1-2 year	3-10 year	>10 year	HMP staff	Community	NHS
Difficulties	42	67	44	27	36	46	50
No Difficulties	58	33	56	73	73	80	50

4.5 Summary

Of the doctors surveyed, at least one in eight (12%) practised exclusively in prison without any external sessions. However, fewer than two fifths (38%) were employed directly by prisons. Although a majority (58%) cared for mentally ill in-patients, most doctors lacked training in psychiatry. The respondents regard themselves positively as integral members of the prison healthcare team and recognised their leadership, change management, and advocacy roles. They were clear, however, that generic training in the community was not sufficient for prison practice.

Although from a variety of establishments, with differing patterns and length of experience, our respondents generally demonstrated a high degree of consistency in prioritising training needs relating to clinical conditions and patient contexts in custody. While the type of prison establishment had no discernible influence on the training priorities of doctors, experience of practising in prisons seemed to exert a limited influence. Those with more than 10 years experience, for example, afforded lower priority to stress, schizophrenia and paranoia, to the criminal justice and prison system, and how dirty protests are managed and comparatively higher priority to professional ethics in prison, service planning, seeing prisoners before adjudication and assessing fitness to attend court. They also found fewer difficulties in accessing appropriate training.

There are some differences in training priorities between prison employed and community employed doctors working in prisons. The former gave more training needs a high priority than did the community employed doctors. They gave more importance to training in prescribing, medico-legal reports, mental health legislation, consent, managing critical incidents, complaints, and relating with prisoner patients. But they also gave lower priority to training needs in

human rights, custodial priorities for Governor, and the role of the PCTs. They also found fewer difficulties in accessing training.

Overall, however, the differences are much less significant than the generally consistent agreement over the needs and priorities for training across a wide range of clinical and non clinical areas.

End note 1

Method of analysis

The Likert scale questionnaire items were examined using principal component analysis. This technique highlights correlations between questionnaire items and produces independent dimensions or factors which can be defined to summarise the data. Factor scores can be generated for any nominated variable such as age, role and experience. Factor scores should be interpreted such that larger scores indicate strong agreement and lower scores indicate less agreement with the issue under consideration. Similarly, negative factor scores indicate disagreement and positive factor scores indicate agreement with the issue.

Section 5

The Training Needs of Doctors Working in Prisons: Findings and Issues

This section considers some issues arising from the investigation. It reflects on the distinctive challenge of realising a standard of healthcare in prison equivalent to that in community general practice. It observes how our analysis of documents relating to prison health and our interviews of doctors and healthcare governor-managers identified a wide variety of clinical conditions and custodial contexts with which general practitioners should be trained to deal if this challenge is to be met. Our findings show that the highest training priorities in these conditions and contexts are in 'exclusive' and 'special interest' competences. Although these distinctions are easier to identify than operationalise, training in 'exclusive clinical competences' might be provided through a dedicated national programme and that in 'exclusive patient contexts' by and with the Prison Service. Training in 'special interest clinical competences' might be provided through arrangements with postgraduate deaneries that ensure ready access to programmes and opportunities such as those available to GPs developing Special Interests (GPwSI). Training in 'special interest patient context competences' might require similar working with the Prison Service to ensure that there are appropriate programmes and that general practitioners have access to them. Finally, many of these needs are shared by nurses and other medical practitioners. Reciprocally, members of the prison service staff have training needs in dealing with the effects of clinical conditions. The desire for multidisciplinary practice might be met in appropriate joint training.

5.1 Training Need Priorities

The portrait of healthcare in prisons painted by our earlier sections is not notably comforting. The patient population has unusual patterns of morbidity, reinforced by the custodial setting, the threats to public health are severe and the provision of health care displays considerable variety in the organisation and quality of delivery. Indeed, healthcare has not received the highest priority in prison management. The command regime of prisons has traditionally imposed unusual procedures on doctors (that some describe as 'archaic') and limited the initiative taken by nursing staff. The development of clinical governance has been at best patchy and there appear to have been few attempts to help doctors place their work in the context of the prison.

For their part, of the doctors working in prisons and responding to our survey reported in Section 4, one in eight still practised exclusively in prison, i.e., without any external sessions in the wider community. Moreover, they were generally not trained to deal with some conditions that are prevalent amongst the prison population. Nearly three fifths of the doctors surveyed, for example, cared for mentally ill *in-patients* yet most of them lacked training in general psychiatry.

