

Black and other ethnic minorities — including foreign national prisoners and immigration detainees

Introduction

Healthcare workers in prisons will see many people whose nationality, ethnic group, language, culture or religion is different from their own. These differences affect the way individuals express mental distress, their beliefs about their problems, the treatment they find acceptable and also basic communication with the health worker. Ethnic minorities in prison fall into three main groups.

- British ethnic minorities, eg a Briton of Indian, Chinese or West Indian extraction.
- Foreign national prisoners who are sentenced or held on remand for an offence under criminal law.
- Asylum seekers and other immigration detainees who are detained under the Immigration Act 1971.

This section aims to summarise the main issues affecting the delivery of a good primary mental-health service to these groups and outline possible ways of responding. Some problems (eg experience of racial abuse, discrimination, not speaking English) may be common to all groups. Other problems are specific to only one group. It is intended to be read in conjunction with the guidelines on assessing and managing mental disorders.

All groups

Language

It is impossible to diagnose and manage mental (or physical) ill-health if the patient and clinician do not share a common language. Prisoners who have difficulties with English should have access to an interpreter. Healthcare workers have a duty to ensure that they can provide a health service. The governor will authorise any necessary interpretation or translation facilities.

Language Line is a 24-hour telephone interpreting service covering over 100 languages. A central, part subsidised, contract is held by Prison Service Headquarters (Prisoner Administration Group). The prison race relation's liaison officer will have details. All prisons can access Language Line interpreters, subject to governor authority, by telephoning 020 7713 0090 and quoting their individual identification code. The prison race relation's liaison officer will have a copy of the *Interpreters Directory* and may be able to assist with local sources. The Local Authority, the local Health Authority, and some voluntary and community groups may also offer access to interpreters or translators.

Some people from countries where English is usually spoken may not themselves speak it; eg the language of Irish travellers is Gammon.

Negotiating a shared problem description and management plan with patients from other cultures

Some prisoners come from cultures whose ways of expressing distress and whose views of the causes and appropriate treatments of that distress differ markedly from that of the dominant 'Western' culture. For example, in some cultures, depression may be seen as the result of 'thinking too much' or witchcraft.^{1,2} Some mental-health treatments, such as counselling, are based on Western values and are not familiar to people from all cultures. Some ethnic groups do not have a Western diagnostic concept, such as alcoholism, in their vocabulary. There may be an even greater stigma attached to mental illness in some cultures than in Western culture. All this may make communication between the healthcare worker and the patient very difficult. The result may be that the doctor or nurse misunderstands the problem and makes a wrong diagnosis or that the patient refuses to follow the management advice given.

There are too many different races, nationalities and cultures represented in prisons to make it possible to describe here how their citizens typically express and think about mental distress and illness. It is, in any event, very dangerous to make such generalisations. What follows is a step-by-step approach to drawing out the patient's own beliefs about his/her problem. Once this is done, it is possible either to discuss management using the patient's own concepts or (where the belief systems are very different) to negotiate a definition of the problem and a management plan that incorporate both the health worker's and the patient's beliefs.

Wherever possible, obtain general information about the patient's cultural norms from local community groups, the local branch of the Racial Equality Council or a healthcare worker from the same nationality, ethnic group or cultural background.

Step 1: Introductions

- Clarify which is the patient's personal name and which name (if any) is the family name and which name is used as a surname. Clarify how the patient wishes to be addressed. Be aware that naming systems generally reflect cultural and religious backgrounds and may have considerable significance for the individual.
- Explain who you are and the purpose of the interview, ie to identify health problems (in the body and also emotional distress) and seek to provide help. Reassure the patient that the interview is confidential. Explain that the rules of confidentiality apply to any interpreter present.

Step 2: Establish what the problem is

Ask: 'What is the problem?' and 'How can I help you?' If the patient says that there is no problem but you have evidence otherwise, gently press further, eg 'The wing officer tells me that you haven't been talking to anyone or eating for some time. This indicates to me that you may have some distress. How do you feel?'

Step 3: Explore the patient's own beliefs about their problem, its causes and his/her expectations of what might help³

Ask:

- 'Can you describe your problem?'
- 'What do you think caused your problem?'
- 'Why do you think it started when it did?'
- 'How severe is it?'
- 'What kind of care do you think you should receive?'
- 'What result do you expect from your care?'
- 'What are the direct problems caused by your problems or illness?'
- 'How satisfied are you with the treatment you have received so far?'

Record the answers to these questions, as far as possible, verbatim.

Step 4: Compare the patient's beliefs about their problems with your own

Explain how these differ; eg the patient may attribute their problems to someone wishing them ill and see the solution as persuading a third party to intervene; you see the problem as an illness and see the solution as transfer to hospital and medication. Check that you have each understood your different perspectives accurately.

Step 5: Seek ways of resolving the differences

The following are examples only.

- If the patient sees their symptoms (eg depressive symptoms) as the result of ill-wishing or sorcery and you are not sure if this is a paranoid delusion or a culturally normal explanation, the patient may agree to your seeking further information or opinions from other people, eg relatives, friends.
- If possible and appropriate, use the patient's words to communicate with him/her, eg 'thinking too much' or 'spiritual problems'.
- If possible and appropriate, agree to incorporate elements of both parties' explanatory models in the management plan. For example, the patient may agree to seek advice and support from a spiritual healer and also to take medication.
- If the patient expects a powerful, immediate and lasting response to antidepressant medication, take particular care to explain that there may be a delayed response and that treatment is likely to continue even when they feel better.

Supporting and encouraging links to family and community

Distress, disorientation and loss may be caused by an inability to maintain cultural identity and some links with family and the community. Where the individual is isolated, it can be very helpful to encourage them to form links with an appropriate community group (see **Resources Directory** page 316). Probation officers, chaplains and race relations liaison officers may help maintain family contacts. You may also be able to advocate for institutional changes, eg the celebration of festivals, allowing the wearing of cultural dress and following their religion, the provision of culturally specific food.

Other cultural issues

Issues to consider include the following.

- Religious or cultural implications of admission of abuse, especially sexual abuse or rape. The family may regard any sexual abuse, however it occurred, as bringing shame upon the family. The chaplain may be able to advise.
- Religious or cultural implications of self-harm. An individual may self-harm and then experience added shame as suicide may not be acceptable in their religion (eg Muslims). The individual may then feel cut off from the support of their faith community. Care may need to be taken in liaising with religious leaders.
- Allowing female patients to see a female doctor or nurse if they wish. Modesty and privacy are crucial to many groups, especially so to women.
- Clothes, hygiene and appearance. Will the patient find health centre clothes immodest? Do they observe the right hand/left hand rule of hygiene?

Experience of racism and discrimination

Being the subject of verbal or physical racist abuse can affect mental health by intimidating the individual and causing anxiety and by leading to self-doubt or dilemmas over cultural identity. This is more likely to happen where members of a particular ethnic group are small in number and lack the support of others. Consider supporting the individual to use the appropriate complaints procedure. Where the experience of racial abuse has resulted in feelings of fear or anger, local Victim Support schemes, available in most areas, may help, though they cannot deal with mental disorders. Racial harassment and abuse are unlawful.

British ethnic minorities

African-Caribbeans

African-Caribbeans are over-represented in the prison population. The research on their mental-health needs is inconclusive. Despite evidence that the prevalence of schizophrenia is similar in different countries,¹⁴ there are consistent reports that, in the UK, mental illness, particularly schizophrenia, is diagnosed more commonly (three to six times more commonly) in African-Caribbeans compared with whites.⁵ It is also well established that African-Caribbeans in the UK are more likely to experience compulsory psychiatric treatment, more likely to be diagnosed as violent and be detained in secure Mental Health Units, less likely to receive diagnosis and treatment at an early stage, and less likely to receive psychotherapy and counselling. The reasons are not clear, though possible explanations include the following.

- African-Caribbeans have a greater biological susceptibility to schizophrenia.
- The stress of social adversity, racism and migration leads to a higher rate of schizophrenia.
- African-Caribbeans do not have a higher rate of schizophrenia but white healthcare staff over-diagnose because of their poor understanding of the cultural background of the patients.

Both in prison and in the community, Caribbean-born people have lower rates of suicide and self-harm compared with the general population.

Asians

Although research in India suggests that the prevalence of mental disorders, including schizophrenia and depression, are similar to those in other countries, Asians in the UK are referred for psychiatric treatment less frequently than whites. Again, the reasons are unclear, but explanations include the following.

- Genuinely low rates of mental disorder.
- Under-diagnosis resulting from a reluctance to approach the health services, language and communication difficulties or poor understanding of cultural differences on the part of white staff.

Community suicide rates are higher for Asian-born women, especially those aged 15–34, than for the general population, while Asian-born men have a lower suicide rate than the average.

What can be done to help?

The guidance outlined under **All groups** above may help to reduce misdiagnosis.

Foreign national prisoners

Who are foreign national prisoners?

