Managing practice innovations in prison health care services

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Prison health care is undergoing significant organisational change. This article highlights the potential for practice development in this setting, giving two examples of ongoing developments undertaken as part of a programme of research and development in mental health.

Prison health care is undergoing significant organisational change affecting both the service and the health care staff who deliver it (HM Prison Service and NHS Executive, 2000; 1999). The nursing workforce in prisons is composed mainly of health care officers – prison officers who have undertaken specialist training in health care – and civilian nurses who have undertaken training in security. Some health care officers also have a nursing qualification. Most nurses working in prisons in England and Wales carry out a role incorporating both security and nursing, and therefore need skills in both areas (UKCC and University of Central Lancashire, 1999).

As Norman and Parrish (1999) note, prisons focus on custody and rehabilitation. Their nursing staff care for patients with a wide range of needs, such as chronic illness, mental illness, drug and alcohol problems, acute medical illness and trauma. They also undertake health screening for new prisoners and provide primary care services such as well-man, well-woman and asthma clinics, while many prisons also provide inpatient care.

Policy into practice

In 1996 the chief inspector of prisons published the report Prisoner or Patient? (HM Chief Inspector of Prisons, 1996), which highlighted weaknesses in prison health care services and poor links between prisons and the NHS. It recommended that the NHS should take responsibility for health care in prison. The following year the report The Provision of Mental Health Care Services in Prison (Health Advisory Committee, 1997) highlighted concerns about the mental health care provided for prisoners.

A working party was convened to consider the recommendations of the chief inspector concerning health care for prisoners. The working party published The Future Organisation of Prison Health Care (HM Prison Service and NHS Executive, 1999), which recommended a formal partnership between the NHS and the Prison Service be set up with the aim of ensuring prisoners received the same level of health care as that provided for the wider community.

In April 2003 funding for prison health care was transferred to the DoH. Services are now commissioned through local primary care trusts. As a result of these changes, links between PCTs and prisons have strengthened and the professional isolation reported previously (HM Chief Inspector of Prisons, 1996) is at last being addressed.

A key finding reported in The Future Organisation of Prison Health Care (HM Prison Service and NHS Executive, 1999) was the lack of supervision, training and continuing development for staff in prison health care. However, some staff are now able to access training and development via the local PCT. In some areas, the prison nursing workforce is now accounted for within PCT development plans. Even so, there is still a substantial amount of work needed to bring prison care in line with national priorities.

Practice development within prison

There is now extensive development within prison health services, and prisons are beginning to employ nurse practitioners and nurse consultants with a specific remit for practice development.

Although such developments are not new to the NHS, they are a significant step forward for the Prison Service in the development of both staff and services. Some of the areas being addressed in terms of practice development in prisons are the increased use of prisons as learning environments for student health and social care professionals (Walsh and Smith, 2002), the development of mental health awareness (Musselwhite et al, 2004) and the introduction of clinical supervision for multidisciplinary health care teams in the prison setting (Freshwater et al, 2002).

Clarke and Proctor (1999) highlight findings from their own study in which health care staff discussed their practice development activities and described ‘the stultifying effect of feeling obliged to wait for an evidence base before progressing practice, despite “knowing” that something needs to be done’.

This can be overcome if practice development is
taken out of the traditional research framework and more closely linked to a practitioner-research model.

In addition, total commitment by staff to change is vital. In the examples set out below, practitioners are central to the development of their practice, although it is facilitated by external agents. McCormack et al (1999) emphasise that any change or development in the practice setting needs to be underpinned by strategic planning.

**Action learning**

McGill and Brockbank (2004) describe action learning as ‘a continuous process of learning and reflection that happens with the support of a group or “set” of colleagues, with the intention of getting things done’. The use of action learning groups is seen as the best way of embedding learning in practice development activities. Participants can learn through reflection between each meeting and use the groups to discuss their learning, develop their skills and initiate change in the workplace and in their own practice.