More comforting, therefore, might be the way respondents regarded themselves as integral members of the prison healthcare team and recognised

their leadership, change management, and advocacy roles. Moreover, they expressed a clear view that generic training in the community was not sufficient in itself for prison practice. We might have expected the doctors to express such training needs on the grounds that their professional orientation would not only recognise but seek personal development. On the other hand, we are aware that general practitioners are not usually regarded as so predisposed to training as other medical practitioners. Thus their expression of the general inadequacy of generic general practice training for their practice in prisons might in itself be regarded as significant.

The question then arises as to where this training need is most acute. The statements of potential training needs in clinical conditions and custodial contexts that we presented to the respondents were derived from (a) an analysis of documents relating to prison health, (b) the interviews of doctors and governor-managers in a sample of five different types of institution in the North East of England and (c) the reflections on (a) and (b) of our expert panel members. It is notable, and reassuring both methodologically and in policy terms, that the resulting sets of statements were not only exhaustive (no other features were suggested by respondents) but that the pattern of prioritisation was to a high degree consistent across the different experience and employment status of responding doctors and different types of prison establishment.

Drawing on the survey results we find it justifiable to present in Table 5.1 the prioritised needs for training in (a) clinical conditions and (b) patient contexts in prison, noting that the boundaries between high, medium and low priorities are based on statistical patterns in the weightings awarded by respondents rather than any external imposed criteria. The high priorities relate more to patient contexts found in prison than to clinical condition. This distinction brings us necessarily to the characterisation of these needs and the appropriate ways in which they might be met.

The distinction referred to in Table 5.1 between 'exclusive' and 'special interest' competences relates to the triangle of competences we discussed in Section 1 (see Figure 1.1). From this triangle we expressed *exclusive competences* as those required only for doctors working in prisons and *special interest competences* as those that, although applicable to practice in the community, are particularly required in doctors working in prisons because of the prevalence of conditions they are obliged to address. On the basis of our analysis of relevant documents (Section 2) and our interviews of a sample of doctors working in prisons and their health care governor-managers we were able in our survey to distinguish further between clinical conditions and prisoner patient contexts.

Our respondents confirmed the general validity of all these distinctions. They clearly recognised them in the survey statements and in the priorities they attached to training needs. As we observed in Chapter 4, the highest priorities of training need were awarded to those conditions and contexts that are unique to prisons or at least found in unusually high incidence or patterns among the prison populations. Conversely, our respondents placed the lowest priority on those conditions and contexts which are, in effect, generic to general practice in the community and in which, therefore, they are already likely to feel and be competent. We have therefore used these distinctions in Table 5.1 to characterise the priorities for training we have identified.

Table 5.1 Prioritised Training Needs in Clinical Conditions and Patient Contexts
(a) High Priority

<u>1 Conditions</u>	<u>Training in Patient Contexts</u>
<i>Detoxification regimes</i>	Managing hunger strikes
<i>Violent & aggressive behaviour</i>	Limits of medical authority
<i>Assessing & managing self-harm</i>	Professional ethics in prison
Segregation unit prisoners	Managing dirty protests
<i>Suicide</i>	Role of Governor
Vulnerable prisoners	Criminal justice and prison system
<i>Clinical aspects of substance abuse</i>	Custodial priorities for Governor
<i>Personality disorders</i>	<i>Human rights</i>
<i>Schizophrenia and paranoid states</i>	Prescribing in prison
<i>Clinical aspects of sexual abuse</i>	Behaviour of prisoners
Stress & adjustment reaction	Immigration Act detainees
<i>Genito-urinary medicine</i>	Young offenders
	<i>Confidentiality</i>
	Women in prison
	<i>Consent</i>
	Medico-legal reports
	<i>Role of PCTs in prison health</i>
	<i>Mental health legislation</i>
	Compassionate release
	Screening and reception
	<i>Clinical governance in prisons</i>
	Advocacy in custodial environments

(b) Medium Priority

<u>1 Conditions</u>	<u>Training in Patient Contexts</u>
<i>Communicable diseases</i>	Health and Safety
<i>Adolescent mental health</i>	Seeing prisoners before adjudication
Referral criteria to psychiatric team	Assessing fitness to attend court
<i>Affective disorders</i>	Relating with prisoner patients
<i>Identifying learning disabilities</i>	Complex case management and audit
Neurosis	Managing critical incidents
Transexuality	Service planning
Epilepsy	Access to rehabilitation programmes
	Patient records and record keeping
	Complaints
	Avoidance of discrimination and prejudice
	Trans-cultural practice