Foreign national prisoners are either sentenced or held on remand for an offence under criminal law. As at June 1999:

- 8% of the prison population were foreign nationals
- 3% of white prisoners and 24% of black prisoners were foreign nationals
- 15% of women prisoners and 47% of black female prisoners were foreign nationals
- 75% of female foreign nationals were serving sentences for drug offences, often as 'drug mules'
- foreign national prisoners come from many countries in Europe, the West Indies, Asia, Africa, South and North America, and Australia and New Zealand and
- foreign national prisoners have needs that are distinct from those of British ethnic minorities. Some prisons have a foreign nationals' liaison officer. In most prisons, issues relating to foreign national prisoners are the responsibility of the race relations officer.

What are their mental-health needs?

There have been no studies of the particular mental-health needs of foreign national prisoners. However, in addition to the factors affecting all ethnic minority groups, the following factors all increase the likelihood of mental disorders, particularly depression, developing.

- Isolation: many are imprisoned vast distances from home and contact with family and friends is difficult or impossible. Language difficulties make it harder for them to make friends or seek support in the prison.
- Worry about the fate of their family at home. Women, in particular, may be trying to send money home from prison wages to keep their families. Probation officers may assist in maintaining links with the family at home and any children in care in the UK.
- Long sentences may reduce hope. Drug couriers, in particular, often serve long sentences.
- Shame and concern about what will happen to them when they return home on release. In some countries, being in prison may lead to rejection by the family and the community. In Nigeria, Decree 33 states that any Nigerian found guilty in a foreign country of a drugs offence may face another 5 years' imprisonment on their return.

What can be done to help?

The following ideas have all been implemented in some prisons in England and Wales. Healthcare workers may wish to promote with senior managers and others the adoption of some or all of these measures in their own establishment in order to serve better the mental-health needs of this group.

- Improving interpreting and translating services.
- Increasing the letter allowance in lieu of visits, allowing air mail letters or the provision of a telephone call home for those who have not received a visit in the previous month.
- Making telephone calls easier, eg by installing a phone that receives incoming calls or checking that there are no local restrictions on the purchase of phone cards by foreign national prisoners.
- Allowing foreign national prisoners to avoid using the prison address in order to conceal their whereabouts from their family.
- Encouraging the maintenance of cultural and spiritual identity by, for example, taking newspapers and videos from the foreign nationals' own country, allowing the wearing of cultural dress, ensuring that the prison shop stocks ethnic foods, organising cultural events to coincide with religious festivals, providing religious services in the prisoners' own language.
- Adapting educational provision to suit the needs of foreign national prisoners by, for example, providing courses in English as a second language.
- Allowing and facilitating the use of audio- and videocassettes by foreign national prisoners as a means for them to allay their families' fears about their safety.
- Inviting cultural groups into the prison to provide support for foreign national prisoners (see **Resources Directory** page 316).
- Accommodating some prisoners from the same nationality together.
- Facilitating temporary release on licence in this country.
- Helping prepare foreign national prisoners for release, eg by allowing foreign nationals to earn money and save, and by running a prerelease course.
- Facilitating support and information from the embassy and consular staff where a bilateral agreement between the country and the UK exists. The race relations officer will have a list of countries with which the UK has such an

agreement. Care must be taken not to reveal prisoner details to diplomats without prisoner permission, in order to prevent possible reprisals.

Immigration detainees

Asylum seekers: who are they?

An asylum seeker, as defined in the Immigration Act 1971, is someone who is applying for refugee status, ie permission to stay in the UK 'on the ground that if he were required to leave, he would have to go to a country to which he is unwilling to go owing to a well founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion'. Some asylum applicants are detained under the Immigration Act 1971 while awaiting the outcome of their application or appeal following a refusal. Some are detained when applying for asylum at the port of entry; some have applied for asylum after entry and identification as illegal immigrants; some are awaiting removal. If they have been detained when applying for asylum at the port of entry, the immigration officer who decides that detention is appropriate should give the applicant a written explanation for why they have been detained. However, this does not always happen and decisions are often experienced as arbitrary.⁶ There is no time limit on their period of detention. The average length of detention is 68 days, but this includes a span of a few hours to over 2 years. Most detainees are men, but around one-quarter are women. In 1997, the top 12 countries of origin of asylum seekers in the UK were: Afghanistan, China, Colombia, Ecuador, India, Nigeria, Pakistan, Somalia, Sri Lanka, Turkey, the former Soviet Union and the former Yugoslavia.⁷

Immigration detainees are held in dedicated Immigration Service detention centres or in centres run by the Prison Service or in prisons. In June 1999, 54% of detained asylum seekers were held in prison establishments, though there are plans to reduce this number. The detainee population varies but, as of May 2001, there were 1787 people in immigration detention, of whom approximately two-thirds have made application for asylum. Because of the nature of healthcare facilities in immigration centres, people may be transferred from them to prisons, following hunger strikes or unsuccessful suicide attempts or where they are thought to be at exceptional risk of suicide, as some prisons have 24-hour medical facilities.⁸

Who else may be detained under the Immigration Act?

Some immigration detainees are individuals who have not claimed or sought asylum, but have overstayed, absconded or who are subject to deportation action on recommendation of a court, following a criminal conviction and custodial sentence. They may be held pending the outcome of appeals or before removal. Some may have been in the UK for some time and may have community or family ties here.

What are their mental-health needs?

Studies of refugee communities (those whose applications for asylum have been successful) in the UK show a high prevalence of mental-health problems and disorders. There are broadly two levels of problems: most common are problems of adjustment, while a smaller proportion of people experience persistent post-traumatic disorders.⁹

Information about the mental-health needs of detainees is more sparse, but shows the same overall pattern: high levels of psychosocial and spiritual distress, acute stress reactions and sleep disturbance, lower levels of severe depression and severe, persistent post-traumatic stress disorder (PTSD) with psychosis being quite rare.^{10,11} Substance abuse appears uncommon in detained asylum seekers, though it has been reported as developing later in the community, particularly among young men. Khat usage in the young Somali population in the community may exacerbate an individual's mental distress and lead in some cases to suicide.

A particular feature of immigration detainees is the widespread nature of suicidal thoughts. These may be either a feature of depression or a rational strategy for dealing with the potential event of deportation, should their application for refugee status fail. It is important that these events are dealt with in accordance with ethical principles governing the right to die (see **Food refusal**, page 292).

Factors (causal and exacerbating) include the following.

- The impact of indeterminate detention. Detention with an unknown time limit is a known causal factor in the development of a range of symptoms of mental disorder, including: sleep disturbances, such as nightmares, insomnia, night-sweats and early morning waking, depression, somatic symptoms such as dyspepsia and constipation, brief reactive psychosis, self-injury and (post-release) problems with control of mood or temper, withdrawal, anxiety, mistrust and forgetfulness.¹² Lack of information about why they were detained and what will happen to them in the future is a source of significant stress.
- The experience of detention (eg cells, uniformed security personnel, seclusion or segregation, body searches) may also reactivate and exacerbate previous trauma. The Medical Foundation for the Care of Victims of Torture reports that where

indeterminate detention is suffered by someone who has previously been imprisoned and tortured, it may continue the psychological 'demolition' of the person and cause high stress, despair and anxiety.¹³

- Isolation caused by language difficulties, separation from family and friends and cultural isolation. Poor social support and isolation from the family and the community is a more important predictor of depression in refugees than previous trauma.¹⁴
- Fear and uncertainty about the future and possible deportation.¹⁵
- Bereavement: this may include loss of country and cultural values (cultural bereavement) as well as loss of family members and close friends. Bereavement reactions may be aggravated by the difficulty of grieving because of the lack of a body or because they cannot take part in the related religious ceremony that normally plays a part in the grieving process (see **Bereavement**, page 23).
- Previous experience of torture and other traumatic events.
- Shame at being detained. Some detainees will not inform their families in their country of origin as they feel that they will not believe that they have not committed a crime.
- Loss of status. Some asylum seekers are successful, educated, professional people. Adapting to detention, especially in a criminal prison, is stressful.
- A sense of guilt at having survived and escaped when other loved ones did not or are still at risk.
- Shock and anger at how they are treated on arrival in the UK. Problems of anxiety and stress are closely related to feelings of acceptance or otherwise in Britain.¹⁵

A pattern of initial coping, repeated attempts to seek information about the reason for detention and its likely duration, followed by a 'crash' or collapse into depression has been described in detained asylum seekers.¹¹

The key protective factors that reduce the likelihood of developing mental-health problems in refugees and asylum seekers in the community are thought to be:

- contact with family members and/or family reunification
- social support and links with local community groups
- a strong religious or political ideology and
- an active problem-solving style.¹⁶

Range of health problems that may follow torture

Physical

- Persistent back or shoulder pain
- Aches and arthritic pain
- Convulsions
- Inability to walk unaided
- Organ damage (eg liver, kidney, lung)

Psychological

- Nightmares
- Hallucinations (eg seeing apparitions of torture)
- Panic attacks
- Sexual problems
- Phobias
- Difficulty trusting people
- Depressive illness/anxiety

Source: Medical Foundation for the Care of Victims of Torture. *Some Background Information*. London, 1999.

Issues affecting access to health services

- Asylum seekers may fear that consultations will not be confidential. Frequent reassurance may be required. Asylum applicants may fear that the doctor will give information about their physical or mental health to the Home Office and that this will jeopardise their chances of being allowed to stay in the UK. They may refuse health screening for this (or other) reasons.
- Experiences of individual and institutional racism may lead to a breakdown in trust, including a reluctance to trust health professionals.
- Asylum seekers and foreign nationals may have very different experiences and expectations of healthcare. They may not understand the appointments system.

