

# THE SEXUAL HEALTH NEEDS OF WOMEN WITHIN THE CRIMINAL JUSTICE SYSTEM IN GREATER GLASGOW AND CLYDE

**A health needs assessment**

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A multi-disciplinary working group oversaw this Health Needs Assessment (HNA). The group comprised of;

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Lucy Michie was lead researcher and author for the project. The retrospective review of Sandyford clinic within HMP Greenock was conducted by Kirsty Harris, Foundation Year 2 Trainee Doctor, under the supervision of Lucy Michie. The interviews with Community Criminal Justice staff were conducted by Margaret McCarthy, Health Improvement NHS GG&C.

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## EXECUTIVE SUMMARY

### BACKGROUND

The sexual health needs of women within the criminal justice system in Greater Glasgow and Clyde (GG&C) have never been assessed. Female offenders have disproportionately high levels of risk factors for poor sexual health, including socio-economic deprivation, substance abuse and a previous history of gender based violence, in comparison to the general female population. (1-4) They also have specific sexual healthcare needs related to their gender including prevention of unplanned pregnancy and cervical screening. Poor sexual health not only impacts on the individual affected, but can have wider social and economic consequences. These include the impact of unintended pregnancy and the transmission of undiagnosed sexually transmitted infections.

There is one prison located within NHS GG&C which has female prisoners, HMP Greenock in Inverclyde. There are additional community criminal justice 'settings' that support women who have been involved in the criminal justice system or provide alternatives to a custodial sentence. Tomorrows Women Glasgow is a multi-agency organisation managed by Glasgow City Council Criminal Justice Social Work Services. Staff working within this service, and women attending it, were included in this Health Needs Assessment (HNA). Of the various criminal justice services providing community alternatives to custody within GG&C, we included a cohort of staff working within the Glasgow City Council Drug Court and Persistent Offender Project social work services at Norfolk Street, as well as women attending these services as alternatives to a custodial sentence.

### AIM

The aim of the HNA was to systematically describe and measure the sexual health needs of women within the justice system, both incarcerated and in community settings. This will inform services in designing and delivering appropriate patient-centred sexual health care.

### METHODS

The HNA was conducted from September 2016 through to June 2017. The working group established the aim and objectives of the HNA and agreed the methods and schedule for implementation. This HNA combined three methods of conducting a HNA, an epidemiological, corporate and comparative approach.

- The Epidemiological Needs Assessment describes the sexual health of women in prison or involved with the criminal justice system from the findings of a literature review, an audit of prison sexual health clinic attendances, and from questions within an anonymous questionnaire.

- The Corporate Needs Assessment discusses the views of those women involved in criminal justice services in GG&C, and also of staff members working with these women regarding the provision of sexual health services in these settings.
- The Comparative Needs Assessment compares current services provided by NHS GG&C to those provided by other Scottish Health Boards, and describes recognised standards for sexual healthcare service provision.

## CONCLUSIONS

This is the first time a HNA has specifically looked at the sexual health needs of women in prison and women involved in the criminal justice system in the community. It set out to describe and measure the sexual health needs of this population of women and to enable services to plan and deliver patient-centred sexual healthcare for these women. It is clear they are a vulnerable group of women, who are more likely to be socio-economically deprived, with a higher prevalence of risk factors for poor sexual health, including substance abuse and GBV.

Given our findings of a past experience of GBV in over 80% of women it is disappointing that the recommendation from the previous HNA in 2012, (5) to consider routine enquiry be introduced for all prisoners, has not been met. GBV predisposes women both to poor general health and poor sexual health (6) and women have told us that they may be more likely to discuss sexual health issues when asked. Routine enquiry regarding GBV is therefore important to offer an opportunity to elicit such a history and therefore enable appropriate interventions to be offered to women. We recommend that routine enquiry regarding any past experience of gender based violence should be part of any initial assessment on admission to prison or registration with a Community Criminal Justice Service. Staff training in recognising and responding to disclosure of GBV should be offered to all staff members working with this group of women, and links to services providing counselling for women disclosing previous GBV should be made clear, to allow easy onward referral for those women who so wish.

Women have gender specific sexual health care needs, and this population of women are less likely to attend for regular cervical screening, (7) and have unmet need for contraception. The opportunity to identify any such unmet need for sexual healthcare in these women could be harnessed with the use of a routine sexual health questionnaire, closely following admission to prison or registration with a community service. Similarly, a routine sexual health consultation prior to liberation with a member of health centre staff, can provide an opportunity to consider any sexual healthcare needs, such as contraception, and to signpost women to services local to them upon release to the community. Embarrassment amongst women when discussing sexual health issues was identified as a barrier to accessing services. Women suggested it was often easier for them to discuss such

issues if they were asked, as opposed to having to bring it up themselves, which further supports the idea that incorporating routine sexual health questions into these discussions with women may be beneficial.

The presence of Sandyford sexual health clinic within HMP Greenock was viewed positively by both women and staff. It is clear that women do not like travelling out of prison in custody for healthcare, finding the experience embarrassing and degrading, and having some concerns about confidentiality. This is likely to be particularly important for sexual health issues, both because of the heightened embarrassment and because it may be another reason to avoid care for an issue that may not be acutely symptomatic. Both staff and women in custody within HMP Greenock identified problems with the current system for referral and appointment to the Sandyford sexual health clinic within the prison. We identified that approximately one third of women fail to attend on the scheduled day of attendance. There is scope to consider revising this system and improve attendance rates. Similar sexual health services provided within prison are not available at a prison housing female inmates in another Health Board in Scotland.

Similarly, whilst most women and staff within community services were aware of Sandyford sexual health services, difficulty in both obtaining an appointment and managing to get to any booked appointments in a sexual health service in the community was identified as a barrier for women in the community setting. The HNA highlights that there may be specific reasons why this population find accessing these services more challenging. Ensuring a clear referral pathway exists for women engaging with community services to access such services, and considering the possibility of providing outreach sexual health services to community criminal justice services, will ensure that these vulnerable women in the community receive the same equity of care as those women who are within custody and can access a clinic within the prison.

Although we only have information regarding the provision of sexual health care to women in custody in two other geographical health boards in Scotland, NHS Lothian and NHS Forth Valley, inequity exists in the service that women can expect to receive whilst in prison. Women in custody where onsite sexual health services are provided have easier access to sexual health services than their counterparts attending community criminal justice services as an alternative to custody. It is important to strive to ensure access to such services in the community is made achievable for women who may struggle to engage with medical services.

It is clear that sexual health is not be a priority for some women when they enter prison, or are attending a community criminal justice service. Whilst a proportion of women will have no sexual health care needs, it is also true that there are a number of barriers to seeking support with sexual health needs including knowledge, confidence in accessing services and prioritising issues that are not symptomatic or a 'crisis'. Education for women and health

promotion about sexual health can improve lack of knowledge amongst them and decrease misinformation, and was suggested as being important by members of staff from criminal justice services. Staff members both in the prison setting and in the community, acknowledge that sexual healthcare is part of their role, mainly through provision of advice, health promotion and signposting. When women are in custody or engaging with community services there is an opportunity to introduce education and health promotion about sexual health to a vulnerable group of women.

## RECOMMENDATIONS

Whilst some of the recommendations relate to women in the criminal justice system in any setting, we present them separately to focus the specific recommendations for each setting. Although this HNA and these recommendations pertain to women in NHS GG&C we believe that many of these recommendations are transferable to other services nationally.

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### CUSTODIAL SETTINGS

#### GENDER BASED VIOLENCE ENQUIRY

1. Routine enquiry regarding any previous experience of GBV should be part of any initial medical assessment on admission to prison.
2. Staff training in recognising and responding to disclosure of GBV should be offered to all staff members working with this group of women, including prison officers and NHS staff.
3. Links to services that are available in prison providing counselling for women disclosing previous GBV should be made clear, to allow easy referral for those women who so wish.

#### SEXUAL HEALTH ENQUIRY

4. Consideration should be made to introducing a routine sexual health enquiry for women, to be conducted by a member of nursing staff from the prison health centre within a week of admission to prison. This short questionnaire should prioritise questions relating to; previous sexual health testing and risk factors for this (e.g. recent new sexual partner), cervical screening history and contraceptive history and plans. This could highlight issues requiring onward referral to a sexual health clinic.

#### PROVISION OF SEXUAL HEALTH SERVICES

5. Specialist sexual health services, e.g. the monthly women's sexual health clinic at HMP Greenock, should continue to be provided within the prison, preventing transfer out to the community for sexual health services where possible. Staff working within this clinic should be able to perform symptomatic sexual health screens and to provide LARC.

6. Revise and update the written information and posters promoting the sexual health clinic within HMP Greenock to women.
7. Review the system for receiving referrals and appointing women to the clinic in HMP Greenock, such that the referral system is more confidential and the appointment system is more transparent to women, with the aim of decreasing the number of women who fail to attend on the scheduled day.
8. Consider the introduction of a routine pre-liberation consultation with women, by a member of the prison nursing team, to provide an opportunity to discuss contraception, plans for safe sex, date of next cervical smear and signposting to services local to them. This should be 4-6 weeks prior to planned liberation where possible, to allow plans for provision of long acting reversible contraception (LARC) where required. In circumstances of short notice of unplanned liberation signposting to services available within the community should occur.
9. Consideration should be made to making some LARC methods available out with the timing of the Sandyford sexual health clinic once a month, by means of training members of staff from within the prison healthcare team (e.g. provision of contraceptive injection or insertion of subdermal contraceptive implants).

#### EDUCATION AND HEALTH PROMOTION

10. Consider the introduction of a sexual health education session open to both NHS health centre staff and prison officers, to enable better information provision to women.
11. Introduce health promotions 'events' for women relating to sexual health (e.g. cervical screening).

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#### COMMUNITY CRIMINAL JUSTICE SETTINGS

##### GENDER BASED VIOLENCE ENQUIRY

12. Routine enquiry regarding any previous experience of gender based violence should be part of any initial assessment on registration with a Community Criminal Justice Service and should be audited.
13. Staff training in recognising and responding to disclosure of GBV should be offered to all staff members working with this group of women.
14. Links to services available in the community providing counselling for women disclosing previous GBV should be made clear, to allow easy referral for those women who so wish.

##### SEXUAL HEALTH ENQUIRY

15. Consideration should be made to training Community Criminal Justice staff members to be able to introduce a simple routine sexual health enquiry into their discussions

with women. A short questionnaire should prioritise questions relating to; previous sexual health testing, cervical screening history and contraceptive history and plans. This could be introduced within the first 2 weeks after registration with a community criminal justice service and could highlight issues requiring onward referral to or signposting to sexual health services.

#### PROVISION OF SEXUAL HEALTH SERVICES

16. Establish a clear pathway of referral from community criminal justice services to local sexual health services (Sandyford service in NHS GG&C), aiming to simplify this process for women and ensuring they have the required support to attend.
17. Consideration should be given to the provision of an outreach model of care from Sandyford services, to women involved in community criminal justice services.

#### EDUCATION AND HEALTH PROMOTION

18. Consider offering sexual health education sessions for staff in community criminal justice services, to ensure they are knowledgeable about sexual health services available, the process for referral into such services and to help them better inform women about sexual health issues.
19. Consider the introduction of education and health promotion relating to sexual health for women in community service setting.

## INTRODUCTION

The World Health Organisation (WHO) definition of sexual health is;

*'...a state of physical, emotional, mental and social well-being in relation to sexuality; it is not merely the absence of disease, dysfunction or infirmity'* (8)

Sexual health care involves the prevention, diagnosis and treatment of sexually transmitted infections. Women have specific sexual healthcare needs related to their gender in terms of the prevention of unplanned pregnancy and cervical screening for early detection of pre-malignant disease. Their sexual health care needs also include managing symptoms of menopause and menstrual problems such as menorrhagia.

It is important to recognise that poor sexual health not only impacts the individual affected, but can have wider social and economic consequences. The impact of unintended pregnancy and the transmission of sexually transmitted infections are key examples.

The Sexual Health and Blood Borne Virus Framework describes the national priorities for improving sexual health. (9,10) All are relevant to women within the criminal justice system.

### **SHBBV Framework outcomes**

- Outcome 1: Fewer newly acquired blood borne virus and sexually transmitted infections; fewer unintended pregnancies
- Outcome 2: A reduction in the health inequalities gap in sexual health and blood borne viruses.
- Outcome 3: People affected by blood borne viruses lead longer, healthier lives, with a good quality of life.
- Outcome 4: Sexual relationships are free from coercion and harm.
- Outcome 5: A society where the attitudes of individuals, the public, professionals and the media in Scotland towards sexual health and blood borne viruses are positive, non-stigmatising and supportive.

Female offenders have disproportionately high levels of poor physical and mental health when compared to females in the general population. (5,11) They are more likely to have risk factors for poor sexual health, including socio-economic deprivation, higher rates of substance abuse and gender based violence (GBV). (1-4) GBV predisposes women to be at greater risk of poor general health and poor sexual health, including gynaecological problems and sexually transmitted infections. (6)

Women in prison represent a small proportion of the total prison population in Scotland, at approximately 5% of all prisoners, however the female prison population has doubled in recent years (12) and Scotland has one of the highest female prison populations in Northern Europe. (13) There are also female offenders within the community setting, for example those returning to the community after release and those within community alternatives to prison. These women may be in contact with criminal justices services, either mandated by a court order or for support. They are likely to have many of the same risk factors for poor sexual health as those women within a custodial setting.

In 2015 a Scottish Government decision was made to halt plans for a new female prison in Inverclyde and move towards the development of smaller, regional, community based custodial units. (14) Whilst previous health needs assessments recommended improvements to health care within the current prison estate, (5,11) such changes to the female custodial estate in Scotland will require consideration of a different model of healthcare.