(c) Low Priority

<u>1 Conditions</u>	<u>Training in Patient Contexts</u>
Diabetes	Cross sector working
Dermatology	Access to secondary/tertiary care
Asthma	Multi-disciplinary team working
Ischaemic heart disease	Supervision of students
COPD	
Minor Surgery	
Palliative Care	

Bold indicates an ‘exclusive’ competence; *italics* indicate ‘special interest competence’ (see text below for discussion)

5.2 Training Policy Issues

The prioritisation helps to identify the content to be addressed in any training strategy for doctors working in prisons. In effect a 3 x 2 matrix of content is provided: one dimension distinguishes clinical conditions and patient contexts and the second that of highest, medium and lowest priority. There remains the issue of who should provide or be responsible for the training identified. Although making these analytical distinctions is easier than operationalising them in training policy, there are some pointers in our matrix that inform the following observations:

1. The ‘**exclusive clinical condition**’ **competences**, for example, are not to be met in any current programmes provide by postgraduate deaneries and similar professional development provision. They are a set of competences unique to prison practice. Thus they must surely be provided for through a dedicated programme provided nationally under the auspices of the Prison Health service.
2. The ‘**exclusive patient context**’ **competences** are also unique to prisons but here the emphasis is less on the clinical condition than on the custodial dimension of treatment. Thus it could be expected that training in such contexts could be provided by the prison service in a programme dedicated to medical practitioners. However, our view is that the challenge to the general practitioner is the integration of clinical with custodial and this might be better met (and offer a visible symbol of joint working) through a Prison Health and Prison Service dedicated national programme.
3. Training in the ‘**special interest clinical competences**’ is available in CPD programmes and others designed for GPs to develop special interests. It will be necessary, however, for Prison Health to ensure availability and access. This will involve not only a national policy of access but working with deaneries and other providers to ensure appropriate availability.
4. Training in ‘**special interest patient context competences**’ might similarly require working with the Prison Service to ensure that there are

appropriate programmes and that general practitioners have access to them.

5. We have been struck by the extent to which many of these needs are shared by nurses and other medical practitioners. We have also observed that, reciprocally, members of the prison service staff have training needs in what might be termed dealing with the effects of clinical conditions. Although we have not investigated these explicitly we have recognised both the training needs and the shared desire for **multidisciplinary practice** to be reflected where appropriate in multidisciplinary training or at least that designed to enhance integrated working.

At this point we are leaving the investigation of training needs and entering the world of training policy, beyond our brief and competence. However, the research team would of course be pleased to discuss these findings further.

Appendix A

Doctor Interviews: The Questions

[Explain Aims

- to identify practitioners' views of the main issues in providing primary care in prisons
- to identify skills which are specific to a prison context
- to explore issues arising from closer integration of primary care in prisons with community-based primary care

Interviews will be recorded with interviewees' permission. All information will be non attributable.]

Question one

Could you describe the range of tasks you carry out as a prison doctor?

- a. Which responsibilities are specific to the prison context?*
- b. What have you found to be the main differences between providing general practice in prisons and general practice in the community?*

Question two

What did you find most challenging on first taking up your post in the prison service?

- a. Was an induction programme arranged for you?*
- b. Was it easy to find your way through the prison system?*
- c. Were there expectations of you which you had not anticipated?*
- d. What were the main health care needs you encountered?*
- e. Were there difficulties in providing medical care in a prison environment?*
- f. Any other initial reactions?*

Question three

Could you describe the kind of induction programme you would like to see developed for new entrants?

Question four

What are the main health and health care needs of your patients in prison?

Prompts:

- suicide risk
- self harm
- depression
- psychosis
- GUM
- substance misuse
- detoxification
- communicable diseases
- learning difficulty
- other

Question five

Could you enlarge on challenges in meeting health care needs for specific clinical conditions in a prison environment?

Prompts

- screening
- diagnosis
- management/ treatment
- prescribing and administering drugs
- referral arrangements (secondary care, within the prison)
- continuity of care
- other

Question six

In your view, are there ways in which the difficulties you have mentioned could be addressed?

Prompts

- screening tools
- protocol development
- referral guidelines
- training
- other

Question seven

Do your patients in prison pose difficulties for the doctor/patient relationship?