What can be done to help?

All asylum seekers/immigration detainees

- Learn about what has happened in the countries from which the individuals have fled. Use this knowledge both to help establish a relationship and to understand the likely context of their distress.
- Ensure that all asylum seekers in your institution have access to information about their legal rights, legal representation and agencies providing support and assistance to detainees (see **Resources Directory** page 316).
- If you have reason to believe that an asylum seeker has been tortured, contact the Medical Foundation for the Care of Victims of Torture (see **Resources Directory** page 316). Home Office policy is to avoid detaining applicants where there is independent evidence of torture. The Medical Foundation will visit the prison to make such an assessment.
- Advocate for increased opportunities for activity, support to resolve practical problems and help in planning post-release accommodation and support before release. People recently released from detention are mentally vulnerable, especially if released to no accommodation or support.
- Ensure that relevant community groups are invited into the establishment to support asylum seekers (see **Resources Directory** page 316).
- Encourage the individual to be active and use any skills they can to play a role in helping others (eg teaching other detainees, learning English). This may raise self-esteem and help them to cope better.
- Encourage individuals to identify the strengths, resilience, skills and coping mechanisms that they have used in the past. Encourage them to use any of these that are feasible in the current situation.
- Provide a comprehensive health screening, including mental-health screening, suicidal ideation and intent, evidence of torture. Screening should occur with the consent of the asylum seeker after appropriate explanation in his/her language.

Management of acute stress reactions, sleep problems and low-level anxiety/depression

- Encourage the individual to see their experience as a normal reaction to severe stress rather than a sign of being a 'sick' or 'disordered' individual within a normal environment. Indeterminate detention is a current trauma and symptoms of distress are a normal reaction to it. Encourage them to seek support from others who have been through similar experiences.¹⁷ Give them a copy of the leaflet *Stress and Stress Reactions* (see **Resources Directory** page 316).
- If flashbacks or painful memories are a feature, explain that this is a normal reaction to severe trauma and encourage the individual, if possible, simply to allow these thoughts to pass through his/her head and not to suppress them actively. There is some evidence that it is the suppression of the thoughts that leads to their persistence.
- Do not take somatic complaints such as indigestion at face value. They may have a psychological component (see **Unexplained somatic complaints**, page 94).
- Complementary therapies, if available, may be more culturally acceptable than medication. Shiatsu, massage, aromatherapy and herbal remedies may all be useful.
- Yoga and meditation may also be helpful and acceptable. They are widely used in the East as a means of achieving psychological and spiritual well being. Several organisations run meditation sessions in prisons (see **Resources Directory** page 316).
- See **Adjustment disorder** (page 15) for further advice.

Management of persistent post-traumatic stress disorder (PTSD)

It is important to stress that mental-health problems are not an inevitable consequence of trauma, even of severe torture. It is important to avoid diagnosing natural distress as medical pathology.¹⁸ However, a minority of refugees will require specialised trauma services to deal with the severe, long-term psychological effects of trauma.

While the individual remains in detention, it may be helpful to do the following.

- Refer for a psychiatric assessment. A medical report can be influential in deciding what happens to a detainee.
- Provide the opportunity for individuals to talk through their experiences in their own way. This may include not talking about more extreme experiences. The recognition that certain experiences are 'there' but 'unutterable' can be positive.¹⁹
- Provide counselling that focuses on helping the individual cope better with their current situation and practical problems. Cognitive-behavioural approaches may be particularly appropriate if they work with the individual's own belief systems and encourage them to develop coping mechanisms.
- Encourage the individual to use existing, traditional forms of solace such as traditional healers and religious leaders.
- Provide information about specialist trauma centres for treatment after release from detention. These may be more effective once the asylum seeker's status has been settled, or at least after release from detention. Until then, the asylum

seeker may feel that they remain in a traumatic situation and may be less able to move on to more detailed psychological work on their problems.

Therapy based on the retrieval and working through of memories of trauma should only be done by specialists following a culturally sensitive assessment. There is disagreement about when and for whom such therapy is appropriate. While some individuals may benefit greatly from trauma therapy, for others therapy based on the retrieval and treatment of trauma may interfere with culturally normative ways of coping with past difficulties and cause psychological deterioration.²⁰

Treatment for PTSD combining antidepressants and cognitive-behavioural therapy can be effective (see **Post-traumatic stress disorder**, page 82).²¹ See **Managing the interface with the NHS and other agencies** (page 149) for information about making referrals and the responsibility for funding.

Resources for patients and primary support groups

Stress and Stress Reactions: Information for Asylum Seekers

Leaflets explaining the normal effects of acute stress are available on the disk in English, Albanian, French, Spanish, Portuguese, Russian, Somali and Lingala (spoken in Zaire), and in hard copy for photocopying at the end of the book in Arabic, Tamil, Turkish and Farsi (spoken in Iraq and Afghanistan).

The local Primary Care Trust (especially in London) may provide a range of specific health-promotion resources such as leaflets, posters and videos.

Many agencies are also listed in the **Resource directory** under **Ethnic minorities and foreign nationals** and **Immigration detainees** (see pages 323 and 326)

- 1 Patel V, Simunyu E, Gwanzura F. *Kufungisisa* (thinking too much): a Shona idiom for non-psychotic mental illness. *Central African Journal of Medicine* 1995; 41: 209–215.
- 2 Patel V. Spiritual distress: an indigenous concept of non-psychotic mental disorder in Harare. *Acta Psychiatrica Scandinavica* 1995; 92: 103–107.
- 3 Adapted from Kleinman, A. *Patients and Healers in the Context of Culture*. Berkeley: University of California Press, 1980.
- 4 Sartorius N, Jablensky A, Korten A *et al*. Early manifestations and first-contact incidence of schizophrenia in different cultures. *Psychological Medicine* 1986; 16: 909–928.
- 5 King M, Coker E, Leavey G *et al*. Incidence of psychotic illness in London: comparison of ethnic groups. *British Medical Journal* 1994; 309: 1115–1119.
- 6 Amnesty International. *Prisoners Without a Voice: Asylum Seekers Detained in the United Kingdom*, 2nd revd edn. London: Amnesty International British Section, 1995.
- 7 Home Office. *Asylum Statistics 1997*. London: Home Office, 1998.
- 8 Committee for the Prevention of Torture. *Report to the United Kingdom Carried out by the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT) from 15 to 31 May 1994*. Strasbourg: Council of Europe, 1996.
- 9 Aldous J, Bardsley M, Daniell R *et al*. *Refugee Health in London: Key Issues for Public Health*. London: Health of Londoners Project, East London & the City Health Authority, 1999.
- 10 Bracken P, Gorst-Unsworth C. The mental state of detained asylum seekers. *Psychiatric Bulletin* 1991; 15: 657–659.
- 11 Pourgourides CK, Sashidharan SP, Bracken PJ. *A Second Exile: The Mental Health Implications of Detention of Asylum Seekers in the United Kingdom*. Birmingham: Northern Birmingham Mental Health NHS Trust, 1996.
- 12 Davis P. Medical problems of detainees: a review of 21 ex-detainees seen in the past 2 years in Johannesburg. In Zwi AB, Saunders LD (eds), *Proceedings of the NAMDA Conference 1985, Towards Health Care for All*. Johannesburg: National Medical and Dental Association, 1985, pp. 12–18, as quoted in Pourgourides *et al.*, *A Second Exile*.
- 13 Medical Foundation for the Care of Victims of Torture. *A Betrayal of Hope and Trust: Detention in the UK of Survivors of Torture*. London: Medical Foundation, 1994.
- 14 Gorst-Unsworth C, Golderberg E. Psychological sequelae of torture and organised violence suffered by refugees from Iraq: trauma related factors compared with social factors in exile. *British Journal of Psychiatry* 1998; 172: 90–94.
- 15 Carey-Wood J, Duke K, Karn V, Marshall T. *The Settlement of Refugees in Britain*. Home Office Research Study No. 141. London: HMSO, 1995.
- 16 CVS Consultants and Migrant and Refugee Communities Forum. *A Shattered World: The Mental Health Needs of Refugees and Newly Arrived Communities*. London: CVS Consultants, 1999.
- 17 Manson S. Detention rehabilitation. In Seminar presentation, OASSSA Conference, South Africa, 1996, pp. 67–73, as quoted in Pourgourides *et al.*, *A Second Exile*.
- 18 Summerfield D. Post traumatic stress and mental health. In Symposium on Refugee Health Issues, Selby Centre, Tottenham, London, 1994.
- 19 Professor Papadopoulos, Tavistock Clinic Refugee Centre, personal communication, as quoted in CVS Consultants, *A Shattered World*.
- 20 Migrant and Refugees Community Forum. *Refugees and the Use of Mental Health Services in Kensington and Chelsea*, October 1996, as quoted in CVS Consultants, *A Shattered World*.
- 21 Sherman J. Effects of psychotherapeutic treatments for PTSD: a meta-analysis of controlled clinical trials. *Journal of Traumatic Stress* 1998; 11: 413–435.