The sexual health needs of women within the criminal justice system in Greater Glasgow and Clyde (GG&C) have never been specifically assessed. A report of the Health Needs of Prisoners in NHS GG&C published in 2012, sought to determine the baseline overall health needs of all prisoners within NHS GG&C. (5) A 2007 health needs assessment (HNA) of all prisoners in Scotland (11) described poor levels of health amongst prisoners generally.

A health needs assessment was carried out to systematically describe and measure the sexual health needs of women within the criminal justice system. This will enable current and future services to be better informed when planning sexual healthcare provision for this vulnerable population group.

## BACKGROUND

### CUSTODIAL ESTATE: HMP GREENOCK

#### THE PRISON AND FEMALE POPULATION

HMP Greenock is the only prison located within NHS GG&C which has female prisoners. It opened in 1910 and has had female prisoners since 2002. The prison holds remand, and both short-term and long-term convicted female offenders. Female prisoners are housed separately from male prisoners in Darroch Hall. The prison has a total capacity of 249, the capacity for female prisoners is 58. In 2016, 189 female prisoners were admitted in total across the year, and the mean average stay of convicted female prisoners was 107 days.

<b>Prison capacity</b>	Female = 58 (Male = 191)
<b>Average daily female prisoner population (2015-2016)</b>	43
<b>Total female admissions 2016</b>	189
<b>Age (years)</b>	
<b>21-30</b>	23.4%
<b>31-45</b>	70.3%
<b>≥46</b>	6.3%

#### PRISON HEALTHCARE

The responsibility for all healthcare in Scottish prisons was transferred to the NHS in 2011.

The health centre in HMP Greenock provides a primary care service 7 days a week for all prisoners. All aspects of primary care services are provided through the health centre, including unplanned emergency care, chronic disease clinics and well person checks.

The health centre is managed by a nurse manager with staff including; 1 primary care team lead nurse, 6 practitioner nurses, 1 health care assistant, 1 nurse team lead for addictions, 2 addiction service nurses, 1 mental health nurse and 2 addiction support workers. Medical staff cover is provided Monday to Friday by General Practitioners (GP) employed by NHS GG&C.

GPs can refer women onto secondary care when required. Specialist services run within the health centre including dentist, optician, forensic psychiatrist and blood borne virus (BBV) clinic.

#### SEXUAL HEALTHCARE IN HMP GREENOCK

On admission to HMP Greenock all women are asked their cervical smears status by a health centre nurse, to establish if a routine cervical smear may be due. There is no routine offer of sexual health testing for sexually transmitted infections, although it is available if women

request it. There is no process of routine enquiry about any previous history of GBV when women are admitted to the prison or during health centre attendances. All women are given the option of opt out BBV testing. There is no routine enquiry regarding sexual orientation or contraceptive needs.

Once monthly a sexual health clinic for women operates within the health centre. This 'Well Women' clinic is provided and staffed by Sandyford sexual health service, with one female doctor and one female nurse. This clinic is supported by a health centre nurse practitioner with a special interest in sexual health who organises referrals and liaises with Sandyford staff to determine which women are scheduled to be seen. The clinic has the capacity to see 8 women each month. The clinic can provide; cervical smears, sexual health screens for sexually transmitted infections in symptomatic and asymptomatic patients, contraception including insertion and removal of contraceptive implants and intrauterine methods, and review of gynaecological problems such as menstrual disorders or menopause. Women can be referred directly to the clinic by any member of health centre staff, or they can self-refer. Women are asked to complete a paper referral slip to self-refer to the clinic. The clinic is advertised to women by posters on the walls in the accommodation hall, through word of mouth, and health centre and SPS prison staff can inform them about it should it be relevant.

One prison nurse practitioner has undertaken additional training and has a special interest in sexual healthcare in women. They can perform asymptomatic sexual health screens, although this is done infrequently at present. They are able to take cervical smears and do this as and when required. They are not able to prescribe contraception, or to insert or remove contraceptive implants, at present. There is no cross-cover of this role.

Women can be referred to the health centre GP to discuss any sexual health concerns, in particular if they are due to be liberated prior to the next scheduled Sandyford clinic. This may be a male GP. Where necessary, women can be referred out of the prison to either Sandyford or local hospital services (e.g. for colposcopy, ultrasound or specialist gynaecology services).

A specialist BBV clinic runs separately to the Sandyford clinic, staffed by a health centre nurse practitioner with a special interest in blood borne viruses. This clinic is supported by the Brownlee Infectious Diseases and HIV team.

## COMMUNITY CRIMINAL JUSTICE

### COMMUNITY CRIMINAL JUSTICE SERVICES

Glasgow City Criminal Justice Social Work Service oversees the delivery of services that aim to tackle criminal behaviour and reduce the risk of re-offending. They supervise offenders in

the community and assist persons with convictions to re-settle into the community after release from custody.

The services provided by Criminal Justice Social Work include community alternatives to custody; bail information and supervision services, supervising offenders on drug treatment and testing orders, supervising offenders in the community on community payback orders including those required to perform unpaid work for the benefit of the community as part of their order.

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#### WOMENS JUSTICE SERVICE: TOMORROW'S WOMEN GLASGOW (TWG)

Tomorrows Women Glasgow (TWG) was established in 2013 and began taking referrals in December of that year. It is a multi-agency service based in the Adelphi Centre in the Gorbals in Glasgow. It works with women with complex needs as a throughcare service on release from a custodial sentence or those who are involved with the community criminal justice service. These women are thought to be at high risk of re-offending and the service provides a women-centred, trauma informed, model of care to support them in the community and reduce the risk of re-offending. Attendance at TWG is voluntary.

TWG provides a range of services and advice to women including mental health and addictions healthcare, social care and housing. User involvement is an important part of the service. The service is staffed by 1 team leader, 1 social worker, 3 social care workers, 2 mental health nurses, 1 housing officer and 1 prison officer on secondment. One SHINE mentor is co-located within the team. There is direct referral to a Consultant Clinical Psychologist within the Anchor (Mental Health Trauma) Service.

The service has seen 371 women since it began in 2013 and currently has 70 women registered, ranging from age 20 to 61 years (mean age 38 years). Women initially present to the service with a range of concerns including, mental health (89%), substance misuse (80%), work and education (73%) and accommodation (65%).

<b>Source of referrals to TWG (%)</b>	
Criminal justice Social Work Services	55%
SPS	27%
Third sector	11%
Addictions	4%
Other (court social work, NHS, self-referrals)	3%

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#### SEXUAL HEALTHCARE ACCESS FOR WOMEN IN COMMUNITY CRIMINAL JUSTICE SERVICES

Women involved in the community criminal justice system or attending TWG have access to health care in the same way as all other residents of GG&C. They may have contact with mental health nurses, directly within TWG, or addictions nurses, through referral to community addiction services.

They can access sexual health care services through Sandyford sexual health services. Sandyford provides sexual health services at 15 separate sites across NHS GG&C 5 days a week from Monday to Friday. Until 2015, women could access services through walk-in clinics. The service model has changed and women can now access services by telephoning for an appointment. A triage system is in operation whereby they can speak with a nurse if they feel they need to be seen, or it is deemed the issue they are presenting with needs to be seen sooner than a routine appointment.

Sandyford service has an inclusion team, led by a consultant in Sexual and Reproductive Health and a senior sexual health nurse. They aim to co-ordinate the sexual health care for the most vulnerable clients at Sandyford, including those who are homeless, have drug or alcohol problems, those who have experienced gender based violence, those seeking asylum and those with learning difficulties. Women currently involved with or recently within the criminal justice system would also fall under their care.

Women are referred to the Sandyford inclusion team through a variety of methods; through outreach services at the homelessness services in Elder Street, Govan and at Chara House; through self-referrals from women themselves at Hunter Street homelessness service; from addictions services and from the asylum health bridging teams. Although sexual health outreach clinics have been located at the drug court in the past, this service is no longer provided as it was felt to be poorly attended. There is no specific sexual health service provision based within TWG, or through the community criminal justice service, however referral to Sandyford inclusion services from these services would be possible.

#### PROPOSED CHANGES TO PRISON ESTATE

In 2015 the Cabinet Secretary for Justice in the Scottish Government announced plans to change the female custodial estate in Scotland. He announced plans for a new national prison housing 80 women at HMP Cornton Vale, and the creation of 5 smaller community-based custodial units accommodating up to 20 women in each, across the country. The location of the first two of these units has been announced as being Glasgow and Dundee. The unit which will be situated within the NHS GGC area will be based in Maryhill, at the site of the former Maryhill Health Centre, with a plan to open in 2020. The intention is for women to be able to receive targeted support with alcohol, drugs and mental health in locations closer to their community and family.

The document, '**Better health, better lives for prisoners: A framework for improving the lives of Scotland's prisoner**' (15) establishes a set of priorities for health improvement in prisons. One such priority within this document is to 'increase safer sex and better personal relationships'. Relevant recommendations within this include;

- increasing staff awareness about sexual health issues
- raising general awareness of gender based violence
- ensuring access to options for contraception
- signposting to sexual health services on liberation

The **Sexual Health and Blood Borne Virus Framework** published in 2011, and its subsequent update in 2015, recognise that prisoners, in particular women and young offenders, are vulnerable to poor sexual health. (9,10) It recommends that SPS and NHS Boards should work together to ensure that

- 'the sexual health and wellbeing needs of prisoners, and their partners where possible, are addressed, including the provision of contraception, which may include LARC, where appropriate'
- 'sex and relationships education is prioritised; in the first instance to young offenders and women'

A health needs assessment of prisoner health in NHS GGC published in 2012 which concerned both male and female prisoners, made some recommendations for future practice regarding sexual health, which included; (5)

- Prisoners have limited access to information and education around sexual health, well-being and relationships. This should be improved and include access to contraceptive advice and provision, with a focus on the pre-liberation period.
- Routine sensitive enquiry of abuse should be undertaken and resources to support affected prisoners put in place.

## OVERVIEW OF HEALTH NEEDS ASSESSMENT

A health needs assessment can be defined as *'a systematic method for reviewing the health issues facing a population, leading to agreed priorities and resource allocation that will improve health and reduce inequalities'* (16)

Health care needs can include; the perceptions and expectations of both the population concerned and the professionals providing the service; normative needs, which are those judged by professionals based upon available data about a population compared to other populations; and corporate needs, taking into account local, regional or national priorities. In the context of a health needs assessment, need exists when a population can benefit from a healthcare intervention or service. Demand is the expressed desire for a service or intervention, whilst supply is what is actually provided. (16,17)

There are various described methods and guides to conducting a HNA. An epidemiological approach includes the incidence and prevalence of the chosen health problem, the availability of any services or interventions to address the problem and any evidence of the effectiveness of these. A comparative approach compares the provision of services between different populations, or similar populations in different locations, whilst a corporate approach includes the views of key stakeholders. (16,17)

### AIM

The overall aim of the HNA was to systematically describe and measure the sexual health needs of women currently within the justice system in broad terms, not just women who are incarcerated, but also women who are involved in the criminal justice system although based in the community. This will allow current and future services to design and deliver appropriate patient-centred sexual health care, in suitable settings.

### OBJECTIVES

- Determine the specific pre-existing difficulties faced by women within the criminal justice system, which pose risks to their sexual health, including rates of gender based violence and drug misuse.
- Describe the sexual and reproductive health problems vulnerable adult females within the criminal justice system may face.
- To attempt to quantify the current unmet sexual and reproductive health needs of this group of women and any gaps in sexual healthcare provision, both those within custody and those based in the community.
- To inform further work on the general health needs of female offenders, which may be required given planned changes to the female custodial estate in Scotland. This may include

identifying possible data sources and findings related to themes central to all areas of healthcare (e.g. barriers to access).

- To identify any gaps for further routine or research data collection.
- To make recommendations for future planning and development of sexual health services for women within the criminal justice system in NHS GG&C.

## METHODS

The HNA was conducted from September 2016 through to June 2017. The working group established the aim and objectives of the HNA and agreed the methods and schedule for implementation. The fieldwork for the HNA was conducted by the specialty trainee doctor with the support of the working group. The HNA process was also supported by Glasgow City Council Criminal Justice Social Work Department Manager and staff, and HMP Greenock Healthcare Manager and staff.

Settings included within the HNA;

- HMP Greenock in Inverclyde. Staff working within the prison and the female prisoners.
- Tomorrows Women Glasgow. Staff working within this service, and women attending it.
- A cohort of staff working within the Glasgow City Council Drug Court and Persistent Offender Project social work services at Norfolk Street, as well as women attending these services.

This HNA combined three methods of conducting a HNA as described above, an epidemiological, corporate and comparative approach.

- The Epidemiological Needs Assessment describes;
  - the findings of a literature review,
  - an audit of prison sexual health clinic attendances, and
  - a questionnaire completed by women in prison and community settings.
- The Corporate Needs Assessment discusses the views of those women involved in criminal justice services in GG&C, and also of staff members working with these women regarding the provision of sexual health services in these settings.
- The Comparative Needs Assessment compares current services provided by NHS GG&C to those provided by other Scottish Health Boards, and describes recognised standards for sexual healthcare service provision.

The methodology for the literature review, audit, questionnaire and interviews are outlined in the sections below.

