Health Inequalities and Women in Contact with the Criminal Justice System

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POPULATIONS OF OFFENDER WOMEN

- Prison
- Secure Hospital
- Community

Focus on mental health
PATHWAYS OF CARE FOR WOMEN IN CONTACT WITH THE CJS WITH MENTAL HEALTH PROBLEMS

- Secure Hospital
- Community
- Prison
HEALTH INEQUALITY

- By what standards?
  - When compared to the general population
  - When compared to men

- To avoid health inequality
  - Identify needs (including gender specific needs)
  - Allocate resources and plan services accordingly
  - Provide individual treatment fairly
  - Measure outcomes
HEALTH INEQUALITY and the CJS

- What is the starting point?
  - Disadvantaged populations
  - Is gender equality most important?

- What is the intended outcome of treatment?
  - Recidivism
  - Good health
WOMEN in PRISON

- Social profile of women in prison
  - 60% single v. 17% gen pop.
  - 34% single parents
  - Two thirds mothers living with children prior to imprisonment
  - 20% NFA before imprisonment v. 14% men
  - 40% no employment in last 5 years
  - 39% have some qualifications v. 82% gen pop.
  - 10% significant literacy problems
  - 28% ethnic minorities
  - 19% foreign nationals
PRISON POLICY

- Women in custody Feb 2008 = 4389
- Women are c.6% of the prison population
- 20% of women in prison are on remand, of whom 60% do not receive a custodial sentence
- 18% are held on sentences of less than 12 months

MoJ/NOMS 2008

- 12,500 first receptions annually

Corston 2007
PRISON POLICY : WOMEN

- 2006 Women at Risk  CSIP 2006
- 2007 Govt. Response to Corston
- 2008 Prison Service Order 4800
- 2007 Provision for Women Offenders in the Community  (Fawcett Society 2007)
- 2008 National Service Framework: Improving Services to Women Offenders  (MoJ/NOMS 2008)
PRISON POLICY: WOMEN

- **Corston Report**

- Response to a high number of deaths in custody
- Suggests that women are marginalised in a system designed for men
- This system has ignored important differences in the criminal histories of men and women offenders as well as differences in their health and social care needs
PRISON POLICY : WOMEN

- **Corston Report**
  - Highlights the gender equality duty
  - Replace existing women’s prisons with small multi-functional local custodial units within 10 years
  - Leadership at inter-ministerial level
  - Revisit pathways to resettlement to include consideration of DV and prostitution
  - Alterations to remand and sentencing such that women unlikely to have custodial sentences not be remanded into custody
Prior to imprisonment more women than men were in contact with mental health services (Singleton et al 1998)

Epidemiology shows that patterns and frequency of psychiatric morbidity in male and female prisoners are distinctive (Maden et al 1994, Singleton et al 1998)

Relationships of psychiatric disorder to offending in general and violent offending in particular are different in women and men (Hodgins 1996, Wessely 1997, O’Brien et al 2003, Simpson et al 2004)
ISSUES IN PRISON: WOMEN’S MENTAL HEALTH

- Very high levels of psychiatric morbidity
- Multiple morbidity i.e. mental illness, substance misuse, personality disorder often combined with trauma histories
- Very high rates of DSH in women’s prison estate

- Services designed to address mental illness
- Short term nature of women’s imprisonment makes it difficult to address needs requiring long term intervention
- Most women’s offending would fall below the level that warrants medium secure beds but their psychopathology is not suited to PICUs
PRISON MENTAL HEALTH: INTERVENTIONS FOR WOMEN

- **Generic**
  - In-reach teams

- **Gender Specific**
  - Therapeutic Communities – Send Prison
  - DBT initiatives – HOST and CARE
  - DSPD – Low Newton Prison
PRISON MENTAL HEALTH OUTCOMES

- Historical absence of systematic, routine assessment
- Introduction of NHS style commissioning and Partnership Boards makes this possible
- KPI not gender specific
- PSO4800 does not include gender specific audit standards
- SCMH and the RCPsych tackling this topic
SECURE HOSPITAL BEDS: NATIONAL

- NHS and Private Bed Provision

- 2001: 342 =19% of total beds

- NHS: 184 beds (170 mixed and 14 single sex)
- Private sector: 158 beds (79 mixed and 79 single sex)
LONDON WIDE PICTURE: BEDS

- There has been an expansion in total secure bed numbers from 207 NHS beds in 1996 to 758 NHS beds in 2006 = 366%. The prison population over the same period increased only by 140%.

- Variation in unit size and scope even when population served is taken into account
- Access to secure beds for women is uneven
- Male and female populations distinctive in offending and psychiatric terms
- Variation and gender inequality in use of private sector

(Bartlett et al 2007)
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**569 MSU**
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ISSUES IN SECURE HOSPITAL CARE

- Gender sensitive care
- Over containment
- Nature of treatment
- Types of security (environmental, internal, procedural, relational)
- Complex needs
- Safety (single sex provision debate)
PRINCIPLES OF TREATMENT IN SECURE HOSPITAL CARE: PHILOSOPHY

- Safe, validating and self affirming environment that will enable women to recover from severe abuse and trauma that they may have experienced as children, adolescents and adults (both outside and within the mental health system)
- A conducive therapeutic context, including a high level of relational security, that will enable women to address the complexity of their mental distress including risk behaviours and offences they may have committed
- A level of environmental and physical security no greater than women require
- A flexible and responsive secure service that is fully integrated into the broader mental health system

(Dept. of Health 2003)
PRINCIPLES OF TREATMENT IN SECURE CARE: SERVICE SPECIFICATION

- Range of inpatient facilities
- Community hostels (single sex)
- WEMSS

- Complex needs
  - Psycho-dynamically informed therapeutic work
  - Physical care needs properly addressed
  - Women only activities the norm
  - 70% female staff
TREATMENT OUTCOME IN SECURE HOSPITAL CARE

- Attempt to amend MSU DH standards to incorporate gender specific needs
- These standards do not get to grips with the “black box” of treatment
- It is valuable to audit care delivery but outcome is different
- Are different reconviction rates a product of treatment or of the different offending profiles of men and women prior to admission?
COMMUNITY CARE

- Small number of women in forensic community services
- Most women with offending histories in mainstream services
- Transition into the community either from prison or from hospital problematic
- CJS initiatives include “one stop shops” but are not health initiatives as such although may impact positively on health (WORP). Sustainable funding may be an issue
CONCLUSIONS

Challenges to gender equality in health and the CJS include:

- Critical mass
- Gender awareness (commissioning and service planning)
- Gender specificity (treatment approaches and outcome measurement)

Set against a general failure to integrate research findings into service planning and the relative absence of rigorous clinical trials in forensic (with a small) populations of men and women

- Policy drivers cannot be assumed to have led as yet to major changes in practice, consensus as to the goals of treatment or treatment efficacy