Learning disability — F70

May be known internationally as 'mental retardation'

Presenting complaints

- Difficulties with peers, leading to social isolation.
- Inappropriate sexual behaviour.
- Difficulties in everyday functioning, requiring extra support (eg cleaning, working).
- Moodiness or aggression (may be referred by staff concerned about these).
- Problems with normal social development and establishing an independent life (in adulthood) or difficulties making the transition to adulthood (in adolescence).

Diagnostic features

- Slow or incomplete mental development resulting in:
 - problems with learning and
 - social adjustment problems.
- The range of severity includes:
 - severe learning disability (usually identified before 2 years of age); unable to take care of themselves or organise their lives without help
 - moderate learning disability (usually identified by age 3-5, able to do simple work with support, needs guidance or support in daily activities) and
 - mild disability (usually identified during school years; limited in schoolwork, but able to live alone and work at simple jobs).

People with mild and moderate learning disability show an overall excess of offending behaviour, mainly offences against people (generally aggressive and assaultive behaviour). Sex offences and fire-setting also occur and cause most concern. People with severe disability do not have the capacity to form intent and are not often charged with crime in respect of their antisocial behaviour.

The majority of individuals with learning disability have been detected and assessed well before leaving school. If there is any doubt about diagnosis, obtain intelligence and psychometric tests.

Differential diagnosis

The following may also interfere with performance at work or with education.

- Specific learning difficulties (eg dyslexia).
- Attention deficit disorder.
- Motor disorders (eg cerebral palsy, etc.).
- Sensory problems (eg deafness).

Diagnosis of comorbid conditions

Learning disability is associated with an increased prevalence of many other disorders. For example:

- Schizophrenia, depression and manic depression are twice as common as among the general population.
- Autism is particularly common.
- Because people with learning disability often have brain damage, the rates of epilepsy are high (25% people with learning disability, 50% of those with severe learning disability) and so are the rates of epilepsy-related mental-health problems.
- Hearing impairments (40%).
- Visual impairments (40%).
- Hypothyroidism (people with Down's syndrome).
- Dementia (people with Down's syndrome and those over 50 years of age).

People with learning disabilities are more prone to develop mental-health problems when under stress than others. They usually have fewer experiences of personal success, fewer supportive relationships and are less likely to be regarded by others with respect — all factors that protect against mental ill health.

Diagnosis of mental disorder is often overlooked as people with learning disability are prone to emotional problems, and are often changeable and moody.

Mental disorders may also present in slightly different ways.

- **Schizophrenic people** with a learning disability may not admit to hearing 'voices' and may just behave in a very disturbed, excited and bizarre way.
- **Depressed people** with learning disabilities may not be suicidal but may be very tearful and withdrawn.
- **Manic people** with learning disabilities may simply appear to be play acting or generally being silly.
- **Autism** presents as a combination of:
 - lacking a capacity to socialise with others or having little language or an odd style of speech and
 - a preoccupation or obsession with sameness
 - In prison, these individuals often earn themselves nicknames such as 'Mr Bean' or 'Mr Magoo'
 - Individuals with learning disabilities and autism are very likely to become involved in criminal behaviour.
- **Epilepsy** can affect behaviour in many ways. For example, people with epilepsy may:
 - become irritable, on edge or even aggressive before having a fit and
 - become confused, and this might also lead to aggressionFor a variety of reasons — including the fact that people with learning disability in prison might not comply with medication — these problems are quite common.
- Irritability may be an indication of pain or emotional distress.

Support and advice for the patient

- People with a learning disability frequently underreport illnesses. Arranging regular health screening can be useful actively to seek out treatable sensory disorders, depression, obesity, skin infections, diabetes and other conditions. It is valuable to review care also at times of transition (eg before release or transfer to another prison).
- Encourage the patient to see the same doctor at every appointment, if possible, in order to build trust and reduce problems in communication. Staff who know the patient well are invaluable as informants.
- If the patient becomes depressed, it is helpful to review the social networks and support in addition to other treatment (see **Depression — F32#**, page 47).

Advice and information for prison officers and other staff

- People with learning disability need a structure and daily routine. Left to themselves, they do not have the capacity to organise themselves. Help them form a plan for getting out of bed, doing useful work and having adult education. They may need different sorts of activities to be available during association (eg manual jobs, drawing, simple puzzles, painting by numbers). They will also need help with writing letters to those outside prison.
- Inform the residential officers, teachers and workshop supervisors, as appropriate, of any visual or hearing difficulty the individual has.
- Consider asking one or more reliable prisoners on the Residential Unit who may agree to mentor the individual to help him/her to avoid problems with other inmates.
- Reward effort. Allow the individual to function at the highest level of their ability at education, work and on the unit.
- Watch out for exploitation of the individual by others. People with learning disability like to please others by agreeing with them. They are easily duped by more dominant people and may be 'taxed' (encouraged to 'give' tobacco, food or possessions to others) or be victims of theft. They commonly get into debt without understanding that loans are expected to be repaid and may also engage in criminal behaviour at the direction of others. In prison, a fit, young adult with learning disabilities might be used as a 'hit man' for others. A less assertive adult with learning disabilities can easily become a victim of sexual abuse. If exploitation is identified, consider removing the aggressors or placing them on an antibullying regime. If the aggressors cannot be identified, consider protective relocation of the individual.
- People with learning disability have poor concentration and often do not understand what has been said to them the first time or pick things up as well as others. Be aware that what may seem to be non-compliance with instructions may just mean that they have not understood what is required of them.

Medication

- Learning disabilities may occur with other disorders that require medical treatment (eg seizures, spasticity and psychiatric illness such as depression).
- Unnecessary medication should be avoided, and medication reviewed regularly, as side-effects and idiosyncratic reactions are common. People with learning disabilities underreport side-effects, so consideration should be given to proactive checks (eg blood levels for anticonvulsants).

Referral

For court purposes

A remanded prisoner may need an appropriate adult or an expert in learning disability to represent them or comment on the special circumstances of the case in court. Liaise with the court to ensure that all parties can agree a time schedule for legal processes.

For routine care planning

Most individuals with learning disability who come into prison will already be well known to their general practitioner and local, specialist learning disability team. Involve these routinely, with the individual's permission, in order to devise and implement an appropriate care plan in the prison.

To obtain assessments and initiate contact with specialist teams

Where the individual does not already have contact with a specialist learning disability service, contact should be established (either with the service in their catchment area or the service local to the prison) and an assessment requested for:

- any individual where autism is suspected (they do not cope well with prison life) and
- all inmates with a learning disability (IQ < 70) when they first come into prison, especially if they also have epilepsy.

To assess recent changes

Consult with the specialist learning disability team.

- Urgently if the individual's behaviour becomes disturbed or odd in the prison.
- Non-urgently following the death of a close relative, as there is increased risk of pathological grief.
- Where there is significant weight change that persists for longer than 1 month to exclude emotional or psychiatric disorder.

Prerelease planning

Arrange follow-up care for all with an IQ < 70, if possible, well before release. Where a young person is below school-leaving age, a transition plan can be requested from the social services for when the young person leaves school, whether or not the child has a statement of special educational need.

Structures to support liaison and referral

Satisfactory liaison with other services is more difficult to achieve on an ad-hoc basis, and for prisons with a local catchment there should be established structures to facilitate liaison and referral. It is recommended that each prison forge links with local learning disability and mental-health services. It may also be possible to develop a nurse-led epilepsy clinic with protocols agreed by the local epilepsy team.

Resources for patients and primary support groups

Down's Syndrome Association: 020 8682 4001

Mencap: 020 7454 0454

Mencap Northern Ireland: 02890 6911351, 0345 636227 (family advisory service)

National Autistic Society: 020 7833 2299, 020 7903 3555 (helpline)

SPOD (Association to Aid the Sexual and Personal Relationships of People with a Disability): 020 7607 8851

Respond: 020 7383 0700

(Services for adults with learning disabilities who have been or may have been sexually abused)

Leaflets:

Learning Disability – information for Prison Officers and other staff

Depression in People with a Learning Disability. Free and available from the Royal College of Psychiatrists. Tel: 020 7235 2351

Learning Disabilities and the Family: The Teenager with a Severe Learning Disability. Available from the Mental Health Foundation. Tel: 020 7535 7400

'Books Beyond Words' is a series of picture books for adolescents and adults who cannot read. They may be used by parents, carers, general practitioners, nurses and staff to help communication about important topics. Titles include: *Feeling Blue* (about depression), *You're On Trial, I Can Get Through It* (the story of a woman who is abused), *Going to the Doctor*, *Going into Hospital*, *When Dad Died* and *Making Friends*. Available for £10.00 each from: Royal College of Psychiatrists, 17 Belgrave Square, London SW1X 8PG. Tel: 020 7235 2351 ext. 146

The guideline was based on information provided by Dr Gregory O'Brien, Dr E. Milne, Mr Paul Thornton and Graham English from Northgate and Prodhoe NHS Trust, Morpeth, Northumberland.

Helping victims of sexual assault

Although most victims of sexual assault do not develop a chronic mental disorder, it is associated with mental-health disturbance in a significant minority. Patients who disclose sexual assaults may be referring to either recent or more remote events. The level of distress apparent and the treatment needs differ depending on how recently the assault occurred and whether there is a risk of the assault being repeated.