## LITERATURE REVIEW

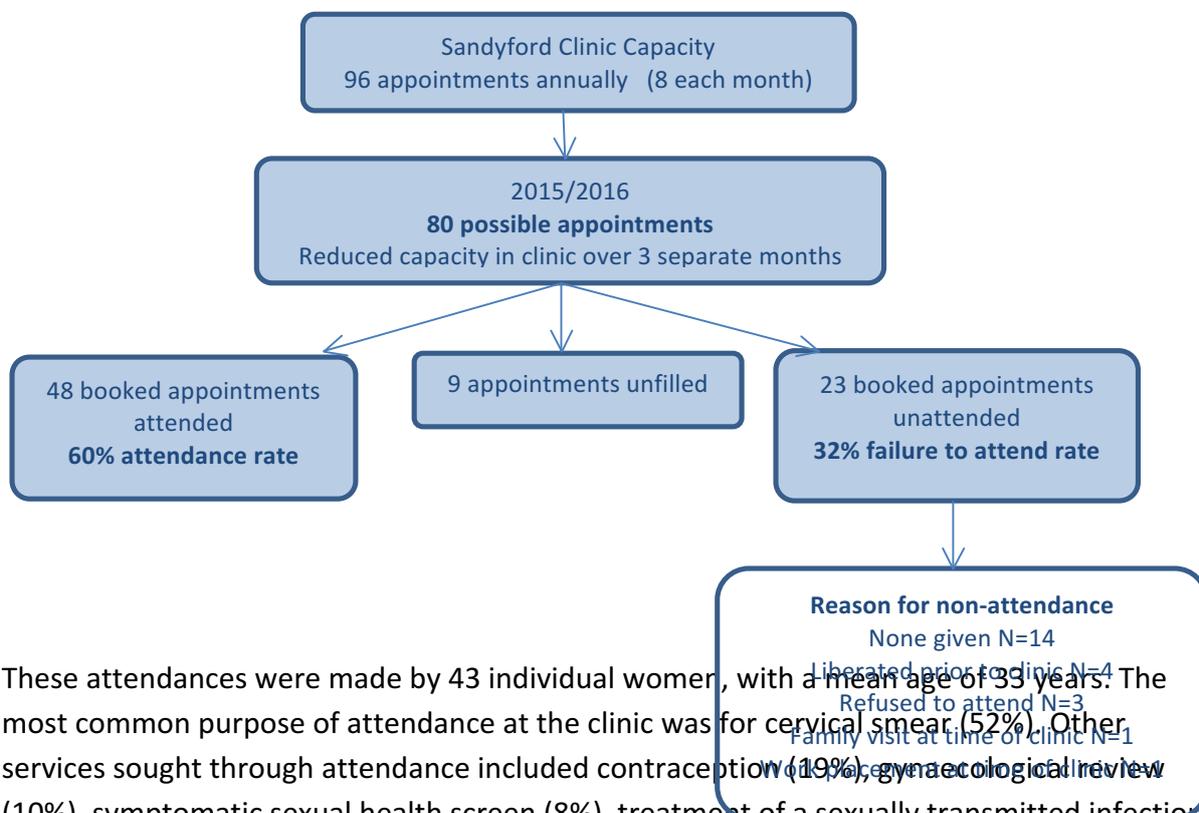
A literature review was conducted on the sexual health of women within the criminal justice system. A review of databases including, OVID Medline, Embase, Psychinfo, Cochrane and CINAHL from 1980 to September 2016, limited to human and English language studies, was performed. The search terms used are detailed in Appendix 1. A further search of the grey literature was conducted. Titles and abstracts of documents were reviewed, and the full text of any relevant documents examined. Priority was given to Scottish and UK based documents.

**AUDIT OF PRISON SEXUAL HEALTH CLINIC**

A retrospective review of the electronic records of all attendances at the clinic over a 12 month period, from September 2015 to August 2016, was conducted. A proforma was used to record information obtained from the electronic records and all data was inputted to an excel database to allow analysis. The electronic records of all attendances were reviewed to determine the number of women attending the clinic, basic demographics of women attending and the primary reason for attendance. Attendance rates and reason for non-attendance were also reviewed.

This retrospective review identified a total of 48 attendances from a total of 80 possible appointments. (Flow chart 1)

Flow Chart 1. Sandyford clinic attendance rates Sep 2015- Aug 2016



These attendances were made by 43 individual women, with a mean age of 33 years. The most common purpose of attendance at the clinic was for cervical smear (52%). Other services sought through attendance included contraception (19%), gynaecological review (10%), symptomatic sexual health screen (8%), treatment of a sexually transmitted infection (2%) and an asymptomatic sexual health screen (2%).

## ANONYMOUS QUESTIONNAIRE FOR WOMEN

An anonymous questionnaire was used to gain an understanding of the demographics of this group of women, and to provide an estimate of the prevalence of risk factors for and measures of poor sexual health in this group of women. The questionnaire was designed by the specialty trainee conducting the fieldwork and approved by the working group. Input was sought from partners supporting the HNA within HMP Greenock and Criminal Justice Social Work Services regarding wording of questions and from Corporate Equalities in NHS GG&C to ensure it would be accessible for women to read. The front page of the questionnaire was an information sheet, which described to participants the nature and purpose of the questionnaire and the HNA, and the voluntary nature of the questionnaire. (Appendices 2-3) An information sheet about the questionnaire explained the purpose and anonymous nature of the questionnaire. Responses were tick box with space for additional free text where required. No patient identifiable information was sought on the questionnaire.

## DISTRIBUTION

In HMP Greenock, the questionnaire was distributed by prison healthcare centre staff over a 2 week period in February 2017. In the community, the questionnaire was distributed from mid-March to mid-April 2017 to a small sample of women, aged 16 years or over, involved with Tomorrow's Women Glasgow, the Drug Court or the Persistent Offenders Project (POP). The questionnaire was distributed by Glasgow City Council Community Criminal Justice Team staff.

Women in all settings were advised that completion was voluntary. No incentive was offered for completion. Women were offered the assistance of a member of the prison health centre staff or community criminal justice team staff to complete the questionnaire if they expressed any difficulty in understanding English language or if they had any literacy problems. Once completed, women were asked to place the completed questionnaire in a place identified by the prison or community criminal justice team.

The questionnaire responses were collated onto an excel database and data analysis was conducted by the specialty trainee doctor.

## RESPONSE RATE

In total 58 questionnaires were completed. In the prison 40 questionnaires were returned from a total of 53 distributed (75% response). In the community, 15 women attending TWG were asked to complete the questionnaire and all completed it (100% response rate). Three questionnaires were returned from the Drug Court and Persistent Offenders Projects. It was

not possible to determine an accurate response rate from this setting as no accurate record of the number distributed was kept. Staff distributing the questionnaires to these women stated only small numbers of women were actively involved with these services during this month, and so only a small number of questionnaires were distributed.

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#### FOCUS GROUPS WITH WOMEN WITHIN CRIMINAL JUSTICE SERVICES

Two separate focus group discussions were conducted. One was held in HMP Greenock with 5 women currently in custody (age range 28-54 years), and one was held at TWG, with 5 women currently accessing the service (age range 31-44 years). Women were asked to advise a member of staff distributing the questionnaire if they were interested in participating. Participation in the focus group was incentivised; women in prison received a small monetary sum into their prison account following participation in the focus group, whilst those in the community were given a high street shop voucher.

Only the specialty trainee doctor conducting the fieldwork was present during both focus groups. Audio recording equipment was used to record the focus groups and the recordings were transcribed by an external company. No patient identifiable information was disclosed during the recordings. Women agreeing to participate were provided with written information regarding the purpose and nature of the focus group discussion and the HNA and asked to complete a consent form. (Appendices 6-7) They had the opportunity to decline to participate at the time of the focus group if they wished. A structured topic guide was used to help guide the discussion in both groups. (Appendices 8-9) Each group session was conducted in under 40 minutes. The transcribed recordings for each group were reviewed and coded to allow identification of any themes within each group.

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#### INTERVIEWS WITH CRIMINAL JUSTICE STAFF MEMBERS

Semi-structured one to one interviews were conducted with members of staff from HMP Greenock and from Community Criminal Justice Services. The schedule for the interviews was designed by the specialty trainee doctor based upon the schedule used in the previous HNA in 2012. (5) (Appendices 4-5) The schedule was reviewed and subsequent drafts agreed by the working group.

In HMP Greenock, 5 staff members were interviewed, including 2 nurse practitioners, 2 addiction nurses and a prison officer. The interviews were conducted in person in HMP Greenock by the specialty trainee doctor. These interviews were noted by hand at the time of interview. In the community, 5 criminal justice staff members were interviewed, 3 working within TWG and 2 working within criminal justice social work services at the drug court and persistent offenders project. These interviews were conducted by a member of Health Improvement staff from NHS GG&C who was not a member of the core working group. The interviews were conducted by telephone, noted by hand during the interview

and subsequently typed up. Data were organised by cross-sectional indexing and analysed using thematic analysis.

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#### COMPARISON WITH SERVICES PROVIDED IN PRISONS IN OTHER SCOTTISH HEALTH BOARDS

Health Centre Managers in prisons with female inmates in Scotland (HMP Edinburgh, HMP Cornton Vale, HMP Polmont and HMP Grampian) were asked for information on how sexual healthcare services are provided in that prison. They were sent a short questionnaire by email and asked to complete it in relation to their service. (Appendix 10) Responses were obtained from Health Centre Managers at HMP Edinburgh and HMP Cornton Vale.

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#### ETHICAL APPROVAL

Advice was sought from the West of Scotland Research Ethics Service, who confirmed that the HNA constituted service evaluation (as opposed to research), and formal NHS ethics approval was not required. The HNA was approved by both Glasgow City Council Social Work and Scottish Prison Service ethics committees.

The Epidemiological Needs Assessment seeks to describe the sexual health of women in prison or involved with the criminal justice system.

Data measuring sexual health in the female prison population or wider criminal justice system is not routinely collected. There are therefore significant gaps in the available local or published data on the prevalence and incidence of sexual health conditions amongst this population. The literature review therefore primarily describes the prevalence of risk factors for poor sexual health and measures of sexual health.

Given the limitations to routine data collection the findings from a) the anonymous questionnaires from women in HMP Greenock and in the community settings carried out as part of this needs assessment, and, b) audit data from the HMP Greenock Sexual Health Clinic, provide important information on the likely levels of need.

### LITERATURE REVIEW FINDINGS

Prisoners have been shown to have poorer health when compared to the general population. A review of literature related to the health of prisoners identified a greater likelihood of mental illness, infectious diseases, and mortality from all causes upon release from prison. (18)

A high proportion of prisoners are from a deprived background. It has been reported that whilst only 10% of the general population live in the most deprived communities in Scotland, over 28% of prisoners in Scotland provided an address in one of these areas as their last home address. (4) Socio-economic deprivation is in itself linked with poorer health and health outcomes across a range of conditions. No studies were identified directly comparing the health outcomes of prisoners to non-prisoner populations from deprived areas.

Although there have been no similar studies in the UK, it has been reported that in comparison to men, women in custody in the US experience a higher burden of physical and psychiatric disorders and drug dependence than their male counterparts. (19) There are few studies measuring sexual health outcomes in a prison population however a review identified a greater likelihood of sexually transmitted infections amongst women prisoners when compared to males. (20)

Previous history of substance abuse or experience of GBV are risk factors for poor sexual health. Several studies have shown higher prevalence rates of past substance abuse in female prisoners compared to those found within the general population, (1, 21-22) including one UK study suggesting a prevalence of 86%. (1)

The Scottish Prisoners survey is an annual anonymous survey of all prisoners conducted by SPS. In 2015, 27% reported an experience of GBV towards them, by a spouse or partner. (23) It is expected that this is an underestimate of levels of GBV, with women making up only 8% of respondents and the question excluding GBV outside of a partner relationship. This expectation is supported by other studies reporting higher rates of GBV in female prisoners. In one study, 67% of female inmates in a US jail reported a history of sexual abuse, whilst 79% reported a history of physical abuse. (20) In another study in prisons in Australia, 60% of women questioned reported a history of having been sexually coerced in the past. (24) GBV itself is known to predispose women to be at greater risk of poor general health and poor sexual health, including gynaecological problems and sexually transmitted infections. (6)

Two previous health needs assessments of prison health in Scotland have reported the higher prevalence of chlamydia rates in young male prisoners, as compared to the general population, as a marker of poorer sexual health in prisoners. (5,11) A UK study has looked at the prevalence rates of chlamydia genital infections in young female inmates (age 18-22), and similarly identified a higher prevalence. This study reported an overall prevalence of 13.2% in these young female inmates compared to an expected prevalence of 8.1% in a similar age group in the general population. (22)

Women have gender specific sexual health needs, including cervical screening to prevent cervical cancer, and contraception to prevent unplanned pregnancy. Socio-economic deprivation is associated with both lower levels of cervical screening, and higher mortality rates from cervical cancer. (25) We know that prisoners are more likely to be socio-economically deprived. (4) It has also been reported that female prisoners have a greater likelihood of risk factors for cervical cancer, including Human Papillomavirus (HPV) infection and abnormal cervical smears, and are less likely to have had cervical smear in the last 5 years compared to the general population. (7)

No studies relating to the contraceptive needs of women in prison in the UK have been published however there are two US reports. One study investigated contraceptive use amongst women admitted to prison, identified that only 21% were using a method of contraception at the time of entry to prison and 61% had not used any method of contraception in the year prior to entering prison. However, only 22% of these women had a positive attitude to becoming pregnant, suggesting a need for contraception in this group of women to prevent pregnancy following liberation. (26) A further study from the US reported findings from an anonymous survey completed by women in prison and similarly identified a potential high risk of unplanned pregnancy following liberation. (27) Although these studies do not directly relate to women in Scottish prisons, with differences in health systems and populations, they highlight the importance of considering provision of effective contraception as a sexual health need in this group of women.

The age range of women attending the sexual health clinic in HMP Greenock and responding to the anonymous questionnaire was similar. The mean age of women attending the clinic was 33 years (range 23-55 years). The demographics of those completing the anonymous questionnaire are shown in Table 1. 93% reported to be white British ethnicity. 78% of respondents reported sexual orientation as heterosexual.