- a. Do you encounter aggressive behaviour from patients?*
- b. Are there difficulties in communicating with patients?*
- c. What expectations do patients have of you?*

Question eight

Do you consider that additional support or training could be helpful in any of the areas you have identified?

Question nine

What do you consider the main ethical issues arising from the nature of the doctor/ patient relationship within prisons?

Question ten

Could you describe any ethical difficulties you may have experienced in relation to:

- a. patient confidentiality*
- b. patient compliance*
- c. patient consent*
- d. medico-legal issues*
- e. treatment regimens*
- f. prisoner conditions/prison environment and patient health*
- g. prison conditions and public health*
- h. access to patients*
- i. other*

Question eleven

Do you consider that additional support or training would be helpful in any of these areas?

Question twelve

How would you define a critical incident within the prison context?

- a. Can you give any examples of critical incidents or significant events?*
- b. Does risk management pose any specific problems within a prison context?*

Question thirteen

How would you describe your current level of involvement in

- a. health promotion and disease prevention?*
- b. screening?*
- c. chronic disease management (asthma, diabetes, heart disease, epilepsy)?*
- d. implementation of National Service Frameworks?*
- e. palliative care?*

Question fourteen

How would you see these activities developing over the next year or so?

Question fifteen

Which kinds of training or support would enable you to develop your activities in these areas?

Question sixteen

Could you describe opportunities for professional development available to you at present?

- a. Are there opportunities for professional advice, peer support, or supervision?*
- b. Is there access to evidence?*
- c. Are there opportunities to carry out research?*
- d. Are there arrangements for clinical governance within the prison?*

Question seventeen

Have you encountered any practical obstacles to furthering your opportunities for professional development?

Question eighteen

To what extent does your work require you to take a leadership role?

Is this an area where training would be useful?

Question nineteen

In which areas of your work do you feel that you have acquired particular expertise as a result of working in the prison service?

Question twenty

Is there any thing further you would like to add on the challenges faced by doctors working in prisons?

Question twenty one

Do you have any further thoughts on training needs of doctors working in prisons?

Question twenty two

Do you have any questions you would like to ask about this study?

Conclusion and thanks

Appendix B

Governor-Manager Interviews: The Questions

Preliminary Questions

Is the aim and context of the interview clear to you?

Are you content for your responses to be recorded?

Question 1:

What, briefly, are the responsibilities you have as a prison healthcare governor/manager?

Question 2:

What did you find most challenging on first taking up your present healthcare post in the prison service?

Prompt:

- Establishing effective relationships with medical practitioners
- Providing medical care in a prison environment

Question 3:

Was an induction programme arranged for you? Did it include any introductions to the workings of medical practitioners?

Question 4:

Do you provide an induction programme for doctors new to prison medicine?

If so, ***What are its components?***

May I see a copy?

Question 5:

What are the main health and health care needs of patients in prison?

Prompts:

- suicide risk
- self harm
- depression
- psychosis
- GUM
- substance misuse
- detoxification
- communicable diseases
- learning difficulty
- other

Question 6:

What are the challenges of meeting health care needs for these clinical conditions in a prison environment?

Prompts

- screening
- diagnosis
- management/ treatment
- prescribing and administering drugs
- referral arrangements (secondary care, within the prison)
- continuity of care
- other

Question 7:***In what ways can the challenges you have mentioned be addressed?******Prompts***

- screening tools
- protocol development
- referral guidelines
- training
- other

Question 8:***What challenges do patients in prison pose for the doctor/patient relationship?******Prompts***

- Aggressive behaviour from patients
- Communicating with patients
- Patient expectations of healthcare in prison

Question 9:***What additional support or training for medical practitioners could be helpful in any of the clinical areas you have identified?*****Question 10:*****What ethical challenges arise in relating medical practice with custodial practice?******Prompt:***

- patient confidentiality
- patient compliance
- patient consent
- medico-legal issues
- treatment regimens
- prisoner conditions/prison environment and patient health
- prison conditions and public health
- access to patients
- other

Question 11:***What additional support or training for medical practitioners would be helpful in relating clinical to custodial practice?*****Question 12: *How would you define a critical clinical incident within the prison context?******Prompt***

- Examples of critical incidents or significant events

Question 13:***What, if any, challenge does clinical risk management pose within a prison context?*****Question 14:*****What additional support or training for medical practitioners would be helpful in managing critical incidents?***

Question 15:

Are there any other matters you have not mentioned for which doctors ought to have the benefit of training?

