The provision of racially aware healthcare services in prisons

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In a report published in 2005 the Inspectorate of Prisons explored the fact that many black and minority ethnic (BME) prisoners have poor perceptions of their treatment in all areas of prison life. It also attempted to identify barriers that still exist to delivering race equality in prisons and examined the extent to which prison healthcare departments are providing a racially aware health service that assesses and meets individual needs.

Her Majesty’s Inspectorate of Prisons (HMIP) has a statutory duty to inspect healthcare within custodial settings as part of its annual criteria-based inspection programme. It also undertakes thematic reviews of specific issues. One such issue is that of race relations in prisons. The report *Parallel Worlds* (HMIP, 2005) provides insights for those managing and seeking to improve race equality in prisons as well as highlighting areas that need development.

The *Patient’s Charter* (Department of Health, 1992) had as its first national charter standard that ‘the privacy, dignity and religious and cultural beliefs of individuals should be respected’. More recently the *Future Organisation of Prison Health Care* (OH, 1999a) emphasised the government’s commitment to providing a health service to prisoners equivalent to that in the wider community.

This is all relevant to the prison population, which Home Office statistics have shown has a disproportionate number of BME people and an increasing proportion of older prisoners.

**Chronic conditions**

BME groups have been identified as being particularly susceptible to chronic illnesses such as coronary heart disease, chronic renal disease and diabetes.

**Coronary heart disease**

The British Heart Foundation (BHF) estimates that the prevalence of angina is 5.3% in the general male population of the UK but 9.9% among Bangladeshi men and 1.7% among Black Caribbeans. There are similar disparities for other cardiovascular conditions. For example, the prevalence of heart attacks in men is estimated as 0.6% in Black Caribbeans, 4% in Indians, 7.1% in Bangladeshis and 4.2% in the general male population (BHF, 1999).

**Diabetes**

The *National Service Framework for Diabetes* (OH, 2001) recognised that the burden of diabetes falls disproportionately on members of minority ethnic groups and is particularly prevalent among South Asians. It comments that BME groups require skills for the self-management of the condition.

**Sickle cell disease**

In the UK the most common groups affected by sickle cell disease are of African and Caribbean descent. The Sickle Cell Society estimates that one in 10–40 of the general population has the genetic trait and one in 60–200 has sickle cell disease. There are more than 6,000 people in the UK with sickle cell disease. Those with the condition should be regularly screened to monitor renal function and infections should be treated early. Screening for the trait is advised during discussions about sexual health and contraception (Sickle Cell Society, 2006).
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For related articles on this subject and links to relevant websites see www.nursingtimes.net

#### REFERENCES

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### Mental health

**Mental Health and Britain’s Black Communities** (King’s Fund, 1993) identified the difficulties faced by black people using mental health services. In 1994 the NHS Mental Health Task Force concluded that black communities required services appropriate to their needs and that many black people regarded racism and its effects as a major contributing factor to the mental ill health of black people. Afro-Caribbean young men are more likely to be referred to mental health services by the criminal justice system than by GPs or social care services.

A one-day census of all psychiatric inpatients in acute and low-security psychiatric units and seven private psychiatric units in London and the south east showed that 16% of inpatients came from BME communities, although they only represented 3.7% of the local population (DH, 1999b).

### Prisons

At each establishment that was visited for Parallel Worlds, MMP spoke to the healthcare manager. We asked questions about chronic disease management. We also explored BME prisoners’ access to mental health services and looked at the clinical records of the prisoners who were part of the focus group discussions. While they had the opportunity to raise matters about healthcare as part of the focus group discussions, we were particularly interested to identify whether their clinical records made any specific reference to the health needs of BME patients.

Of the 16 healthcare managers (or representatives) spoken to only 50% were aware of their prison’s BME population, and only 11% had any ethnicity statistics specific to healthcare. Only HMP Sudbury, an open (male) prison, included BME statistics in their health needs assessment, while HM Young Offenders Institute Deerbolt recorded ethnicity at reception and as part of the vaccination statistics.

Some 56 per cent of healthcare centres had a life-long conditions register but of those only 10% could undertake analysis to identify how many BME patients had particular conditions. Although mental health inreach teams kept a variety of statistics in relation to referral rates for various services and transfers to NHS mental health beds under the Mental Health Act 1983, only HMYOI Deerbolt kept information about how many BME prisoners accessed their services. We were pleased to note that HMP Styal (women’s closed prison) and HMP Forest Bank (male category B prison) were able to access the services of a local Afro-Caribbean mental health partnership to see Afro-Caribbean patients with mental health problems.

Obtaining information about ethnicity from clinical records proved very difficult. Only 5% of records reviewed included a patient’s ethnic status during the initial health screen. A third of clinical records had a photograph of the prisoner attached to them as the only indication of ethnicity, while in more than half the records reviewed, it was impossible to determine the patient’s ethnicity. In the remainder there was a comment in the records (usually a referral letter) that gave an indication, for example, ‘this small Philippine lady’, but this might have been written months or years after she first arrived at prison.

As a result of the poor recording of ethnicity, we were unable to make any assessment of links between substance misuse, smoking habits, alcohol consumption or mental distress and ethnicity. Furthermore, only one-quarter of records reviewed made any mention of a chronic disease (including sickle cell and thalassaemia). Family history was rarely recorded and we found one instance where it was noted that the prisoner’s father had diabetes but the doctor had written ‘no family history of note’.

In three-quarters of the clinical records there was either no record of mental illness or a comment that the individual had no mental illness. A further 10% had an unspecified mental health problem, such as comments in the records referring to a previous suicide attempt, a previous overdose or drug-linked mental health issues. These numbers were too low to allow any further analysis.

### Conclusion

Our fieldwork has shown that it is not possible from recorded evidence to know whether visible minority ethnic prisoners are receiving the health interventions that they require. From our surveys the views of black and Asian prisoners were less positive than those of white prisoners but in most cases their ethnicity was not recorded in their clinical records, so we were not able to investigate further.

We were often told by nursing staff that a patient’s ethnicity was not relevant, as all patients were treated in the same way. The NMC’s (2002) Code of Professional Conduct states that nurses should respect the patient as an individual, promoting and protecting her or his interests irrespective of gender, age, race, ability, sexuality, economic status, lifestyle, culture and religious or political beliefs. It also states that nurses should help individuals gain access to healthcare, information and support relevant to their needs. By not recognising an individual’s ethnicity, nurses are failing to meet an individual’s needs.

The report includes areas for development. Those relating to healthcare highlight the need for recording a prisoner’s ethnicity at reception and thereafter monitoring referral patterns to healthcare services. They also suggest that there should be strategies to meet the differential physical and mental healthcare needs of different groups of BME prisoners and that the professional development of staff should reflect the needs of their client group.