Table 1. Demographics of anonymous questionnaire respondents			
	Prison (N=40)	Community (N=18)	All (N=58)
<b>Average age (range)</b>	35.6 (21-54)	37.3 (21-51)	36.2 (21-54)
<b>Have a home address</b>	19 (47.5%)	16 (88.9%)	35 (60.3%)
<b>Ethnicity</b>			
White British	36 (90%)	18 (100%)	54 (93.1%)
White other	4 (10%)	0	4 (6.9%)
<b>Sexuality</b>			
Heterosexual	31 (77.5%)	14 (78%)	45 (77.6%)
Lesbian/Gay	4 (10%)	0	4 (6.9%)
Bisexual	4 (10%)	3 (16.7%)	7 (12.1%)
Other	1	0	1

Both sources show that there are high rates of substance misuse in this population. 34 of 43 women (79%) attending the clinic reported a previous history of substance abuse. From the anonymous questionnaire 51 of 58 respondents (88%) gave a history of current or past substance misuse, including 58% who had ever injected drugs (Table 2). Approximately half of the respondents reported either previous or current concern about alcohol intake. Over half of respondents had attended a mental health service in the last 3 years.

	Prison (N=40)	Community (N=18)	All (N=58)
<b>Alcohol: Concern about intake</b>			
Yes, currently	4 (10%)	1 (5.6%)	5 (8.6%)
Yes, previously	17 (42.5%)	8 (44.4%)	25 (43.1%)
No, never	18 (45%)	8 (44.4%)	26 (44.8%)
Not sure	1 (2.5%)	0	1 (1.7%)
<b>Drugs</b>			
Ever used recreational drugs	38 (95%)	13 (72%)	51 (87.9%)
Current use	3 (7.5)	3 (16.7%)	6 (10.3%)
Use within last year	19 (47.5%)	8 (44.4%)	27 (46.6%)
>1 year since used	13 (32.5%)	2 (11.1%)	15 (25.9%)
Ever injected drugs	26 (65%)	8 (44.4%)	34 (58.6%)
<b>Smoking</b>			
Current	34 (85%)	12 (66.7%)	46 (79.3%)
Previous	4 (10%)	3 (16.7%)	7 (12.1%)
Never	2 (5%)	3 (16.7%)	5 (8.6%)

Both sources also show high rates of previous experience of GBV in this population. Information regarding routine enquiry about previous GBV was recorded at 77% of prison sexual health clinic attendances, with 26 of 33 women (79%) asked reporting a previous history. 48 of 58 questionnaire respondents (83%) reported a history of gender-based violence (Table 3). A third of women reported having experienced 3 or more types of GBV.

Experience of GBV	Prison (N=40)	Community (N=18)	All (N=58)
Yes	33 (82.5%)	15 (83.3%)	48 (82.8%)
No	6 (15%)	2 (11.1%)	8 (13.8%)
Rather not say	1 (2.5%)	1 (5.6%)	2 (3.4%)
<b>Types of GBV reported</b>			
Physical abuse	24 (60%)	9 (50%)	33 (56.9%)
Rape/Sexual assault	20 (50%)	8 (44.4%)	28 (48.3%)
Emotional abuse	26 (65%)	11 (61.1%)	37 (63.8%)
Childhood sexual abuse	17 (42.5%)	3 (16.7%)	20 (34.5%)
<b>Number of women reporting experience of 3+ of the above types of GBV</b>	14 (35%)	4 (22.2%)	18 (31%)

A higher proportion of women than would be expected in the general population reported having previously been paid for sex, with 29% of questionnaire respondents reporting this.

Women were asked in the anonymous questionnaire whether they had at any time in the past, had a test for a sexually transmitted infection (STI), or tests for blood borne viruses. 64% reported to have had an STI test (Table 4), whilst 16% reported a history of a positive

STI result at some point in time. The question did not specify which STI and we could not verify positive results. 78% reported a previous test for blood borne viruses. Two women (3%) reported a previous positive HIV test result, one woman (2%) reported a positive hepatitis B result and 22 women (38%) reported a previous positive hepatitis C result.

Table 4. Anonymous questionnaire responses – previous sexual and reproductive health tests

	<b>Prison (N=40)</b>	<b>Community (N=18)</b>	<b>All (N=58)</b>
<b>Ever tested for STIs</b>	27 (67.5%)	10 (55.6%)	37 (63.8%)
<b>Ever tested for HIV</b>	32 (80%)	10 (55.6%)	42 (72.4%)
<b>Last cervical smear</b>			
Within last 3 years	22 (55%)	8 (44.4%)	30 (51.7%)
Over 3 years ago	11 (27.5%)	9 (50%)	20 (34.5%)
Don't know	3 (7.5%)	0	3 (5.2%)
Never had cervical smear	4 (10%)	1 (5.6%)	5 (8.6%)

The review of attendances at the Sandyford clinic identified that 49% of women were overdue for their cervical smear. Four women (9%) were at least 12 months overdue and 1 women aged in her 30's had never had a smear. 28% of women responding in prison and 50% of women in the community reported being overdue to have their cervical smear taken (Table 4). Five women (9%) had never had one taken, despite falling within the age range for cervical screening and 4 of these 5 women were currently in HMP Greenock with access to cervical screening.

A large number of women (90%) responding to the questionnaire had used contraception at some point in their life (Table 5). Women were asked to report any methods of contraception they had previously used. 67% of women had used at least one of the long acting reversible methods of contraception previously (contraceptive injection, implant or intrauterine method). 19% of women had previously used condoms and contraceptive pills, whilst 3 women had only used condoms. The most common reason given for not using any contraception was not having sex (43%). 7% of all women were not currently using any contraception, but would like to.

	Prison (n=40)	Community (n=18)	All (n=58)
<b>Ever used any method</b>	35 (87.5%)	17 (94.4%)	52 (89.6%)
<b>Types of contraception used</b>			
Condom	18 (45%)	10 (55.6%)	28 (48.3%)
Pill	23 (57.5%)	13 (72.2%)	36 (62%)
Injection	13 (32.5%)	6 (33.3%)	19 (32.8%)
Implant	20 (50%)	10 (55.5%)	30 (51.7%)
Coil	1 (2.5%)	2 (11.1%)	3 (5.2%)
<b>Previous use of any long acting reversible method (LARC)</b>	26 (65%)	13 (72.2%)	39 (67.2%)
<b>Ever had an abortion</b>	12 (30%)	7 (38.9%)	19 (32.8%)
<b>Current use of contraception</b>			
Yes	13 (32.5%)	6 (33.3%)	19 (32.8%)
Rather not say	0	0	0
No, not having sex	17 (42.5%)	8 (44.4%)	25 (43.1%)
No, but I'd like to	2 (5%)	2 (11.1%)	4 (6.9%)
No, I don't like using it	3 (7.5%)	0	3 (5.2%)
No, other reason	4 (10%)	1 (5.6%)	5 (8.6%)

## DISCUSSION

Female prisoners and those involved in the criminal justice system in the community are more likely to be socio-economically deprived and to suffer poor general health. It has previously been shown that female offenders are more likely to have a history of previous substance abuse or GBV, and we found similarly high rates of such risk factors for poor sexual health in this population of women, with a history of substance abuse in 88% of women and a history of gender based violence in 83%. A history of GBV predisposes women to both poor general health and sexual health, and it is therefore important to consider how to identify such women in these settings. It will also be necessary to consider how services respond to possible disclosure of previous GBV.

Sexual health needs specific to females include regular cervical screening and contraception. We identified that these are areas of unmet need in this population of women. Almost a third of women in the general population fail to attend for a regular smear, with 31% of women in Scotland not taking up their invitation to attend for a scheduled cervical smear in the year up to end March 2016. (28) We found a slightly smaller proportion (28%) of women in prison were overdue for their smear, possibly as it had been highlighted as being required whilst they were in prison. However, 10% of respondents in prison had never had a cervical smear, despite currently being in prison where access to having a smear should be relatively easy. More work is required to increase the proportion of women in the community who attend for cervical smears, as half of those in this HNA reported being overdue.

Approximately two thirds of women in custody and two thirds of those in the community were not currently using any contraception. The most common reason women gave for not using any contraception was not currently having sex. For women in prison, this may change following liberation from prison, and there is therefore a need to consider contraceptive provision to this group of women before liberation. We identified a small proportion of women not currently using contraception who wish to do so, suggesting there is a potential unmet need for contraception.

The views of women both in custody in HMP Greenock and involved with criminal justice services in the community, and of staff members working with this group of women in both settings were sought for this section of the HNA. The first part describes further findings from the anonymous questionnaire of women relating to service use, and from focus group discussions with women in both settings. The second part describes the findings from interviews with staff members both in HMP Greenock and those working in community criminal justice services, with regard to sexual healthcare provision to this group of women.

## THE VIEWS OF WOMEN USING CRIMINAL JUSTICE SERVICES

## RESULTS

## ANONYMOUS QUESTIONNAIRE

Women were asked in the anonymous questionnaire if they have ever attended a sexual health service at any time. 36 of 58 respondents (62%) said they had and 33% of them had done so within the last 12 months. Almost a third of women in prison (28%) and a third in the community (33%) had never attended a sexual health service (Table 6).

Ever attended at a women's sexual health service	Prison (N=40)	Community (N=18)	All (N=58)
Yes	25 (62.5%)	11 (61.1%)	36 (62.1%)
No	11 (27.5%)	6 (33.3%)	17 (29.3%)
Not sure	4 (10%)	1 (5.6%)	5 (8.6%)
<b>Attended in last year</b>	9 (22.5%)	3 (16.7%)	12 (20.7%)
<b>Settings previously attended for sexual health services</b>			
Prison	14 (35%)	2 (11.1%)	16 (27.6%)
GP	8 (20%)	4 (22.2%)	12 (20.7%)
Women's health clinic (Scotland)	9 (22.5%)	8 (44.4%)	17 (29.3%)
Other	1	1	2

The most common reason given for having never attended a sexual health service was that they felt there was no reason they required to do so (70%). Other reasons for having never attended a service were embarrassment (25%) and fear (15%).

	<b>Prison (n=13)</b>	<b>Community (n=7)</b>	<b>All (n=20)</b>
No problems/no need to go	11 (84.6%)	3 (42.9%)	14 (70%)
Didn't know where to go	0	2 (28.6%)	2 (10%)
Difficulty travelling	0	1 (14.3%)	1 (5%)
Too far to travel	0	0	0
Unable to go when it was open	0	0	0
Scared	1 (7.7%)	2 (28.6%)	3 (15%)
Embarrassed	2 (15.4%)	3 (42.9%)	5 (25%)
Concerned in case someone found out	0	1 (14.3%)	1 (5%)

Those women who reported having never had a cervical smear, 9% of all respondents, were also asked for any reason why they had not attended. Three of the 5 women who had never had a cervical smear stated that they did not know they should have them taken. One felt they personally did not need a cervical smear and one reported being too scared to attend.

Reviewing the questionnaire responses of the 14 women who had never attended a sexual health service because they felt there was no reason to do so, highlights that they are a group of women with risk factors for poor sexual health (Table 8).

Expressed current or past concern about alcohol consumption	5 (35.7%)
Have ever used recreational drugs	10 (71.4%)
Have ever injected drugs	6 (42.9%)
Have given birth	10 (71%)
Have had an abortion	4 (28.6%)
Have used contraception	10 (71%)
Have used any method of LARC	6 (42.9%)
Have had an STI test	4 (28.6%)
Have had a HIV test	8 (57.1%)
Cervical smear in last 3 years	8 (57%)
Never had cervical smear	1 (7%)
Have experienced GBV	12 (85.7%)
Have ever been paid for sex acts	2 (14.3%)

## FOCUS GROUPS

### WOMEN IN CUSTODY OR COMMUNITY CRIMINAL JUSTICE SETTINGS

Three main themes of discussion were evident from the focus group with women;

1. Awareness of sexual health issues and sexual health services
2. Staff attitudes and comfort discussing sexual health issues
3. Access and barriers to sexual health services

#### *AWARENESS OF SEXUAL HEALTH SERVICES AND HEALTH PROMOTION*

Several, although not all women in the group, were aware of sexual health promotion campaigns and had come across sexual health promotion information (posters and leaflets) in the prison or in the community. In the community group this was primarily in primary care setting. Addictions services (community) were an additional setting for information, although materials discussed were primarily about HIV.

Written material was described as having limited impact, being primarily useful as a reminder (e.g. to arrange an appointment for a cervical smear) or as advertising (e.g. a new contraception). This contrasted with enthusiastic discussion in the prison group about learning from a recent breast examination health promotion event in the prison.

*“To be honest sometimes I think they just, they look quite boring, do you know what I mean. So, you're not drawn to really pick them up a lot of the time.”*

Focus group participant, prison

*“When I see a poster of something, sometimes it'll just go in one ear, and I'll just not think about it....But if I do think about it, it's thinking about my smear test. And I'll come down and go, I'd better go and get a smear test.”*

Focus group participant, community

When asked about what they considered to be sexual health care priorities for them, the group felt contraception, cervical screening, tests for STI's and blood borne viruses, gynaecological review if required and breast examinations if required were important. In discussions about the need for cervical screening, Jade Goody remained a source of reference over 8 years after her death.

It was clear that sexual healthcare was often not of importance to women in comparison with other issues, particularly when they first entered prison. They would be likely to have many other concerns at this time and described being unable to 'think straight'. Reflecting on this some women, but not all, remembered related discussions at their first health centre appointment in prison.

*“you've got a lot more things going on in your mind than your sexual health”*

Focus group participant, prison

In the community several of them discussed not attending for a sexual health related issues, such as a cervical smear, often as they forget about it.

*'I've not been near anybody about sexual health things, or anything like that, for a while'*

Focus group participant, community

All of the women were aware of the existence of the Sandyford sexual clinic within the prison and the referral process to attend it, although there was uncertainty amongst them regarding the frequency of the clinic.

Most, but not all, of the focus group participants were aware of local sexual health services in their local home community, both at their GP and in Sandyford services, and how they could access them if required. Within the community several also mentioned that they felt addictions services were a possible source of information or advice for them regarding sexual health concerns.

#### *STAFF ATTITUDES AND COMFORT DISCUSSING SEXUAL HEALTH RELATED ISSUES WITH THEM*

The women described feeling more comfortable discussing sexual health matters with a member of nursing or medical staff, seeing it as their role, and generally found the healthcare staff to be helpful.