Prompt

- providing healthcare in prisons equivalent to that in the community
- relating custodial and clinical care
- managing the clinical dimension of critical incidents

Question 16:

Is there any thing further you would like to add on the challenges faced by doctors working in prisons and their training needs?

Question 17:

Do you have any questions you would like to ask about this study?

Conclusion and thanks

Appendix C: The National Survey of Doctors Working in Prisons

Part A: About Yourself

We begin with some questions about your current general practice in prisons and your clinical background. Please circle the answers that most closely match your position.

1. How long have you worked as a doctor in prisons?

<1 year	1-2 years	3-5 years	5-10 years	>10 years
---------	-----------	-----------	------------	-----------

2. What type of prison establishment do you now work in? Circle all that apply:

High security	Local	Closed training	Open training
YOI	Remand centre	Female	Male

3. In what capacity do you now work in prisons? Circle all that apply:

Prison employed GP; no external sessions	Prison employed GP; some external sessions	Practice based GP; some prison sessions	Salaried GP; some prison sessions	Prison Medical Lead
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Other medical practitioner: please state

4. Is your post Permanent or Temporary? Permanent Temporary

5. How many sessions per week do you work in prisons?

1	2	3	4	5	6	7	8	9	10	11
---	---	---	---	---	---	---	---	---	----	----

6. Do you provide out of hours cover for prisons? Yes No

7. How many primary care patients do you see as a practitioner in prison on average per week?

<10	11-20	21-30	31-40	41-50	51-60	>60
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Continued overleaf

8. Do you have any one of the following?
 (a) a certificate of prescribed or equivalent experience in general practice issued by the Joint Committee Yes No

(b) an exemption from the need to have the experience referred to in the Vocational Training Regulations Yes No

(c) acquired rights? Yes No

9. Are you responsible for the care of mentally ill *inpatients* within prison? Yes No

10. Have you spent six months or more at SHO level or higher in general psychiatry? Yes No

11. Are you approved under S12/2 of the Mental Health Act as having specialist experience in Psychiatry? Yes No

12. What postgraduate training schemes have you attended in the last three years? Please list:

.....

13. How do you keep up to date with general practice? Please circle all that apply:

Attendance at accredited Educational events	Personal development plan	Reading journals	Working in NHS general practice	Other: please state:
			
			

Please turn over

Part B: The Role of the General Practitioner Working in Prisons

This part of the survey sets out statements about the role of the doctor working in prisons. Please indicate how strongly you agree with the statements by circling your chosen score as follows:

- 5: strongly agree
- 4: agree
- 3: neither agree nor disagree
- 2: disagree
- 1: strongly disagree.

14. GPs working in prison are integral members of the prison healthcare team, liaising with other members of the primary care team, the Governor of Healthcare, the Healthcare Manager and Clinical Manager within the prison.

5 4 3 2 1

15. General practice in prisons includes a leadership role in promoting healthy prisons.

5 4 3 2 1

16. Providing general practice in prisons to an equivalent standard to that in the community requires me to lead change.

5 4 3 2 1

17. General practice in prisons includes acting as an advocate for prisoners.

5 4 3 2 1

18. Clinical decisions in prisons are influenced by the custodial dimension of prisons.

5 4 3 2 1

19. GP training in the community is sufficient for effective general practice in prisons.

5 4 3 2 1

please turn over

Part C: Potential Training Needs: Clinical Conditions

In this part we present statements about different areas of clinical practice in prisons that may require training or working knowledge additional to that provided for general practice in the community. Please use your experience to indicate how strongly you agree with each statement by circling your chosen score as follows:

- 5: strongly agree
- 4: agree
- 3: neither agree nor disagree
- 2: disagree
- 1: strongly disagree.

Doctors working in prison require training or working knowledge that is additional to that required for general practice in the community in:

20.	Schizophrenia and paranoid states	5	4	3	2	1
21.	Neurosis	5	4	3	2	1
22.	Affective disorders	5	4	3	2	1
23.	Stress and adjustment reaction	5	4	3	2	1
24.	Personality disorders	5	4	3	2	1
25.	Violence and aggressive behaviour	5	4	3	2	1
26.	Adolescent mental health	5	4	3	2	1
27.	Assessing & managing self-harm	5	4	3	2	1
28.	Consequences of sexual abuse	5	4	3	2	1
29.	Identifying learning disabilities	5	4	3	2	1
30.	Assessing suicide risk	5	4	3	2	1
31.	Referral criteria to a psychiatric team	5	4	3	2	1
32.	Transexuality	5	4	3	2	1
33.	Vulnerable prisoners	5	4	3	2	1
34.	Segregation unit prisoners	5	4	3	2	1
35.	Clinical aspects of substance abuse	5	4	3	2	1

Continued over leaf..