This guideline focuses on recent assault. For information about the impact of abuse in the past, see **People who disclose that they were abused as children** (page 271).

Three per cent of women and 1% of men report being the victim of forced sexual attention during their prison sentence in England and Wales, though the nature of that forced attention is not known.¹ Rates of past sexual assault are almost certainly higher, with about one in three female prisoners and just under one in 10 male prisoners reporting having suffered some form of sexual abuse at some time in their lives. Rates in refugees, illegal immigrants and those seeking asylum may also be high, as sexual assault is a frequent part of torture. Common reasons for not reporting sexual assaults include: fears of not being believed, feelings of shame and fears of being considered unmanly or homosexual.

Presenting complaints

The patient may seek help for the following.

- Sleep problems.
- Generalised anxiety.
- Self-injury.
- Depressive symptoms.
- Vague but troublesome somatic symptoms.

Clinical features

Short-term effects of recent sexual assault

An acute stress reaction is a normal, understandable reaction to the trauma of sexual assault. In the days or weeks following the assault, the patient may experience the following.

- Feelings of panic, fear of danger, of being alone or a similar event happening again.
- Sleep problems, including getting to sleep, waking in the middle of the night, dreams or nightmares.
- Physical symptoms, such as tense muscles, trembling or shaking, diarrhoea or constipation, nausea, loss of appetite, headaches, sweating or tiredness.
- Preoccupation with the assault and why it happened.
- Being easily startled by loud noises or sudden movements.
- Loss of interest in usual activities.
- Tearfulness or feelings of loss or loneliness.
- Problems with thinking, concentration or remembering things.
- Shock or disbelief, feeling numb, unreal, isolated or detached from other people.
- Guilt and self-blame for having in some way caused or brought on the assault.
- Anger and irritability.

Recovery from serious trauma, such as sexual assault as an adult, occurs in the majority of people. In over half of those assaulted as adults, the most acute symptoms resolved within 4–6 weeks, with other symptoms reducing within 3–4 months.²

Long-term effects of sexual assault

In a substantial minority of patients, however, common longer-term effects may include the following.

- Self-injury — in both men and women.
- Alcohol misuse.
- Drug misuse.
- Depression: symptoms include retardation, guilt, feelings of worthlessness, hopelessness or suicidal ideation of a severity or duration that significantly interferes with the individual's functioning.
- Generalised anxiety and phobic anxiety.
- Post-traumatic stress disorder (PTSD): symptoms may include re-experiencing the assault, avoidance and hyperarousal.

- Behavioural disturbance.
- Sexual dysfunction (eg erectile dysfunction, loss of libido).

See the relevant guidelines for advice on the management of these conditions.

Essential information for the patient and the primary support group

- Traumatic or life-threatening events often have psychological effects. For the majority, symptoms will subside with support.
- For those who continue to experience symptoms, effective treatments are available.
- Experiencing psychological symptoms after a sexual assault is a reflection of the severity of the trauma; it is not a sign of weakness and does not mean that the individual has 'gone mad'.
- It is not uncommon for men as well as women to be victims of sexual assault. Most male rapes are committed by heterosexual men against heterosexual men or boys, motivated by the desire to hurt and humiliate rather than by simple sexual gratification.

Confidentiality

Explain to the patient the rules of confidentiality in accordance with medical ethics, prison rules and any guidance from your own profession but, if need be, explain the need to break aspects of confidence to protect young people under 18 who are vulnerable. If a current risk to a child is identified (either the patient or another young person), the overriding principle is to secure the best interests of that child (see **Child protection**, page 276).

Advice and support for the patient and the primary support group

- **Ensure the patient is safe from repeated assault.** If the patient alleges sexual assault while in prison, consider a change of location, the use of antibullying procedure and ways in which the patient can extricate him/herself from risk situations. Liaise as appropriate with wing staff (with patient permission).
- **Check the patient's physical and medical needs** where appropriate. Offer a full physical examination, including investigations for HIV and other sexually transmitted diseases. (Consider tests for gonorrhoea, *Chlamydia*, syphilis, *Trichomonas vaginalis* infection, HIV and hepatitis B. Consider prophylaxis for hepatitis B and chlamydial, gonococcal and trichomonal infections and also HIV — if the perpetrator is known to have HIV or is at high risk for HIV. Exams may be repeated at 2 and 12 weeks after the assault³).
- **Support the patient in reporting the assault to the police**, if appropriate. Explore whether the patient wishes to report the assault to the police. A full physical examination carried out by a police surgeon is required if the patient wishes to make a complaint to the police about a current assault. Explain that since the Public Order and Criminal Justice Act 1994, there have been prosecutions and convictions for male rape. Explain that if the crime is reported to the police without avoidable delay, he/she may be eligible for criminal injuries' compensation whether or not the perpetrator is charged or prosecuted. Respect the patient's choices.
- **Listen sympathetically** without judging or pushing for details. Acknowledge the strength and validity of feelings of shame, anger and humiliation. Be aware that some people deal with trauma by not talking about it. Patients may become worse if pushed to talk more about the assault than they are ready to.⁴
- **If you do not have time to listen now**, say that you appreciate the importance of the patient's experience and feelings, and make a definite appointment when you (or another person acceptable to the patient such as nurse, counsellor or chaplain) will be available.
- **Gently challenge distorted beliefs** eg culpability for the assault. Explain that following a sexual assault, victims frequently blame themselves, feeling that they must have done something to attract the assailant.
- **Encourage appropriate coping methods.** Ask about the methods the patient is using to cope with his/her feelings. Explain that some methods such as substance misuse, self-injury, increased aggression, destructiveness and disobedience are likely to make things worse. Encourage the patient to take care of him/herself by, for example, taking up self-defence or assertiveness training if available.⁵ Suggest returning to work, having regular exercise and using opportunities for education or creative expression.
- **Assess the risk of suicide.** Ask a series of questions about suicidal ideas, intent and plans (eg Has the patient often thought of death or dying? Does he/she have a specific suicide plan? Has he/she made serious suicide attempts in the past? Can the patient be sure not to act on suicidal ideas?). Ask about risk of harm to others (see **Assessing and managing people at risk of suicide**, page 204).

- **Assess the risk of violence** to the alleged perpetrator, if appropriate (see 'Assessing the risk of violence' in **Aggression**, page 282).
- **Encourage the use of social support.** Is there a friend, family member, listener or officer in whom the patient can confide? If so, with patient permission, offer information to that person to help them respond appropriately.

Medication

Most acute stress reactions will resolve without the use of medication. If severe anxiety symptoms occur, however, consider using anti-anxiety drugs for up to 3 days. If the patient has severe insomnia, use hypnotic drugs for up to 3 days. Doses should be as low as possible (see *BNF*, Sections 4.1.1 and 4.1.2).

See depression and PTSD for medication for these conditions.

Referral

Referral should be in accordance with recommendations for particular, associated mental disorders. Consider treatment if acute symptoms interfere significantly with everyday functioning and if these are not diminishing 4–8 weeks after the assault.

Treatments for symptoms of PTSD following sexual assault that have shown some effectiveness^{N6} include the following.

- Supportive counselling.
- Cognitive-behavioural therapy (brief behavioural intervention programmes, stress inoculation training, exposure therapy and imaginal exposure).
- Psychodynamic psychotherapy.

For general support and where symptoms do not meet the criteria for a mental disorder, consider recommending voluntary/non-statutory counselling. Rape crisis centres may provide a counselling service for women.

Resources for patients and primary support groups

Chaplain, listeners, personal officer

London Rape Crisis Centre: 020 7837 1600 (national crisisline: Monday–Friday, 6 pm–10 pm, weekends, 10 am–10 pm)

Samaritans: 08457 909090

(Support by listening for those feeling lonely, despairing or suicidal. It also has local helplines and branches across the country)

Survivors UK: 020 7613 0808 (Tuesday, 7 pm–10 pm); 07949 994886 (office: Monday–Friday, 9:30 am–5:30 pm); URL:

<http://www.survivorsuk.co.uk>

(Counselling and group support for male victims of sexual assault and abuse. It is available in most parts of the UK)

UK Register of Counsellors: 08704 435232

PO Box 1050, Rugby CV21 2HZ

(Supplies names and addresses of British Association of Counsellors and Psychotherapists [BACP]-accredited counsellors)

Victim Support Supportline: 0845 30 30 900 (Monday–Friday, 9 am–9 pm; weekends, 9 am–7 pm)

(Emotional and practical support for victims of crime, including help with Criminal Injury Compensation Board claims. It provides support to female and male victims of sexual assault. It does not usually offer long-term counselling or deal with severe psychiatric problems beyond the immediate crisis)

Resource leaflet:

Stress and Stress Reactions

- 1 Singleton N, Meltzer H, Gatward R, Coid J, Deasy D. *Psychiatric Morbidity among Prisoners*. London: Office for National Statistics, 2000.
- 2 Steketee G, Foa EB. Rape victims: post traumatic stress responses and their treatment: a review of the literature. *Journal of Anxiety Disorders* 1987; 1: 69–86.
- 3 Greifinger RB, Glaser J. Desmoteric medicine and the public's health. In Puisis M, *Clinical Practice in Correctional Medicine*. St Louis: Mosby, 1998.