*"the health centre staff, you think they've seen it all, they've heard it all"*

Focus group participant, prison

*"They can put your mind at rest if you're worried about them and they give you information if you don't know what's required of you sort of thing."*

Focus group participant, prison

They were less comfortable discussing sexual health matters with other staff groups. This may contrast with a willingness to discuss other health issues.

*"I don't think I would be comfortable talking about sexual health with them (prison officers), things like that"*

Focus group participant, prison

*"I don't know, I think that's just something that's between you and the doctor, or you and the nurse."*

Focus group participant, community

In both groups there was comment that discussion of sexual health issues might require a relationship with the staff member, particularly for non-nursing staff.

*"..I think it would depend on what staff...and your relationship with that member of staff, do you know what I mean. But, generally, no (discuss with prison staff)"*

Focus group participant, prison

F5: *"I'd talk to anybody about stuff. I've been through so much that I need to talk about it. So any of the workers, I talk to."*

F2: *"Aye, that's like me, aye."*

F1: *"So you're comfortable with that?"*

F5: *"And I've got a social worker that I talk to as well."*

F2: *"Aye, that's like myself."*

Focus group participant, community

They expressed views that they may be more likely to discuss sexual health issues if they were asked about them, and perceived that there was time and interest in the discussion. There appeared to be limited experience of having such discussions unless they had sought help with symptoms.

*"Sometimes, no, aye and no, because I think sometimes other ones rush you, they rush you, that's what I noticed once in here"*

Focus group participant, prison

*"If anybody asked me, then yes, I would probably talk about it to them.....I've not been asked to talk anywhere really"*

Focus group participant, community

*"Aye, like if somebody asked me, then I would talk about it, but I don't feel as if anybody, like, really would ask, like, talk to you about things. Or like, usually, even like a doctor, or something like that, would give you a bit of information. Like, I know they'd give you like a wee.....leaflet, and say, phone this number up, and all that. And then you just put that leaflet in your bag, and then that's it, you don't do it, do you know what I mean. Whereas, you're trying to get the doctor to try and refer you to it, but then, och, I don't know. It's mental, isn't it."*

Focus group participant, community

#### ACCESS AND BARRIERS TO SEXUAL HEALTH SERVICES

There were no concerns about confidentiality when discussing sexual health issues with staff in prison or community settings, however there was concern from some but not all that consultations in the prison health centre lacked privacy. They described being aware of a prison officer, often a male, being present just outside the consultation room, with a window with no blind on, and concern that they would be able to hear or lip read the consultation.

*"you're sitting there and you're speaking to them wondering, can they hear me out there"*

Focus group participant, prison

Women were happy that they could self-refer or be supported in being referred to the prison sexual health clinic. However, there was some concern amongst the women regarding the process for self-referral to the sexual health clinic in the prison. They described the frustration that can result when they do not hear back directly if that means they will be seen in the clinic, and when this is likely to be.

*"I didn't have to put a slip in, it was (health centre nurse) that put me in for you."*  
Focus group participant, prison

*"you've just got to wait, you don't get always get a reply do you, you've just got to wait and hope for the best."*  
Focus group participant, prison

They described feelings of anxiety when waiting for a clinic or appointment (sexual health or GP) if it is several weeks away. Concerns about this wait in the prison group included becoming infertile due to delays in treating an STI, potential delay if they find a breast lump and pregnancy (discounted on basis of testing on admission). Importantly, in both groups there was a theme that waiting may result in the issue is no longer being important to them, or losing momentum, and they fail to attend.

*"..if you've waited that three weeks to try and get an appointment and then that clinic is fully booked, it's another month you're waiting, by that time your problem could have blew up, or gets to the stage where I'm no even going to bother"*  
Focus group participant, prison

*"Instead of the next couple of days, it's the next couple of weeks, until you get to speak to someone and probably, sometimes, it goes right out of somebody's head."*  
Focus group participant, community

*"But you could be on the waiting list for, like, three weeks, or something.....You're like that, aye, I'll take that appointment, and then it's like, when it comes to that, and you're like that, I forget all about it.... you just don't bother going to it"*  
Focus group participant, community

The prison group talked positively of the benefits of having a sexual health service within the prison, as opposed to having to be transferred out of prison to a service. Most had experienced going out for hospital appointments and described feeling embarrassed, both by having to sit in a waiting area whilst chained to a member of security and by the presence of the member of security in the room during their consultation.

*"Wearing that big band is a nightmare."* Focus group participant, prison

*“Yes, and you've got to sit in the waiting rooms and I mean I went out to the hospital for something and it was just so embarrassing.”*

Focus group participant, prison

*“it was a guy and a woman and it was just...even they knew what was going on. The curtain was round they couldn't...but just the thought of that guy sitting there knowing that..”.*

Focus group participant, prison

This was the only situation in which confidentiality was raised as a particular concern

*“No, but really, do they have a confidential clause or anything, do you know what I mean? For all we know they could be going away laughing. So, do you know what I mean, with their buddies.”*

Focus group participant, prison

All women in the group described a preference for seeing a female member of medical staff when discussing sexual health issues.

*“Like I had a (gynaecological issue), and it was a male doctor I had to see in here, that didn't bother me really but if I could have done it at the Well Women clinic.... I would rather see...no, it was a male, but I would rather see a female, do you know what I mean?”*

Focus group participant, prison

Embarrassment was a topic that came up several times throughout the community group discussion. Some women described being more embarrassed at a younger age, although feeling less so as they have got older. They described being embarrassed on accessing free condoms from services with a preference for having access to free condoms in discreet locations (such as in a toilet). They specifically felt embarrassed during any kind of intimate examination (for a smear test). Some described not wishing to attend due to embarrassment. They felt that any body image issues they had, or previous experiences of sexual assault or abuse may impact of this embarrassment further.

*‘they’ll say, you need to open your legs..... and I mean you’re opening your legs and I feel.....things that happened in my past.....’*

Focus group participant, community

Regarding access to services in the community, flexibility of sexual health services and the benefit of this was highlighted by one participant.

*“No, because a lot of them do night time clinics, as well, and first thing in the morning, if you were working, and things.”*

Focus group participant, community

Problems accessing community services included that some people would have financial difficulty in obtaining travel costs to get there, that they may struggle to find it and that childcare can pose a problem for those with young children. Possible suggestions discussed in the group to tackle these barriers included having a means to help fund travel to clinic for those requiring it, having a childcare available within services and locating services closer to them if possible, particularly within their own GP practice.

F6: *“Years ago, at the Sandyford..... and I could not tell you, I didn't know where the Sandyford was. So, like, finding it, getting to it, and if you haven't got any fares to get there.”*

F3: *“Aye, near me, the one in Parkhead, is near me, the Sandyford. But if anybody stays away out from Parkhead, if they're maybe more in different schemes, they've got to walk.”*

*Focus group discussion, community*

*“Aye, I usually go to the doctor's, or something, 'cause the doctor's is more or less near everybody, do you know what I mean.”*

*Focus group participant, community*

*“I was thinking, when I was younger, and I had the kids, when they were young, it's something, before they went to school, it was difficult go get child care. Maybe if they had like a wee child care centre in the places.”*

*Focus group participant, community*

Whilst three of the five women in the community group discussed a previous experience of attending a Sandyford service and all were positive in their view of the service, it may feel daunting for some of this population group to attend a specialist, unfamiliar service.

F6: *“And, I think once they've made the appointment like going into Sandyford or whatever, it's quite daunting as it is, it could be a bit nicer, a bit more welcoming, but that's the clinic itself, do you know what I mean.”*

F3: *“When you've made the appointment you go in and sit in they chairs, I think they're quite rude there the way they speak to you, I've noticed that in the past.”*

F5: *“The one in Parkhead when you go in it's like a Tannoy system and it's just [name] for smear test and doctor whatever, that's mad.”*

*Focus group discussion, prison*

Difficulty in successfully getting through on the phone to make an appointment at the Sandyford was highlighted. Discussions suggested ways of getting round this may differ from what services would expect, for example going there in person as in the quote below. For some website booking of appointments might be an option, but not all.

F3: *“My one that's in Glasgow you can't get through to it, you can't get an answer, it constantly rings and rings out that one at the top Sauchiehall Street somewhere, that is a nightmare to get through to, I've never got through to it in my life.....Got to go up in a taxi or a get a run up and whatever and make an appointment that's it. It's a nightmare to get through.”*

*Focus group participant, community*

F6: *"Have they got a website or something you could go round and get an appointment that way."*

F1: *"Yes, so websites, making an appointment on the website you mean it would easier?"*

F: *"Yes".*

F3: *"I've never done that, no."*

Focus group discussion, prison

Wider use of new technology for giving results or information was cautiously received in this group e.g. emailing or texting results, particularly with information seen as confidential. The community group were aware that Sandyford sexual health service had a website, but described either being unlikely to use it, using it for contact information only, or if they would use it feeling it contained too much information.

F1: *"What about things like websites, or the internet, would any of you ever use anything like that?"*

F2: *"No"*

F5: *"I would, but they tell you too much information."*

F2: *"Aye. "*

F6: *"Aye."*

F5: *"I would look it up to look for addresses, or a local centre, but not really for the advice."*

Focus group discussion, community

To help in accessing services within the community on release the prison group felt it would be useful if they could be provided with information regarding the service local to where they will be living at time of liberation. This may have been about more than signposting; potentially there was interest in the handover of their care to these services to make the process easier.

*"Perhaps if like here could make your clinic nearest where you're going to be aware of things like when you had your last smear and tell you when you're getting out, what the phone number is and where it is, like not everybody knows, like number three doesn't know where there is one. So, perhaps the prison clinic could tell her where to go, give her the address and phone number and then let them know about anything, but give her health notes over."*

Focus group participant, prison

## RESULTS

### STAFF WITHIN HMP GREENOCK

Those interviewed felt the sexual health needs of women in prison included, contraception pre-liberation, testing for STI's and blood borne viruses on admission to prison and cervical screening. They all felt that their job had a role to play in sexual healthcare in this setting, mostly in the form of provision of health promotion advice and being aware that they could refer on to either the nurse with a special interest working in the service, or the Sandyford clinic. All were knowledgeable about the Sandyford clinic which runs within the prison and the referral process, and all were positive about the benefits of having access to such a service within the prison, both for women and health centre staff.

When asked if they felt comfortable discussing sexual health with women in prison, all felt comfortable doing so, although some acknowledged they feel they are lacking in knowledge within this area and would refer to the specialist nurse for advice. There was some concern amongst those interviewed that women may not disclose sexual health problems for several reasons. These included, embarrassment, previous experiences of sexual abuse or due to fear of consequences if information is passed onto SPS staff which they deem may get them 'into trouble'. It was suggested that the paper referral slips used to self-refer to the Sandyford clinic are not confidential, and would be better placed in an envelope.

An additional barrier to provision of sexual healthcare in prison, described by several of the interviewees, was prison regime. Women currently are not given an 'appointment' to attend the health centre for the Sandyford clinic, or other services. This can result in them being requested to attend the health centre without any notice that they are due to be seen that day, possibly at a time when they are involved in another activity, such as a family visit or a work placement. Providing women with appointment times in advance may result in them being more likely to attend.

A suggestion from HMP staff members, as a possible measure to improve sexual healthcare for these women included ensuring all staff (health centre and prison officers) receive training in disclosure and management of disclosure of sexual assault and childhood sexual abuse. Further suggestions included increased promotion of the Sandyford clinic to women and one nurse suggested the possibility of a routine pre-liberation health consultation with women which could cover contraceptive plans. A recent breast screening health promotion event was viewed by staff as having been very popular amongst women, and so a further suggestion was sexual health promotion events, centred around an individual topic which could change intermittently (e.g. cervical screening).

## COMMUNITY CRIMINAL JUSTICE STAFF

A significant theme noted from the interviews with criminal justice staff members, is that women accessing their services do not prioritise their sexual health at all. They have chaotic lives with many other issues which are more important to them than sexual healthcare and often only access healthcare in a crisis or emergency. They felt education was important for this group of women and that a lack of knowledge regarding sexual health may lead to fear or misinformation. Similarly, they felt education of staff regarding sexual healthcare and access to it was important and all stated they would welcome training and updates in this area, allowing them to be more informed when discussing the topic with women. Most staff interviewed felt comfortable in discussing sexual health with women, although expressed views that it can take time to develop a relationship and trust with women, and they may choose not to discuss sexual health straight away when a women attends the service. When asked if they were aware where women could seek sexual health services, all referred to Sandyford sexual health services in the community as where they would direct women to. All felt that sexual healthcare was part of their job, mostly in providing support and advice and signposting to sexual health services.

Two main barriers to women attending sexual healthcare services were identified by this group of interviewees. The first was access to services. Financially it may be difficult to negotiate public transport to get them to a sexual health service if it is not located close to them. They may also not know how to get to services. Locating services where women are was suggested by all interviewees, such as within a GP practice or within addictions services. The phone system to arrange an appointment at a Sandyford sexual health service was also highlighted as posing difficulty for women, who may not persist in their efforts to get through. The second barrier was the stigma, shame or fear women may have when considering attending sexual health services. They may fear being judged if they have previous experience of substance abuse or prostitution, and may have experienced previous traumatic events such as assault or sexual abuse which may make it difficult for them to present.

## DISCUSSION

Due to the timescales for completion of this health needs assessment, a relatively small number of short semi-structured interviews were conducted with staff members in both settings. In-depth interviews with a larger number of staff may have provided some more in-depth information. Similarly, it was only possible to conduct 1 focus group with women in each setting. However, the information we obtained regarding the views of women and staff members about sexual health needs and services in these settings is important.