**Examples of practice development**

**Clinical supervision**

In response to the findings from the UKCC study (UKCC and University of Central Lancashire, 1999) and from the *Future Organisation of Prison Health Care* (HM Prison Service and NHS Executive, 1999), the development of clinical supervision in prison health care settings was undertaken using a three-phase approach.

**REFERENCES**


reflexive action research methodology. The initial phase involved evaluation of training, the second was the national implementation of the training and the third saw development of clinical supervision through regional action learning sets.

The aim of the initial phase of the project was to develop models of supervision appropriate to the needs of prison service health care staff. This involved three cohorts of prison health care staff (35 in total) from five prisons who undertook training in clinical supervision. This included reflective practice, models and modes of supervision, key supervisory skills, and issues of accountability and responsibility.

The three cohorts in phase one represented staff from a young offenders’ institution, three large, male, ‘local’ prisons and a high-security prison. Some of the prisons already had some clinical supervision in place. The young offenders’ institution had in-house supervision, the male local prisons wanted to use inter-prison supervision and the high-security prison had supervisory arrangements with its local acute trust. Although some supervision was in place prior to this project, it was not being used effectively. This phase of the study sought to identify and support the development of supervision, taking into account the needs of the prison and its staff. Findings from this stage of the project highlighted three main themes: education, practice and barriers. These are discussed in more detail in Freshwater et al (2002).

The findings from phase one informed phase two, which involved providing training opportunities on a national scale. Training sessions were offered in Wales, the midlands and the south east with the aim of developing participants’ knowledge and skills in facilitating reflection and promoting understanding of clinical supervision in the prison setting. In total, 71 prison health care staff with mixed prior experience of clinical supervision attended.

A regional implementation strategy has been devised to promote clinical supervision in prisons throughout England. To date, five regional action learning sets have been established, comprising some of the staff trained in phase two of the project along with other volunteers. The purpose of these sets was to enable trained clinical supervisors to gain peer support so as to cascade effective supervision in their prisons. The effectiveness of clinical supervision in prisons nationally will then be evaluated. This project continues and is now in its fifth year.

Mental health awareness training

Mental health care in prisons has been highlighted as an area for improvement and was identified in the National Service Framework for Mental Health (DoH, 1999) as a priority. There is therefore a need for training and support in mental health awareness for all prison staff, particularly wing-based officers, to help them:

- Identify prisoners at risk of developing mental health problems;
- Identify prisoners with mental health problems;
- Respond appropriately to the needs of these prisoners.

To meet the training and development needs of staff caring for prisoners with mental health issues a mental health awareness training package was developed by the Institute of Health and Community Studies at Bournemouth University, to be provided nationally by the Prison Service. The national pilot of the training was delivered in 13 establishments (Musselwhite et al, 2004). Evaluation took place at the same time and it was established that:

- National training was based on generic mental health needs for prison staff across England and Wales so it did not address issues experienced by individual establishments;
- The training was delivered over three days with no further formal learning provided, leaving no opportunities to work with trainees in post-training sessions to help embed their learning in practice;
- The training did not allow for evaluation to take place in practice, so its impact on practice could not be assessed.

The Institute of Health and Community Studies was subsequently asked to develop, deliver and evaluate a training package tailored to meet the local needs of prisoners at a male, adult prison. A case study approach was used to address the above points through the use of the framework in Fig 1 (p33). This framework promotes the use of action learning sets after training to help embed the theory into clinical practice.

Findings from the formal evaluation of the training and support at this prison not only demonstrated an increased awareness and understanding among health care staff of mental health issues on a day-to-day basis but also resulted in a dynamic and creative learning experience through action learning. This, in turn, improved the team’s cohesiveness and many participants described increased self-confidence.

Discussion

Action learning is not the usual model of practice development within prison health care – this generally adopts a more didactic model of training and education based on predetermined mandatory training, but Sleep et al (2002) indicate that staff need to be involved as active participants at all stages of change management.

With prison health care moving into mainstream health services, there is an opportunity for innovative modes of delivering training and education to be used and, importantly, for the focus to be on practice development that is locally relevant, based on sound evidence and that meets patients’ needs.