- 4 Wessely S, Rose S, Bisson J. *Brief Psychological Interventions ('Debriefing') for Treating Immediate Trauma-related Symptoms and Preventing Post Traumatic Stress Disorder*. Oxford: Cochrane Database of Neurotic Disorders, 1997.
- 5 Anderson CL. Males as sexual assault victims: multiple levels of trauma. In Gonsiorek JC (ed.), *A Guide to Psychotherapy with Gay and Lesbian Clients*. New York: Harrington Park, 1985.
- 6 Most available research focuses on the treatment of post-traumatic stress disorder symptoms in women who have been sexually assaulted. Stress inoculation, supportive counselling and prolonged exposure therapy are all significantly more effective in reducing symptoms of anxiety and depression than waiting list controls at 3 months. Stress inoculation may be particularly helpful where there is persistent fear but not avoidance. Imaginal exposure and eye movement desensitisation and reprocessing (EMDR) are emerging as effective treatments. Psychodynamic therapy is little researched but may be appropriate for a victim of a violent sexual assault that triggers a response to a previous episode of childhood victimisation. Specific behavioural treatments may be helpful for sexual dysfunction: (a) Foa EB, Rothbaum BO, Riggs DS *et al.* Treatment of post traumatic stress disorder in rape victims: a comparison between cognitive behavioural procedures and counselling. *Journal of Consulting and Clinical Psychology* 1991; 59: 715-723; (b) Foa EB, Herst-Ikeda D, Perry KJ. The evaluation of a brief cognitive behavioural programme for the prevention of chronic post traumatic stress disorder in recent assault victims. *Journal of Consulting and Clinical Psychology* 1995; 63: 948-955; (c) Tarrier N, Pilgrim H, Sommerfield C *et al.* A randomized trial of cognitive therapy and imaginal exposure in the treatment of chronic post traumatic stress disorder. *Journal of Consulting and Clinical Psychology* 1999; 67: 13-18; (d) Rothbaum B. A controlled study of eye movement desensitization and reprocessing for post traumatic stress disordered sexual assault victims. *Bulletin of the Meuninger Clinic* 1997; 61: 317-334; (e) Brom D, Kleber RJ, Defares PB. Brief psychotherapy for post traumatic stress disorders. *Journal of Consulting and Clinical Psychology* 1989; 57: 607-612; (f) Becker JV, Skinner LJ. Assessment and treatment of rape related sexual dysfunctions. *Clinical Psychologist* 1983; 36: 102-105.

Women who have experienced domestic violence

Introduction

Domestic violence is a common previous experience of imprisoned women. It includes physical violence, such as beating, hitting, forcibly restraining or rape, and emotional or psychological abuse, such as constant criticism, intimidation or threatening future physical violence. Most women who suffer domestic violence are in danger of further violence¹ and are at increased risk of developing a mental disorder. Children living in the family are also at risk of abuse and resulting physical and mental-health problems. The prevalence of domestic violence is similar among people of all income levels and all ethnic backgrounds.

Although imprisoned women are at least temporarily safe from their abusers, without appropriate interventions and reasonable alternatives many women return to the same setting they left. It is important for prison healthcare workers to know about domestic violence in order to:

- be aware of it as an important factor in the mental health of the women they treat
- be able to give appropriate information and support to patients who disclose that they are in violent relationships and
- consider incorporating domestic violence within any out-patient mental-health programme set-up within the establishment to help abused women.

It would, in any event, be valuable for all healthcare centres in female prison establishments to display information about domestic violence. This might act as a signal to women that they can talk to health workers about this issue. The Home Office leaflet *Breaking the Chain* might be used (see **Resources Directory** page 316). A sample copy is provided on the disk .

Effects of domestic violence on mental health

Domestic violence is frequently persistent. Psychological effects may include the following.

- Loss of confidence.
- Low self-esteem.
- Fear.
- Self blame, shame and guilt.
- Anger — unfocused or directed.
- Decreased concentration.
- Eating and sleeping problems.
- Feeling of hopelessness.
- Social withdrawal.
- Feeling of helplessness and passivity.

The following disorders are more common in women who suffer domestic violence than those who do not.

- Substance misuse (see **Alcohol misuse** and **Drug misuse**, pages 18 and 55).
- **Depression** (see page 47).
- **Anxiety disorders** (see **Generalised anxiety**, **Phobias** and **Panic**, pages 64, 79 and 67).
- **Post-traumatic stress disorder (PTSD)** (see page 82). Symptoms may include re-experiencing assaults, avoidance and hyperarousal.
- **Self-injury** (see page 211).

See the relevant guidelines for advice on the management of these conditions.

Management when a woman discloses domestic violence

Essential information for the patient and the primary support group

- Domestic violence affects all kinds of women; it often continues and becomes more severe with time.
- Domestic violence is illegal; offenders can be prosecuted. Even if the perpetrator is not prosecuted under criminal law, some protection may be possible through civil law, by injunctions and court orders.
- Continuing violence may severely affect your health and that of your children.
- There are ways to remove yourself and your children from danger.

- Living with violence usually has psychological effects. This is normal and is not a sign of weakness or madness. For the majority, symptoms will subside with support when the violence is no longer happening. For those who continue to experience symptoms, effective treatments are available.

Be aware that the patient may be in prison herself because of retaliatory violence against her abuser or because of violence to her own children.

Advice and support for the patient and the primary support group

- Listen sympathetically without judging. Acknowledge the strength and validity of feelings of shame, fear or anger. Explain that victims frequently blame themselves as they may find it hard to understand how a loved one can behave in this way and may assume that they themselves must have done something to provoke the violence. Gently challenge distorted beliefs.
- Emphasise confidentiality and that you will seek the woman's consent before sharing information with other health- or socialcare professionals. However, explain that if it is believed that children are at risk of significant harm, you will need to follow child-protection guidelines (see **Child protection** page 276).
- Help the woman assess the risk that she and any children face. Assess the physical and psychological risks. The greater the risk, the more need there is for structured help to be offered. Consider together the type of abuse, whether any violence has increased in intensity, frequency and severity, whether children are being harmed, the woman's current fears, and the outcome of any previous recent attempts to get help.
- Explore with the woman the options open to her, the sources of support she may be able to call upon and the risks involved in each option. The safety of the woman and any dependent children is the paramount consideration. Reassure her that her children will not be taken into care simply because she leaves her partner. (Some abusers threaten that this will happen.) Point out that it is not uncommon for women to find it difficult to leave despite continued violence. Women who leave their partners, however, can face an increased risk of assault.² Respect her choices:
 - If the woman decides to return home, do not criticise her decision. She may not wish to leave her partner, may be worried about financial support and accommodation or may not yet be ready to deal with the situation. Give her information about the help available and help her to plan an escape route in an emergency (money and important documents, such as passport and bank book, should be kept in a safe place).^{2,3}
 - If the woman does not wish to return home, support her in seeking emergency accommodation (see **Resources** below).
- Provide information about domestic violence helplines and emergency women's shelters (see **Resources** below). Encourage the patient to seek help, preferably before release. The prison or home Probation Service may be helpful, but patient consent must be obtained and extra care taken to ensure that nothing is done that could alert the perpetrator to the fact that the woman has taken this course of action.
- While in prison, encourage and, if possible, facilitate access to opportunities for work, creative expression, spiritual counselling or other means of increasing self-esteem. Assertiveness classes may be helpful.
- Consider, if appropriate, parenting classes that help teach alternatives to violence in child rearing.

Record-keeping

Evidence of domestic violence, including the effects on mental health, may be important in helping an abused woman to obtain protection through an injunction or court order, in opposing an immigration/deportation case and may be used by family courts to assess the possible risks in granting access to children to a violent parent. Although prison healthcare staff are unlikely to see the immediate physical effects of domestic violence, they should:

- document clearly the content of the consultation(s), the nature of abuse and any action taken and
- take additional care to ensure the confidentiality of the medical record.

Medication and referral

See the guidelines for relevant disorders.

Developing services in your establishment

Many local areas have multi-agency domestic violence strategies, including protocols and training programmes. Contact the Primary Care Trust/Local Health Group in the first instance to discuss involvement.

NHS and prison health services in female establishments may wish to consider, in response to the needs assessment exercise, including a clinical component focused on recovery from abuse and trauma within the mental-health programme. Models for such services can be found in the Canadian Federally Sentenced Women's Survivors of Abuse & Trauma Program and in some US prisons (see 'The Correctional Program strategy for federally sentenced women' for further information. URL: <http://www.csc-scc.gc.ca>).

Where active identification of women suffering domestic violence is considered, evidence suggests that routine questioning is likely to be superior to case-finding approaches.⁴ Where a screening programme in which all women are routinely asked about domestic violence is set up, it is important that the following factors are in place.

- An explanation to the women that the same inquiry is being made of all women because domestic violence is widespread and often hidden.
- Use of validated screening questions and tools. Most such tools have been developed in the USA. The Department of Health *Resource Manual*⁵ contains a suggested screening questionnaire.
- Protocols for referral to appropriate support services.
- Training for staff in the use of the enquiry tools, interview techniques and responding appropriately.