Reassuringly staff interviewed in both custodial and community settings, felt that sexual health care for women was part of their role, mostly in the provision of support and / or

signposting them to a sexual health service. They describe feeling comfortable talking about sexual health issues with women; however, women in prison and in the community overwhelmingly felt more comfortable discussing such issues with nursing staff as opposed to non-medical staff. Interestingly, women in the community focus group discussed being more inclined to talk about sexual health issues if they were brought up directly, but also describe no one bringing up these issues in discussions with them. Although staff stated they feel comfortable having such discussions, there may be some missed opportunities for this; staff are possibly perceiving women to have other current priorities above sexual health and pre-empting embarrassment from the women.

It is clear that sexual health may not be a priority for women when they enter prison or are attending a community criminal justice service. This was identified by community criminal justice staff and described by women particularly in the prison setting. Although over half of questionnaire respondents had previously attended a sexual health service at some point in time, the most common reason given for having never attended one was having no need to do so. Whilst a proportion of women will have no sexual health care needs, the characteristics of the women who gave this as a reason did not suggest they differed significantly from the wider group. This could suggest that some women either lack knowledge about sexual health, or simply to do not feel it to be of importance at this time – particularly given sexual health related appointments may be preventative; needed without symptoms or ‘crisis’. In such situations, it’s possible that if staff members were to use opportunities to raise sexual health issues with women, such as reminding them they may be due a cervical smear, women may decide to follow up on this.

Staff working in both settings suggested education for women and health promotion about sexual health may improve lack of knowledge amongst them and decrease misinformation. Both women and staff members in prison talked positively about a recent health promotion event related to breast examination, whilst women in both settings discussed the limited benefits of health improvement leaflets and posters. This would suggest that sexual health promotions events may be well received and of more use to women.

During the retrospective review of Sandyford clinic attendances at HMP Greenock, we identified that a third of women fail to attend booked appointments at the clinic. Both staff interviewed and women in the focus group in HMP Greenock identified problems with the current system for referral and appointment to the clinic. This may in part explain some of the problems with failure to attend and there is scope to consider revising this system and improving attendance rates. Both staff and women talked positively about the existence of a Sandyford sexual health clinic within the prison, and women held negative views about having to transfer out of prison with an escort for attendances at a health service out with prison.

Both staff and women identified that provision of information and signposting to sexual health services in the community, prior to liberation, would be of benefit, as would onward transfer of any relevant information about their health to such sexual health services.

Staff interviewed and women participating in the focus group in the community setting identified common barriers. Staff described feeling that women were embarrassed to discuss sexual health issues, and women themselves described feelings of embarrassment when discussing them. Embarrassment was a reason given for having never attended a sexual health service in almost a third of women who responded in the anonymous questionnaire to say they have never attended one. Women suggested it was often easier for them to discuss such issues if they were asked, as opposed to having to bring it up themselves. Incorporating routine sexual health questions into the discussions with women after entering prison or following registration with a community criminal justice service may be beneficial.

Difficulty in both obtaining an appointment and managing to get to any booked appointments in a sexual health service in the community, was identified as a barrier for women by both staff members and described by women in the community setting. This population may be less confident navigating the appointment system and may find some aspects of accessing an unfamiliar specialist service daunting.

It is clear that it is widely known that Sandyford provides sexual health services to women. In relation to where to access such services, all staff interviewed, and all but one of the women participating in the focus groups, mentioned Sandyford services as a place to obtain sexual health care. However, women also referred to their GP as a location to attend for sexual health services, and in some cases Addictions services may be acceptable for some services. It was apparent that services local to them would be their preference.

## COMPARATIVE NEEDS ASSESSMENT

This section compares sexual healthcare services for women involved in the criminal justice system in NHS GG&C, both to other women within custody elsewhere in Scotland, and to women in the general population. It is presented in 2 parts, the first describing the sexual healthcare provision to women in prison in 2 other health board areas in Scotland, NHS Lothian and NHS Forth Valley, and the second outlines policy, standards and guidelines related to sexual healthcare for women in Scotland.

## RESULTS

### SEXUAL HEALTHCARE PROVISION TO WOMEN IN PRISON OUT WITH NHS GG&C

#### NHS FORTH VALLEY

In NHS Forth Valley, female prisoners are held in HMP Polmont (capacity for 110 females) and HMP Cornton Vale (capacity for 90 females). The sexual health service provided to both of these prisons is similar. The NHS Forth Valley prison health service has a lead sexual health nurse who provides sexual health to both female and male prisoners in the prisons across the NHS health board. This resource is for 3 days a week. The nurse is supported by a GP with a specialist interest in sexual health who provides a clinic in prison for a half day once fortnightly, in both HMP Cornton Vale and HMP Polmont.

This clinic is advertised to women through leaflets and by health centre staff, and the referral process is similar to that in HMP Greenock, with use of self-referral slips and direct referral from health centre staff.

The range of service provided to women is similar to that at the sexual health clinic at HMP Greenock, including contraception (implants and intrauterine methods included), sexual health screens, cervical smears and menopause. The Health Centre Manager reported that positive aspects to sexual healthcare provision to women in prison in this health board included; a consistent approach with staff well known to the women, an easy method of referral and health improvement events running within the prison.

When asked regarding any negative aspects to provision of this service, they highlighted that by having a single lead nurse, there is a risk that it may be difficult to maintain the same service if that individual was off unexpectedly for a prolonged period of time.

#### NHS LOTHIAN

In NHS Lothian, female prisoners are held in HMP Edinburgh, which has a capacity for 114 women. A nurse led 'well women' clinic runs for a half day once monthly in the prison. This is staffed by a nurse practitioner member of the prison health centre team, who has an

interest in sexual health. Women can self-refer to this clinic through a paper referral slip. The clinic can provide cervical smears, sexual health tests for STI's and blood borne viruses and contraception, although not provision of implants or intrauterine methods. Women are referred to NHS Lothian sexual health service at Chalmers centre in Edinburgh for these methods of contraception.

The Health Centre Manager feels the referral process to the central sexual health service in Edinburgh works well and women are normally seen at that service within 2-3 weeks. The continuity of care, with the same nurse running the clinic was also highlighted as a positive. They are keen for the nurse running the clinic to be able to train to insert and remove contraceptive implants, to allow this to be done within the prison.

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#### STANDARDS FOR SEXUAL HEALTH CARE FOR WOMEN

The United Nations 'Bangkok Rules' establishes a global standard of care for women prisoners. (29) Two separate standards within these rules relate to sexual healthcare. They stipulate that health screening of women prisoners should determine the presence of sexually transmitted infection and blood borne viruses, the reproductive health history and any history of sexual abuse or violence suffered prior to admission. Furthermore, they stipulate women should receive preventative healthcare, in the form of education about HIV, sexually transmitted infections and gender specific health conditions, and access to screening for gynaecological cancer including cervical smears.

The principal strategy for sexual health care in Scotland is the Sexual Health and Blood Borne Virus Framework (SHBBV Framework) 2015-2020, (10) which updated the previous framework published in 2011. (9) This framework combines policy for sexual health, HIV, hepatitis B and hepatitis C. It describes 5 high level outcomes, and indicators to monitor these outcomes, with the aim of driving forward improvements in sexual healthcare in Scotland. Standards for sexual health services were published by NHS Quality Improvement Scotland in 2008. (30) Scottish Cervical Screening Programme guidance provides standards and policy for cervical screening in Scotland. (31,32)

#### DISCUSSION

Sexual health services for women prisoners do not currently meet the relevant standards of the 'Bangkok Rules'. Whilst some of the relevant screening is available, this is primarily on request. Recommendations from a number of sources about routine GBV enquiry are not in place. There is access to a range of contraception, to cervical screening and to specialist sexual health services within the prison.

Although we only have information regarding the provision of sexual health care to women in custody in two other health board regions in Scotland, differences exist in the service that women can expect to receive whilst in prison between these health boards. Whilst more

extensive sexual health services are provided onsite in prison in NHS Forth Valley, women in custody in NHS Lothian are more likely to be required to transfer out of prison with an escort (e.g. for provision of LARC methods including implant or intrauterine devices).

Whilst women are in custody this time poses an opportunity to introduce sexual health services they may not have attended before, or have only attended infrequently to them. Women in custody where onsite sexual health services are provided have easier access to sexual health services than their counterparts attending community criminal justice services as an alternative to custody. It is also important to strive to ensure access to such services in the community is made achievable for women who may struggle to engage with medical services.

The SHBBV Framework which sets policy for sexual health care in Scotland additionally specifically refers to the sexual health of prisoners. There is a lack of any published evidence relating to interventions to improve sexual health in women either in the prison setting or in those involved with criminal justice systems in the community. A review of literature related to the sexual health and wellbeing of vulnerable groups in Scotland in 2009, revealed there to be no UK based evaluations of interventions to improve sexual health in prisoners. (33) Although not specific to women in prison or in the criminal justice system, there is evidence available from a Cochrane review suggesting educational interventions may increase the uptake of cervical screening uptake. (34) As described above, women in prison are less likely to attend for cervical smears and more likely to have cervical cancer, therefore these interventions would be pertinent to this group.

## CONCLUSIONS AND RECOMMENDATIONS

This section brings all three sections, epidemiological, corporate and comparative together, to draw conclusions and make recommendations for future practice.

This is the first time a HNA has specifically looked at the sexual health needs of women in prison and women involved in the criminal justice system in the community. It set out to describe and measure the sexual health needs of this population of women and to enable services to plan and deliver patient-centred sexual healthcare for these women. It is clear they are a vulnerable group of women, who are more likely to be socio-economically deprived, with a higher prevalence of risk factors for poor sexual health, including substance misuse and GBV.

Given our findings of a past experience of GBV in over 80% of women it is disappointing that the recommendation from the previous HNA in 2012, (5) to consider routine enquiry be introduced for all prisoners, has not been met. GBV predisposes women both to poor general health and poor sexual health (6) and women have told us that they may be more likely to discuss sexual health issues when asked. Routine enquiry regarding GBV is therefore important to offer an opportunity to elicit such a history and enable appropriate interventions to be offered to women. We recommend that routine enquiry regarding any past experience of gender based violence should be part of any initial assessment on admission to prison or registration with a Community Criminal Justice Service. Staff training in recognising and responding to disclosure of GBV should be offered to all staff members working with this group of women. Links to services providing counselling for women disclosing previous GBV should be made clear, so that referral can be made easily for those women who wish it.

Women have gender specific sexual health care needs, and this population of women are less likely to attend for regular cervical screening, and have unmet need for contraception. The opportunity to identify any such unmet need for sexual healthcare in these women could be harnessed with the use of a routine sexual health questionnaire, closely following admission to prison or registration with a community service. Similarly, a routine sexual health consultation prior to liberation with a member of health centre staff, can provide an opportunity to consider any sexual healthcare needs, such as contraception, and to signpost women to services local to them upon release to the community. Embarrassment amongst women when discussing sexual health issues was identified as a barrier to accessing services. Women suggested it was often easier for them to discuss such issues if they were asked, as opposed to having to bring it up themselves, which further supports the idea that incorporating routine sexual health questions into these discussions with women may be beneficial.

The presence of Sandyford sexual health clinic within HMP Greenock was viewed positively by both women and staff. It is clear that women do not like travelling out of prison in custody for healthcare, finding the experience embarrassing and degrading, and have some concerns about confidentiality. This is likely to be particularly important for sexual health issues, both because of the heightened embarrassment and because it may be another reason to avoid care for an issue that may not be acutely symptomatic. Both staff and women in custody within HMP Greenock identified problems with the current system for referral and appointment to the Sandyford sexual health clinic within the prison. We identified that approximately one third of women fail to attend on the scheduled day of attendance. There is scope to consider revising this system and improve attendance rates.

Similarly, whilst both women and staff within community services were aware of Sandyford sexual health services, difficulty in both obtaining an appointment and managing to get to any booked appointments in a sexual health service in the community, was identified as a barrier for women in the community setting. The HNA highlights that there may be specific reasons why this population find accessing these services more challenging. Ensuring a clear referral pathway exists for women engaging with community services to access such services, and considering the possibility of providing outreach sexual health services to community criminal justice services, will ensure that these vulnerable women in the community receive the same equity of care as those women who are within custody and can access a clinic within the prison.

It is clear that sexual health is not be a priority for some women when they enter prison, or are attending a community criminal justice service. Whilst a proportion of women will have no sexual health care needs, it is also true that there are a number of barriers to seeking support with sexual health needs including knowledge, confidence in accessing services and prioritising issues that are not symptomatic or a 'crisis'. Education for women and health promotion about sexual health can improve lack of knowledge amongst them and decrease misinformation, and was suggested as being important by members of staff from criminal justice services. Staff members both in the prison setting and in the community, acknowledge that sexual healthcare is part of their role, mainly through provision of advice, health promotion and signposting. When women are in custody or engaging with community services there is an opportunity to introduce education and health promotion about sexual health to a vulnerable group of women.

There are several strengths to this HNA. The working group consisted of a multi-disciplinary team, and had the full support of partners within NHS prison health services and Glasgow City Council Criminal Justice Social Work services. This resulted in a team with a breadth of knowledge, experience and skills. The use of anonymous questionnaires in the methodology may have provided a more accurate reflection of the sexual health of this group of women as they may have been more honest in their answers, and it allowed us to reach a large number of women than would have been achieved with focus groups alone. Additionally, a

good response rate was achieved within prison. The use of focus groups with women helps provide greater insight into the experiences and views of these women, in relation to sexual health.

However, there are also limitations to the methodology. It was not possible to obtain any accurate statistics as measures of sexual health specific to this population, as no such data is routinely recorded. The anonymous questionnaires provide some valuable information about this population, but from a sample of women. To ensure the HNA was achievable within the timeframe we chose to obtain a small sample of women from 2 areas of the community criminal justice service and carried out a small number of focus groups and interviews with women and staff. Our findings may not be representative of all women in this group or staff, and not all themes may have been identified, however the work provides a helpful insight. A future HNA may wish to widen this sample further.

## RECOMMENDATIONS

Whilst some of the recommendations relate to women in the criminal justice system in any setting, we present them separately to focus the specific recommendations for each setting. Although this HNA and these recommendations pertain to women in NHS GG&C we believe that many of these recommendations are transferable to other services nationally.