36.	Detoxification regimes	5	4	3	2	1
37.	Communicable diseases	5	4	3	2	1
38.	Genito-urinary medicine	5	4	3	2	1
39.	Ischaemic heart disease	5	4	3	2	1
40.	Asthma	5	4	3	2	1
41.	COPD	5	4	3	2	1
42.	Epilepsy	5	4	3	2	1
43.	Diabetes	5	4	3	2	1
44.	Dermatology	5	4	3	2	1
45.	Palliative care	5	4	3	2	1
46.	Minor surgery	5	4	3	2	1
47.	Other (please specify)					
(a)	.....	5	4	3	2	1
(b)	.....	5	4	3	2	1

please turn over

Part D: Potential Training Needs: The Patient and Context

This part presents statements about different aspects of the patient and the prison context that may require training or working knowledge additional to that provided for practice in the community. Please use your experience to indicate how strongly you agree with each statement by circling your chosen score as follows:

- 5: strongly agree
- 4: agree
- 3: neither agree nor disagree
- 2: disagree
- 1: strongly disagree.

Doctors working in prison require training or working knowledge that is additional to that required for general practice in the community in:

48.	Mental health legislation	5	4	3	2	1
49.	Professional ethics in prison	5	4	3	2	1
50.	Confidentiality in prisons	5	4	3	2	1
51.	Avoidance of discrimination and prejudice	5	4	3	2	1
52.	Trans-cultural practice	5	4	3	2	1
53.	Prisoner patient records and record keeping	5	4	3	2	1
54.	Consent in the prison situation	5	4	3	2	1
55.	Complaints	5	4	3	2	1
56.	Screening and Reception	5	4	3	2	1
57.	Prescribing in prisons	5	4	3	2	1
58.	Medico-legal reports	5	4	3	2	1
59.	Seeing prisoners before adjudication	5	4	3	2	1
60.	Assessing fitness to attend court	5	4	3	2	1
61.	Complex case management and audit	5	4	3	2	1
62.	Managing critical incidents	5	4	3	2	1
63.	How hunger strikes are managed	5	4	3	2	1

Part D Continued over leaf..

64.	How dirty protests are managed	5	4	3	2	1
65.	Access to secondary/tertiary care	5	4	3	2	1
66.	Cross sector working	5	4	3	2	1
67.	Multi-disciplinary team working	5	4	3	2	1
68.	Relating with prisoner patients	5	4	3	2	1
69.	Arrangements for compassionate release	5	4	3	2	1
70.	Access to rehabilitation programmes	5	4	3	2	1
71.	Advocacy in custodial environments	5	4	3	2	1
72.	The behaviour of prisoners	5	4	3	2	1
73.	Women in prison	5	4	3	2	1
74.	Young offenders in prison	5	4	3	2	1
75.	Immigration Act detainees	5	4	3	2	1
76.	The criminal justice and prison system	5	4	3	2	1
77.	The role of the Governor	5	4	3	2	1
78.	The custodial priorities for the Governor	5	4	3	2	1
79.	The limits of medical authority in prisons	5	4	3	2	1
80.	Human rights and the prisoner	5	4	3	2	1
81.	Service planning	5	4	3	2	1
82.	The role of PCTs in prison health	5	4	3	2	1
83.	Clinical governance in prisons	5	4	3	2	1
84.	Health and Safety	5	4	3	2	1
85.	Supervision of students	5	4	3	2	1
86.	Other: (a).....	5	4	3	2	1
	(b).....	5	4	3	2	1

Part E: Access to Training

It would assist our appreciation of the current access to training if you could answer the following by circling the responses as appropriate.

87. Are you in the process of applying for training in any of the areas listed in Part C or D? Yes No

If not, please go to Part F
If you are, please enter the code numbers (20-80)

88. Have you found any areas difficult to access training in? Yes No

If not, please go to Part F
If you have, please enter the code numbers (20-80)

And list the difficulties:

.....

.....

Part F: Other Observations

89. Finally, we wish to thank you for completing this survey. Please use the space below to provide any other observations you have about the training needs of doctors working in prisons, ways in which they could best be met or any comments you may have on this questionnaire.

APPENDIX D

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