Resources for patients and primary support groups

Domestic Violence Unit or Community Safety Unit: (contact the local police for details)

Everyman Project: 020 7737 6747 (as a helpline: Tuesday and Thursday, 7:30 pm–10 pm; as an office number: Monday, Wednesday and Friday, 10 am–2 pm)

40 Stockwell Road, Stockwell, London SW9 9ES

(Helpline for anyone concerned about a man's violence. Counselling by appointment for men who want to stop their violent and abusive behaviour)

URL: <http://www.womensaid.org.uk>

(Provides information, local refuge contact details and sources of help for women experiencing domestic violence)

Kiran — Asian Women's Aid: 020 8558 1986

PO Box 899, London E11 1AA

(Advice, support and refuge accommodation for Asian women experiencing domestic violence. It can provide staff fluent in Urdu, Hindi, Punjabi and Bengali)

Muslim Women's Helpline: 020 8904 8193/8908 6715 (Monday–Friday, 10 am–4 pm); 020 8908 3205 (administration)

(Culturally appropriate emotional support over the telephone for Muslim women. Information and advice on domestic violence, sexual abuse, marital problems and health and bereavement; referrals to other services)

Refuge: 0870 599 5443 (24-hour, 7 days per week helpline); 020 7395 7700/7712 (administration)

(National domestic violence helpline offering counselling, support, and advice for women and children escaping domestic violence. Network of refuges across the UK)

Rights of Women (England, Wales and Northern Ireland): 020 7251 6577 (advice line); 020 7251 6575 (administration)

52–54 Featherstone Street, London EC1Y 8RT

(Telephone legal advice for women, mainly in the field of family law, also sexual violence, debt, housing and employment. Referrals to other agencies and sympathetic solicitors)

Shelterline: 0808 800 4444 (24 hours)

(Emergency access to refuge services)

Women's Aid Federation England: 08457 023468 (24-hour, 7 days per week helpline); 0117 944 4411 (administration)

PO Box 391, Bristol BS99 7WS

(Helpline for women experiencing physical, emotional or sexual violence in the home. Advice, information and referral)

Victim Support Line: 0845 3030900

PO Box 11431, London SW9 6ZH

Victim Support National Office: 020 7735 9166

Cranmer House, 39 Brixton Road, London SW9 6DZ

Victim Support Northern Ireland: 028 9024 4039
Annsgate House, 70/74 Ann Street, Belfast BT1 4EH

Victim Support Scotland: 0131 668 4486
15/23 Hardwell Close, Edinburgh EH8 9RX

Leaflet:

Domestic Violence: Break the Chain. It is provided on the disk and is also available from: Home Office Marketing and Communications Group,
Room 157, 50 Queen Anne's Gate, London SW1H 9AT. Tel: 0870 241 4680;
Fax: 020 7 273 2568; E-mail: homeoffice@prolog.uk.com

Resources for health professionals

Health I. *Domestic Violence: The General Practitioner's Role*. London: Royal College of General Practitioners, 1998

Laurent C. *Domestic Violence: The Role of the Community Nurse*. London: Community Practitioners and Health Visitors Association, 1998

British Medical Association. *Domestic Violence: A Health Care Issue*. London: BMA, 1998

Department of Health. *Domestic Violence: A Resource Manual for Health Care Professionals*. London: Department of Health, 2000. Available free from: Department of Health, PO Box 77, London SE1 6XH. URL: <http://www.doh.gov.uk>

'Multi-agency guidance for addressing domestic violence'. URL: <http://www.homeoffice.gov.uk>

'The Correctional Program strategy for federally sentenced women'. URL: <http://www.csc-scc.gc.ca>

- 1 Yearnshire S. Analysis of cohort. In Bewley S, Friend J, Mezey G (eds). *Violence Against Women*. London: Royal College of Obstetricians and Gynaecologists, 1997. Reports that on average a woman will be assaulted by her partner or ex-partner 35 times before reporting it to the police.
- 2 Health I. *Domestic Violence: The General Practitioner's Role*. London: Royal College of General Practitioners, 1998.
- 3 Laurent C. *Domestic Violence: The Role of the Community Nurse*. London: Community Practitioners and Health Visitors Association, 1998.
- 4 Davidson L, King V, Garcia J, Marchant S. What role can the health service play? In Taylor-Browne J (ed.), *Reducing Domestic Violence: What Works?* London: Home Office Research, Development and Statistics Directorate, 2000.
- 5 Department of Health. *Domestic Violence: A Resource Manual for Health Care Professionals*. London: Department of Health, 2000.

Responding to individuals who disclose that they have been abused as children

Many people in prison have been abused, physically, sexually or emotionally, as children. (Figures for sexual abuse range from 5.3% of the general male population,¹ to 15–30% of the general female population, to 42.5% of women detained in special hospitals.²) About one in three female prisoners and just under one in 10 male prisoners report having suffered sexual abuse at some time in their lives.³ The effects can be long-lasting and may manifest in adulthood in disturbed relationships and behaviour, including self-injury.

During consultations for other matters, health workers may find that individuals tell them that they have been abused. The purpose of this section is to enable healthcare workers to respond appropriately and supportively, not to initiate enquiry and not to provide abuse counselling. Counselling/ psychotherapy that helps individuals explore and deal with childhood abuse requires training, a safe and structured environment, and time. Opening issues without the time to deal with them may distress the individual further. If the individual is a young offender who claims that they have been recently abused at home or in their school or children's home, action must be taken to prevent further abuse.

Effects of childhood abuse

Being abused as a child does not automatically condemn a person to a disturbed and disturbing adulthood and it is not itself a mental disorder. However, a proportion of abused children reach adulthood with major emotional problems and dysfunctional personalities. Abuse as a child is associated with the following.

- A sense of helplessness, feelings of vulnerability, a sensitivity to shaming and humiliation, and a difficulty in asking for help.
- Loss of confidence; problems being assertive, difficulties with trust.
- Self-harming behaviour (see **Assessment and management following an act of self-harm**, page 211).
- Aggression and an increased risk of abusing others (some abused children identify with the aggressor).
- Depression, despair and suicidal thoughts (see **Depression**, page 47).
- Substance abuse (see **Alcohol misuse** and **Drug misuse**, pages 18 and 55).
- Relationship difficulties in all areas of life and very disturbed behaviour, consistent with personality disorder (see **Personality disorder**, page 70).
- Eating disorders (see **Eating disorders**, page 60).

The person who is abused sexually may suffer **in addition** from the following.

- Problems with sexual identity.
- Confusion about what sexual behaviours are appropriate.
- Difficulty in describing their experiences. They may experience guilt and self-blame and become very distressed.

See the relevant guideline for advice on managing associated mental disorders.

Action to take initially

- **Listen sympathetically** without judging or asking for details (**unless** there is good reason to believe that another young person is still being abused or is at immediate risk of abuse, in which case ask for more details but refrain from judging).
- **Reduce self-blame.** Explain that some people who have been abused may feel that they are to blame if they did not tell the abuser not to do it or if they did not tell anyone. This is not true. Adults are the powerful ones who are responsible for looking after and protecting children. Children do not have the power to resist overtures and are not to blame for them. Reiterate this whenever blame of self occurs.
- **Explain the rules of confidentiality** in accordance with medical ethics, prison rules and any guidance from your own profession but, if need be, explain the need to break aspects of confidence to protect children who are vulnerable.
- **Ensure that the patient is safe** and does not return to the situation or people where the alleged abuse occurred.
- **Assess the risk of suicide and self-harm.** Ask a series of questions about suicidal ideas, intent and plans (eg has the patient often thought of death or dying? Does the patient have a specific suicide plan? Has he/she made serious suicide attempts in the past? Can the patient be sure not to act on suicidal ideas?). Ask about risk of harm to others (see **Assessing and managing people at risk of suicide**, page 204).
- **Assess the risk of violence** to the perpetrator of abuse, if appropriate (see 'Assessing the risk of violence' in **Aggression**, page 282).
- **Obtain support.** Ensure the individual knows to whom he/she can go for help and support within the institution (eg listener, befriender, chaplain, personal officer) and how to access that support. Explain the sort of support on offer, ie

emotional support when the individual is feeling low, help with current practical problems, rather than exploration of the past abuse.

- **Plan activities.** Try to arrange an appropriate plan that offers meaningful activity, study, creativity or work, so time to brood is limited and self-worth may be boosted.

Considering the possible cultural implications

There may be serious cultural or religious problems arising from admitting or being subject to abuse. Examples include:

- The family may regard any abuse, however it occurred, as bringing shame upon the family. Liaison with the family may not be straightforward.
- Because of the shame attached to abuse, the individual may self-harm and then experience added shame if suicide is not acceptable in their religion (eg Muslims). The individual may then feel cut off from the support of their faith community. Care may need to be taken in liaising with religious leaders.

If at all concerned, consult the chaplain. The Local Authority's race relations officer may be helpful. Voluntary agencies that specialise in helping people from particular cultural or religious groups are listed in the **Resource directory** (page 316).

Child protection

Child-protection issues arise:

- if the patient is under 18 years of age and claims that they have been abused at home, school or in a children's home. If they return, they risk being abused again
- if the patient fears that a younger sibling, relative or other child is at risk or is suffering abuse and
- if the patient is an adult, the abuser is still alive and the patient reveals details indicating that a specific child is being abused or is at risk of abuse.