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### CUSTODIAL SETTINGS

#### GENDER BASED VIOLENCE ENQUIRY

1. Routine enquiry regarding any previous experience of GBV should be part of any initial medical assessment on admission to prison.
2. Staff training in recognising and responding to disclosure of GBV should be offered to all staff members working with this group of women, including prison officers and NHS staff.
3. Links to services that are available in prison providing counselling for women disclosing previous GBV should be made clear, to allow easy referral for those women who so wish.

#### SEXUAL HEALTH ENQUIRY

4. Consideration should be made to introducing a routine sexual health enquiry for women, to be conducted by a member of nursing staff from the prison health centre within a week of admission to prison. This short questionnaire should prioritise questions relating to; previous sexual health testing and risk factors for this (e.g. recent new sexual partner), cervical screening history and contraceptive history and plans. This could highlight issues requiring onward referral to a sexual health clinic.

## PROVISION OF SEXUAL HEALTH SERVICES

5. Specialist sexual health services, e.g. the monthly women's sexual health clinic at HMP Greenock, should continue to be provided within the prison, preventing transfer out to the community for sexual health services where possible. Staff working within this clinic should be able to perform symptomatic sexual health screens and to provide LARC.
6. Revise and update the written information and posters promoting the sexual health clinic within HMP Greenock to women.
7. Review the system for receiving referrals and appointing women to the clinic in HMP Greenock, such that the referral system is more confidential and the appointment system is more transparent to women, with the aim of decreasing the number of women who fail to attend on the scheduled day.
8. Consider the introduction of a routine pre-liberation consultation with women, by a member of the prison nursing team, to provide an opportunity to discuss contraception, plans for safe sex, date of next cervical smear and signposting to services local to them. This should be 4-6 weeks prior to planned liberation where possible, to allow plans for provision of long acting reversible contraception (LARC) where required. In circumstances of short notice of unplanned liberation signposting to services available within the community should occur.
9. Consideration should be made to making some LARC methods available out with the timing of the Sandyford sexual health clinic once a month, by means of training members of staff from within the prison healthcare team (e.g. provision of contraceptive injection or insertion of subdermal contraceptive implants).

## EDUCATION AND HEALTH PROMOTION

10. Consider the introduction of a sexual health education session open to both NHS health centre staff and prison officers, to enable better information provision to women.
11. Introduce health promotions 'events' for women relating to sexual health (e.g. cervical screening).

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## COMMUNITY CRIMINAL JUSTICE SETTINGS

### GENDER BASED VIOLENCE ENQUIRY

12. Routine enquiry regarding any previous experience of gender based violence should be part of any initial assessment on registration with a Community Criminal Justice Service and should be audited.

13. Staff training in recognising and responding to disclosure of GBV should be offered to all staff members working with this group of women.
14. Links to services available in the community providing counselling for women disclosing previous GBV should be made clear, to allow easy referral for those women who so wish.

#### SEXUAL HEALTH ENQUIRY

15. Consideration should be made to training Community Criminal Justice staff members to be able to introduce a simple routine sexual health enquiry into their discussions with women. A short questionnaire should prioritise questions relating to; previous sexual health testing, cervical screening history and contraceptive history and plans. This could be introduced within the first 2 weeks after registration with a community criminal justice service and could highlight issues requiring onward referral to or signposting to sexual health services.

#### PROVISION OF SEXUAL HEALTH SERVICES

16. Establish a clear pathway of referral from community criminal justice services to local sexual health services (Sandyford service in NHS GG&C), aiming to simplify this process for women and ensuring they have the required support to attend.
17. Consideration should be given to the provision of an outreach model of care from Sandyford services, to women involved in community criminal justice services.

#### EDUCATION AND HEALTH PROMOTION

18. Consider offering sexual health education sessions for staff in community criminal justice services, to ensure they are knowledgeable about sexual health services available, the process for referral into such services and to help them better inform women about sexual health issues.
19. Consider the introduction of education and health promotion relating to sexual health for women in community service setting.

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**Search Strategy**

- 
- 1 prison/
  - 2 prison\*.mp.
  - 3 offend\*.mp.
  - 4 custod\*.mp.
  - 5 1 or 2 or 3 or 4
  - 6 female/
  - 7 5 and 6
  - 8 sexual health.mp. or sexual health/ or sexually transmitted disease/ or acquired immune deficiency syndrome/ or Human immunodeficiency virus infection/
  - 9 pregnancy/ or reproductive health/ or reproductive health.mp. or reproduction/
  - 10 urogenital system/ or genitourinary.mp. or sexually transmitted disease/
  - 11 8 or 9 or 10
  - 12 7 and 11
  - 13 limit 12 to (human and female and english language and last 5 years)
  - 14 uk.mp. or United Kingdom/
  - 15 britain.mp.
  - 16 scotland.mp.
  - 17 england.mp.
  - 18 wales.mp.
  - 19 ireland.mp.
  - 20 14 or 15 or 16 or 17 or 18 or 19
  - 21 13 and 20

- 22 partner violence/ or domestic violence/ or battered woman/ or domestic abuse.mp. or family violence/
- 23 sexual crime/ or sexual assault/ or sexual abuse/ or rape/
- 24 mental health/
- 25 addiction/ or drug abuse/
- 26 alcoholism/ or alcohol abuse/
- 27 gender based violence/
- 28 22 or 23 or 24 or 25 or 26 or 27
- 29 11 or 28
- 30 7 and 29
- 31 limit 30 to (human and female and english language and (article or "review") and last 5 years)
- 32 20 and 31



**Anonymous questionnaire of the sexual health needs of women within criminal justice system in Greater Glasgow and Clyde.**

**Why are we asking you these questions?**

We would like to make women's sexual health services better and easier to use. To help us do this, we want to hear from you. We want to know more about your sexual health needs. We want to know if you use our services, and if not, why you don't. We also want to know what you think we could do better.

**Why I am being asked to fill it in?**

We are asking all women in HMP Greenock to complete the questionnaire.

**What will happen with my answers?**

We will not ask anything that can identify you, such as your name or date of birth. Your answers are anonymous; no one will know which answers are yours. The answers will all be grouped together. The results will be included in a report about sexual health services for women. A copy of this report could be made available to you later on if you wished.

**What happens if I do not want to fill it in?**

Completion of the questionnaire is voluntary, so you do not have to fill it in. If you decide not to fill it in it will not impact on your treatment at all.

**Can someone help me fill it in?**

You can ask a member of the health centre staff to help you fill the form in if you wish. They have to keep your answers confidential. Only you and any person who helped you to fill the form will know your answers.

**Do I need to do anything else?**

Once you have completed the form you can place it to be collected in the box shown to you when you were given the form. We are also going to have some small group discussions with women to find out more about their experiences and views of sexual health services. If you would be interested in doing this then please let a member of health centre staff know. The discussion would be with a member of the study team, not prison or health centre staff, and approximately 4 other women. It should take 30 mins to 1 hour at most.

**Please answer both sides of each page.**

**Please write answer or tick the relevant box.**

**1) What age are you? ..... years**

**2) Do you have a home address?**

Yes  No

**3) If you do have an address, what are the first 4 parts of your home postcode?**

\_\_\_\_/\_\_\_\_/\_\_\_\_/\_\_\_\_

**4) Have you ever attended services related to women's sexual health?**

Yes  No  I'm not sure

**If Yes – when?**

Within the last year  Over 1 year ago

**5) If you answered YES to the last question – where did you attend?**

Within prison

GP

A community women's health clinic in Scotland

A clinic somewhere out of Scotland

Other  (please tell us where.....)

**6) If you have **never** attended services related to women's sexual health / women's health clinic, are there any reasons why you have not attended, or have found it difficult to? (please tick any that apply)**

- No sexual health problems / no need to go
- I didn't know where to go
- I couldn't get there – no way to travel
- It was too far for me to go
- I was unable to go when it was open
- I was scared
- I was embarrassed
- I thought someone would find out

**Please write any other reasons why you may not have gone.....**

**7) Have you ever had a cervical smear?**

- Yes, it was within the last 3 years
- Yes, it was over 3 years ago
- I'm not sure/don't know
- No, never

**If you have never had a cervical smear please answer the question below**

Why have you never had a smear?

- I didn't know I should get one  I don't think I need one
- No-one has ever asked me to have one
- I'm scared  I'm embarrassed
- Other  (please write reason.....)

**8) Have you ever given birth?**

- Yes  No  I'd rather not say

**9) Have you ever had an abortion?**

Yes  No  I'd rather not say

**10) Have you ever used contraception?**

Yes  No  I'm not sure

**If YES please tick any you have used before?**

Condom  Pill  Patch  Ring

Injection  Implant  Coil

Other  (please tell us what.....)

**11) Are you using any contraception just now?**

Yes  I'd rather not say

No, I'm not having sex

No, but I'd like to

No, I don't like using it

No, there is another reason why not

please write reason.....

**12) Have you had a sexual health check (test for sexually transmitted infections (STI)) before?**

Yes  No  I'm not sure  I'd rather not say

**13) Have you ever tested positive for an STI?**

Yes  No  I'm not sure  I'd rather not say

**14) Have you ever had an HIV test?**

Yes  No  I'm not sure  I'd rather not say

**15) Have you ever tested positive for HIV?**

Yes  No  I'm not sure  I'd rather not say

**16) Have you ever had a test for hepatitis B or C?**

Yes  No  I'm not sure  I'd rather not say

**17) Have you ever tested positive for hepatitis B?**

Yes  No  I'm not sure  I'd rather not say

**18) Have you ever tested positive for hepatitis C?**

Yes  No  I'm not sure  I'd rather not say

**19) Are you or have you ever been concerned about the amount of alcohol you drink?**

Yes, I am currently concerned

Yes, in the past, not now

No, never  I'm not sure

**20) Have you ever used recreational drugs?**

No  I'd rather not say

Yes

**(If Yes answer below)**

When did you last use?

I currently use  within the last year

More than one year ago

Have you ever injected drugs? Yes  No

**21)** Are you or have you in last 3 years, attended any mental health service, such as / Community psychiatric nurse/ psychiatrist?

Yes  No  I'd rather not say  I'm not sure

**22)** Have you experienced physical, sexual or emotional abuse at any time in your life?

Yes  No  I'd rather not say

**If YES** please complete below (tick any that apply)

Physical abuse  Rape / Sexual assault

Emotional abuse  Childhood sexual abuse

**23)** Have you ever been paid for sexual acts with money or rewards?

Yes  No  I'd rather not say

**24)** What ethnicity are you?

I'd rather not say

White British  White other  Asian

Black /Caribbean  African

Multiple/Mixed  Other

**25)** Which of the following options best describes how you think of yourself?

Heterosexual (straight – attracted to opposite sex)

Lesbian/Gay (attracted to same sex)

Bisexual (attracted to opposite and same sex)

Other  I'd prefer not to say

**26)** Do you smoke tobacco?

Yes  Ex-smoker  Never

**Thank you for your time.**

If this questionnaire had raised any issues for you, you can discuss these with the prison health centre staff.

The women's health clinic runs once a month, on the last Wednesday of the month. If you think you might need an appointment to attend you can speak to one of the health centre staff to arrange this.



## **Anonymous questionnaire of the sexual health needs of women within criminal justice system in Greater Glasgow and Clyde.**

### **Why are we asking you these questions?**

We would like to make women's sexual health services better and easier to use. To help us do this, we want to hear from you. We want to know more about your sexual health needs. We want to know if you use our services, and if not, why you don't. We also want to know what you think we could do better.

### **Why I am being asked to fill it in?**

We are asking women who are involved in the criminal justice system in Glasgow to complete the questionnaire.

### **What will happen with my answers?**

We will not ask anything that can identify you, such as your name or date of birth. Your answers are anonymous; no one will know which answers are yours. The answers will all be grouped together. The results will be included in a report about sexual health services for women. A copy of this report could be made available to you later on if you wished.

### **What happens if I do not want to fill it in?**

Completion of the questionnaire is voluntary, so you do not have to fill it in. If you decide not to fill it in it will not impact on your treatment at all.

### **Can someone help me fill it in?**

You can ask a member of the criminal justice / women's justice team to help you fill the form in if you wish. They have to keep your answers confidential. Only you and any person who helped you to fill the form will know your answers.

### **Do I need to do anything else?**

Once you have completed the form you can return it to the location shown to you when you were given the form, or to the person who gave the form to you. We are also going to have some small group discussions with women to find out more about their experiences and views of sexual health services. If you would be interested in doing this then please let a member of the women's justice team know. The

discussion would be with a member of the study team, and approximately 4 other women. It should take 30 mins to 1 hour at most.

Please answer both sides of each page.

Please write answer or tick the relevant box.

1) What age are you? ..... years

2) Do you have a home address?

Yes  No

3) If you do have an address, what are the **first 4** parts of your home postcode?

\_\_\_\_/\_\_\_\_/\_\_\_\_/\_\_\_\_

4) Have you ever attended services related to women's sexual health?

Yes  No  I'm not sure

**If Yes – when?**

Within the last year  Over 1 year ago

5) If you answered **YES to the last question** – where did you attend?

Within prison

GP

A community women's health clinic in Scotland

A clinic somewhere out of Scotland

Other  (please tell us where.....)

**6) If you have never attended services related to women's sexual health / women's health clinic, are there any reasons why you have not attended, or have found it difficult to? (please tick any that apply)**

- No sexual health problems / no need to go
- I didn't know where to go
- I couldn't get there – no way to travel
- It was too far for me to go
- I was unable to go when it was open
- I was scared
- I was embarrassed
- I thought someone would find out

**Please write any other reasons why you may not have gone.....**

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- Yes, it was over 3 years ago
- I'm not sure/don't know
- No, never

**If you have never had a cervical smear please answer the question below**

Why have you never had a smear?

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- No-one has ever asked me to have one
- I'm scared  I'm embarrassed
- Other  (please write reason.....)

**8) Have you ever given birth?**

Yes  No  I'd rather not say

**9) Have you ever had an abortion?**

Yes  No  I'd rather not say

**10) Have you ever used contraception?**

Yes  No  I'm not sure

**If YES please tick any you have used before?**

Condom  Pill  Patch  Ring

Injection  Implant  Coil

Other  (please tell us what.....)

**11) Are you using any contraception just now?**

Yes  I'd rather not say

No, I'm not having sex

No, but I'd like to

No, I don't like using it

No, there is another reason why not

please write reason.....

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Yes  No  I'm not sure  I'd rather not say

**13) Have you ever tested positive for an STI?**

Yes  No  I'm not sure  I'd rather not say

**14) Have you ever had an HIV test?**

Yes  No  I'm not sure  I'd rather not say

**15) Have you ever tested positive for HIV?**

Yes  No  I'm not sure  I'd rather not say

**16) Have you ever had a test for hepatitis B or C?**

Yes  No  I'm not sure  I'd rather not say

**17) Have you ever tested positive for hepatitis B?**

Yes  No  I'm not sure  I'd rather not say

**18) Have you ever tested positive for hepatitis C?**

Yes  No  I'm not sure  I'd rather not say

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Yes, I am currently concerned

Yes, in the past, not now

No, never  I'm not sure

**20) Have you ever used recreational drugs?**

No  I'd rather not say

Yes

**(If Yes answer below)**

When did you last use?

I currently use  within the last year

More than one year ago

Have you ever injected drugs? Yes  No

**21) Are you or have you in last 3 years, attended any mental health service, such as / Community psychiatric nurse/ psychiatrist?**

Yes  No  I'd rather not say  I'm not sure

**22) Have you experienced physical, sexual or emotional abuse at any time in your life?**

Yes  No  I'd rather not say

**If YES** please complete below (tick any that apply)

Physical abuse  Rape / Sexual assault

Emotional abuse  Childhood sexual abuse

**23) Have you ever been paid for sexual acts with money or rewards?**

Yes  No  I'd rather not say

**24) What ethnicity are you?**

- I'd rather not say
- White British  White other  Asian
- Black /Caribbean  African
- Multiple/Mixed  Other

**25) Which of the following options best describes how you think of yourself?**

- Heterosexual (straight – attracted to opposite sex)
- Lesbian/Gay (attracted to same sex)
- Bisexual (attracted to opposite and same sex)
- Other  I'd prefer not to say

**26) Do you smoke tobacco?**

- Yes  Ex-smoker  Never

**Thank you for your time.**

If this questionnaire had raised any issues for you, you can discuss these with a member of the criminal justice / women's justice team.

If you would like to make a sexual health clinic appointment you can arrange to attend a **Sandyford Sexual Health Clinic -**

**Phone: 0141 2118130**

**Website: [www.sandyford.org](http://www.sandyford.org)**



**Health Needs Assessment of the sexual health of women within the criminal justice system in Greater Glasgow and Clyde.**

**Key informant / staff interviews**

**Why are we asking you these questions?**

We are carrying out a health needs assessment (HNA) of the sexual health of women within the criminal justice system in Greater Glasgow and Clyde. We would like to ask you some questions about the sexual health care needs of female prisoners in HMP Greenock. The aim is to identify areas of good practice and also to identify any areas where there may be room for improvement. We'd like to hear how you think sexual health / women's health services could be changed to better meet the needs of women. There are no right or wrong answers; we'd just like to hear your thoughts.

**What will happen with my answers?**

All the information you provide will be anonymous and confidential. Please don't provide any person identifiable information in the interview. Please answer the questions as open and honestly as possible. Your views will be brought together with the views of others including women in the criminal justice system themselves, prison staff, healthcare staff and criminal justice team staff, to produce a final report.

**Thank you for taking the time to speak to us.**

Date \_\_/\_\_/\_\_ Location \_\_\_\_\_

Male / Female (delete as appropriate)

What is your current role?

How long have you worked in your current role?

- 1) What do you think are the main sexual health needs of women in prison?
- 2) Are you aware of how these women can seek / obtain sexual health care currently?
- 3) What works well about how sexual health care can be / is provided to these women?
- 4) Do you think your job has a role at all to play in providing sexual health services / advice to these women?
- 5) How comfortable and / or confident are you about discussing women's sexual health? Can you think of any specific knowledge gaps / training gaps for you?
- 6) What do you think may act as barriers to women accessing sexual health care?
- 7) What do you think are the main areas to focus on to improve the sexual health services for these women?
- 8) What do you see as potential barriers to making any improvements?

Anything else you would like to add?



**Health Needs Assessment of the sexual health of women within the criminal justice system in Greater Glasgow and Clyde.**

**Key informant / staff interviews**

**Why are we asking you these questions?**

We are carrying out a health needs assessment (HNA) of the sexual health of women within the criminal justice system in Greater Glasgow and Clyde. We would like to ask you some questions about the sexual health care needs of women involved with the community criminal justice team. The aim is to identify areas of good practice and also to identify any areas where there may be room for improvement. We'd like to hear how you think sexual health / women's health services could be changed to better meet the needs of women. There are no right or wrong answers; we'd just like to hear your thoughts.

**What will happen with my answers?**

All the information you provide will be anonymous and confidential. Please don't provide any person identifiable information in the interview. Please answer the questions as open and honestly as possible. Your views will be brought together with the views of others including women in the criminal justice system themselves, prison staff, healthcare staff and criminal justice team staff, to produce a final report.

**Thank you for taking the time to speak to us.**

Date \_\_/\_\_/\_\_ Location \_\_\_\_\_

Male / Female (delete as appropriate)

What is your current role?

How long have you worked in your current role?

- 1) What do you think are the main sexual health needs of women involved in the criminal justice system?
- 2) Are you aware of how these women can seek / obtain sexual health care currently?
- 3) What works well about how sexual health care can be / is provided to these women?
- 4) Do you think your job has a role at all to play in providing sexual health services / advice to these women?
- 5) How comfortable and / or confident are you about discussing women's sexual health? Can you think of any specific knowledge gaps / training gaps for you?
- 6) What do you think may act as barriers to women accessing sexual health care?
- 7) What do you think are the main areas to focus on to improve the sexual health services for these women?
- 8) What do you see as potential barriers to making any improvements?

Anything else you would like to add?



## Public Health and Health Improvement

Corporate HQ

West House

Gartnavel Royal Hospital

1055 Great Western Road

Glasgow

G12 0XH

## Information and Consent Form

### Information

To help NHS GGC (Greater Glasgow and Clyde) provide better sexual health services for women in custody, we are conducting a health needs assessment (HNA). This will help us understand your health care needs and how best to meet them.

We would like to hear your views about your sexual health care needs and how they can best be met. We would also like to hear about your experiences of using sexual health services. Your opinions are important to us.

We would like you to take part in a discussion with a small number of other women also involved in the criminal justice system. This should take approximately an hour or so. It will be led by a member of the team conducting the project. The discussion will be audio recorded.

**All the information you provide will be kept confidential**

Information from the discussion, along with information from some other sources will be brought together into a report which we hope to have finished within the next 4 months.

Thank you for taking the time to speak to us.

### **Consent**

I agree to take part in this health needs assessment. I have read the information above.

I agree to take part in a focus group with a member of the project team from Public Health and Health Improvement at NHS GGC. The information from this group discussion will be held and used to produce a report on the sexual health needs of women within custody in the NHS GGC area.

I understand that:

- The information that I provide is confidential
- The information that I provide will be anonymised – individual(s) will not be identified in any reports that come out of this work, or details disclosed to any other party
- My participation is voluntary
- I can choose not to answer some, or all of the focus group questions
- I can withdraw my consent to take part at any time during or before the discussion without being penalised or disadvantaged in any way.

Name (print) \_\_\_\_\_ Signed \_\_\_\_\_.

Date\_\_\_\_\_.

Interviewer\_\_\_\_\_ Signed \_\_\_\_\_.

### Focus Group Schedule

#### **Introduction**

- Who we are and where we are from?
- Who are they – name and age?

#### **Why**

- What is a Health Needs Assessment?
- What we hope to get from today?
- What are sexual health services? They provide services such as contraception (condoms/pills) / sexual health testing (e.g. STI/Chlamydia tests) / women's health / cervical smears.

#### **Ground Rules**

- Confidentiality
- Allow everyone a chance to speak and express their views / opinions
- Respect each other's views / opinions
- Don't provide specific details related to their own health or criticism of other individuals

#### **Process**

- We have prepared a set of questions to act as a guide
- The member of the project team who is present will ask questions and the responses will be recorded on the digital recording device
- The member of the project team is not here to take part in the conversation, we want you to feel free to talk to each other
- It is important that everyone gets a chance to speak and be heard
- There are no right or wrong answers
- We will keep an audio record of the discussion to help us recall key points, but they will not be able to be identified individually from this
- Information from this and other focus groups and questionnaires will help to produce a final written report
- Thank you for agreeing to take part
- Any questions?

### Focus Group Questions / Topic Guide - HMP Greenock Focus Groups

**Icebreaker** – I'm going to be asking you about where you would go for help or advice with your sexual health or for 'women's problems'. These leaflets/posters are examples of some of the things women might be worried about.

Show selection of leaflets / posters

- Have you seen these leaflets / similar information before?
- *Where? When? What did they think?*

#### **Reception**

- We'd like you to think back to when you were admitted into prison.
- Were / are you able to discuss your health with staff?
  - *Health centre staff*
  - *SPS staff*
  - *Any differences between staff groups?*
  - *Did confidentiality worry them at all?*
- Would you discuss sexual health or women's problems with staff?
  - *Health centre staff? SPS staff?*
  - *Confidentiality a concern?*
  - *Contraception / STI's / smears / periods*
- If you needed to discuss any problems with the nursing staff, was it helpful?

#### **Services within the prison**

- Thinking now about services within the prison.
- Do you know what services you can go to for women's health issues?
  - *Prompt about women's health clinic that runs within the prison if not brought up*
  - *Examples – contraception / STI's / periods / smears*
- What would make it easier for you to use these services?
  - *Prompts – do they know about it? / timing of it / privacy*
- How could we make the women's health clinic better?
  - *staff attitudes (SPS and health centre) / timing of clinic / privacy / services they would like?*
- How would you feel about travelling outside the prison, with SPS staff, to attend a clinic instead?

#### **Priorities**

- What do you feel are the most important services a women's health clinic could offer you in prison?

#### **Through Care**

- We'd like you to think about when you leave prison
- Are you aware if / what women's health services are close to where you live?
  - *how you would access them*
  - *What would make it easier for you to access them*

Is there anything else you would like to discuss today?

**Thank you for agreeing to take part.**

### Focus Group Questions / Topic Guide - Community Focus Groups

**Icebreaker** – I'm going to be asking you about where you would go for help or advice with your sexual health or for 'women's problems'. These leaflets/posters are examples of some of the things women might be worried about.

Show selection of leaflets / posters

- Have you seen these leaflets / similar information before?
- *Where? When? What did they think?*

#### **Initial contact with criminal justice system**

- We'd like you to think about when you met the staff in Norfolk Street.
- Were you able to discuss your health with staff?
- Would you discuss your 'women's health issues' with staff?
  - *Examples - contraception / cervical smears / STI's / pregnancy /*
  - *Has anyone discussed anything with staff?*
  - *Any problems doing this?*
  - *Was confidentiality a concern?*
  - *Did the discussion help?*

#### **Health services within the community**

- Thinking now about sexual health services local to you.
  - *(examples of sexual health include - where to get help for contraception / STI's / pregnancy / rape / women's problems)*
- Do you know what services you can go to if you need help / advice with women's health?
  - *Where you go for contraception/ STI's/pregnancy advice/after rape or assault/problems with periods or vaginal discharge*
  - *GP / Sandyford?*
  - *Any internet / phone /social media support /advice?*
- What would help you to be able to use these services?
  - *Prompt to discuss – at GP / at Sandyford*
  - *Transport? Information? Opening times?*
- If you have ever been to or tried to go to such services, what was it like?
  - *Prompts – Where did they go? Good? Bad? Staff helpful / friendly? Easy/difficult to find?*
- Would you go back?

**Priorities**

- What do you feel are the most important things services could offer you in relation to your sexual health?

Is there anything else you would like to discuss today?

**Thank you for agreeing to take part.**



**Health Needs Assessment of the sexual health of women within the criminal justice system in Greater Glasgow and Clyde.**

**Questionnaire for staff in prisons with female prisoners out with NHS GG&C**

**Why are we asking you these questions?**

We are carrying out a health needs assessment (HNA) of the sexual health of women within the criminal justice system in Greater Glasgow and Clyde. It would be helpful to us to find out some information about sexual health service provision for women in prison in the area you work in.

**Thank you for taking the time to speak to us.**

1) What is your current role?

2) What is the capacity of the prison you work within for female prisoners?

3) Do you have a sexual health clinic running within the prison for females and / or males?  
(IF YES ANSWER QUESTIONS 4 to 7 / IF NO GO TO QUESTION 8)

4) How often does it run? (e.g. weekly / monthly variable?)

5) Who staffs the clinic? (e.g. – prison health centre staff / prison GP / external nurse / external doctor / others – please detail below)

6) How do women find out about the clinic / get appointed to it?

7) What can it provide (within the prison)? (PLEASE CIRCLE AND WRITE IF ANY OTHERS BELOW)

- contraception
- implant fitting / removal
- sexual health screen
- other.....
- coil fitting / removal
- smears

8) If no sexual health clinic within the prison - who provides sexual health services to women if required? (examples below – please specify for your service)

- health centre medical / nursing staff as part of general clinic

- transported out of prison – where to?

-other?

.....

9) What do you think works well for sexual health care provision in your service?

10) Do you think sexual health care provision could be better in your service? What would you wish to change / improve?

11) Anything else you would like to add?

**Thank you for taking the time to speak to us.**