See **Child protection** (page 276).

Arranging therapy, counselling or self-help support

- Explain that many people who have been abused come to terms over time with what has happened to them and regain control of their lives. Contact with others who have had the same experience may be helpful, if this is available (see below). There are several books that can be helpful, eg in enabling the individual to see that their reactions are normal and to feel less alone (see below).
- Be aware that the effects of childhood abuse can be severely disabling with long-lasting effects on the development of the personality, for which the treatment is long-term, specialist psychotherapy. Except where long-term support can be offered to the patient, and especially in the context of remand or a short sentence, appropriate types of help will encourage the patient to focus on the present, and help him/her deal with current problems, for which solutions may be possible, for example:
 - relaxation techniques may be helpful for anxiety
 - self-assertiveness classes may help with self-destructive passivity
 - anger management may help an individual channel their anger constructively and
 - counselling focused on learning coping skills, such as gaining control of intrusive imagery and compartmentalising experiences rather than on the abuse itself, may help reduce immediately disturbing symptoms.
- Treatments for abused adolescents include group work, family therapy and cognitive-behaviour therapy focused on traumatic responses.⁴

If these interventions are not available in prison or the individual is not in the prison long enough to benefit from them, try to ensure that the sentence plan or prerelease plan includes information for the individual about agencies in the community that may provide both support (eg survivors' groups) and long-term therapy.

Developing in-prison resources

- Some individuals will need long-term help either in prison or after release. Consider building into the service agreement with mental-health services' help making appropriate referrals for therapy following release or, where sentences are long, the provision of some long-term psychotherapy in the prison.
- Consider organising a 'Survivors of Abuse' mutual support group, perhaps facilitated by an external counsellor or therapist from a voluntary organisation. For women's prisons, local rape crisis centres (see **Resources Directory** page 316) may have counsellors with special training in working with women who have been sexually abused as children. Issues to

consider in setting up such a group include the training of the facilitator, how confidentiality and child-protection issues will be handled, the time commitment required from participants, the focus of the group (groups should aim to help participants regain some sense of control, feel less alone and learn skills for coping with their present feelings) and the provision for support for participants who need it between sessions and after the group ends.

- Develop a library of literature to lend to patients (see **Resources** below).

Resources for patients and primary support groups

Breaking Free: 020 8648 3500 (helpline)

Suite 23–25 Marshall House, 124 Middleton Road, Morden SM4 6RW

(Support and information by telephone and letter primarily for women. Information and referral service for men and women. Some face-to-face group support sessions)

Childwatch: 01482 325552 (national helpline: Monday–Friday, 9:30 am–4 pm)

206 Hessle Road, Hull HU3 3BE

(Telephone and face-to-face counselling for adults who have been abused as children and for their families)

London Rape Crisis Centre: 020 7837 1600 (national helpline: Monday–Friday, 6 pm–10 pm; Saturday and Sunday, 10 am–10 pm)

PO Box 69, London WC1X 9JN

(For women and girls who have been raped or sexually abused, and for their friends, families and for professionals. Also provides information about local self-help groups and face-to-face counselling services)

Men as Survivors Helpline (MASH): 0117 9077100 (Thursday, 7–9 pm)

c/o Victim Support, 36 Dean Lane, Bedminster, Bristol BS1 1BS

Reach Out: 020 8905 4501

(For men and women who have suffered abuse as children)

Respond: 020 7383 0700

(Services for adults with learning disabilities who have been, or may have been, sexually abused)

Survivors UK: 020 7833 3737

Youth Access: 020 8772 9900

(Provides information and advice for young people and the names of counsellors in local areas)

Videos and books may be available via your Health Authority Health Promotion Unit or Prism (for addresses, see page 316)

Video:

To a Safer Place. National Film Board of Canada, 1987. 58 minutes. Available from: Educational Media, 235 Imperial Drive, Rayners Lane, Harrow HA2 7HE. Tel: 020 8868 1908/1915. Documents the journey of an adult survivor of sexual abuse. All participants are white. It has a very positive message about recovery and can be useful in explaining the healing process to adolescents. Suitable for adults and teenagers

The Survivors' Directory. Manchester: Broadcasting Support Services. Available from: Broadcasting Support Services, Westminster House, 11 Portland Street, Manchester M1 3HU. Tel: 0161 455 1212. £9.00. Produces a resource directory to unfunded groups and individuals

Helen Kennerley. *Overcoming Childhood Trauma: A Self-help Guide Using Cognitive Behavioural Techniques.* London: Constable & Robinson, 2000. Available from: MIND, 15–19 Broadway, London E15 4BQ. Tel: 020 8519 2122. Useful for helpers as well as those who have experienced childhood abuse. Covers all kinds of abuse, including physical and emotional. Helpful section on building short-term coping strategies

L Arnold. *Hurting Inside: A Book for Young People.* 1988 Abergavenny Basement Project

Available for £3.50 from: Basement Project, PO Box 5, Abergavenny NP7 5XW. Tel: 01873 856524. Aims to help young people tackle difficulties they have as a result of physical, sexual or emotional abuse or neglect. It can also be a helpful starting point for adults looking at their experiences

O Bain and M Sanders. *Out in the Open: A Guide for Young People Who Have Been Sexually Abused.* London: Virago, 1990. Excellent book for young people

E Gil. *Outgrowing the Pain: A Book for and About Adults Abused as Children.* New York: Dell, 1983. ISBN 0-440-50006-0. For adults and written in an accessible style with cartoons)

M Wilson. *Crossing the Boundaries: Black Women Survive Incest*. London: Virago, 1993. Personal testimony for black female survivors of sexual abuse; detailed resource section

Ellen Bass and Laura Davis. *The Courage to Heal: A Guide for Women Survivors*, revd edn. New York: Harper Perennial, 1992. Offers hope and encouragement to women abused as children

M Lew. *Victims No Longer: Men Recovering from Incest and Other Sexual Child Abuse*. New York: Harper & Row, 1988. Gives both survivors and therapists essential advice for healing

- ¹ Coxell AW, King MB, Mezey GC, Gordon D. Lifetime prevalence, characteristics and associated problems of non-consensual sex in men: a cross sectional survey. *British Medical Journal* 1999; 318: 846–850.
- ² Bland J, Mezey GC, Dolan B. Special women, special needs: a descriptive study of female special hospital patients. *Journal of Forensic Psychiatry* 1999; 10: 34–45.
- ³ Singleton N, Meltzer H, Gatward R, Coid J, Deasy D. *Psychiatric Morbidity among Prisoners*. London: Office for National Statistics, 2000.
- ⁴ Monck E, Bentovim A, Goodall G *et al*. *Child Sexual Abuse: A Descriptive and Treatment Study*. London: HMSO, 1996. Cognitive-behavioural therapy focused on traumatic responses shows greatest effect.

Child-protection issues

Introduction

Child-protection issues may arise for healthcare staff at any time, but are more likely to do so when dealing with certain situations.

- In Mother and Baby Units (MBU), where the mother's mental state or relationship with the infant is sufficiently disturbed to result in the risk of significant harm to the infant.
- In young offender institutions (YOI), where disclosures of recent or current abuse may be made.
- In adult prisons, where disclosures of past abuse or domestic violence may reveal that a child is currently at risk.
- In any prison holding sex offenders and/or paedophiles, especially if children visit them.
- Participation in risk assessments of individual prisoners to inform decisions on sentence planning or supervision after release.

This section aims to:

- give broad accepted definitions of when child-protection procedures should be invoked
- outline the relevant legal and professional guidance governing breaching confidentiality in order to protect children and
- signpost the child-protection procedures that exist in different types of establishment.

It does not aim to give detailed guidance on how to deal with particular types of situation. Where there is doubt, healthcare staff are advised to contact and discuss the situation with the prison Child Protection Coordinator (CPC), local social services or the designated doctor or nurse in the local Primary Care Trust. (In England and Wales, all Primary Care Trusts must identify a paediatrician or nurse to take a professional lead on the health service contribution to child protection.)

When are child-protection procedures needed?: definitions

The aim of child-protection procedures and the legislation on which they are based is to prevent 'significant harm' occurring to 'children'.

The relevant legislation is the Children Act 1989. While the Act does not apply to regimens for the treatment of under 18 year olds in prison establishments, the Prison Service is required to reflect the standards imposed by the Act through its own delegated legislation and codes of practice. It is important to be aware of what these protocols are. Relevant Prison Service Orders are: Prison Service Order 4950 'Regimes for Under 18 Year Olds' and 'Regimes for Young Women Under 18 Years Old'.

How old is a 'child'?

The Children Act 1989 covers 0-18 years, although the age of consent for sexual activity is 16. Chronological age does not necessarily correspond with the psychological maturity of a young person, nor their ability to recognise and protect themselves against exploitation. Section 31(10) suggests that the child's health and development should be compared with that reasonably expected of a similar child. The United Nations Convention on the Rights of the Child refers to persons below the age of 18 as children. Effectively, all young persons detained in penal establishments should be considered as vulnerable until they have reached the age of 18, even though the age for sexual consent is 16.

What is child abuse?

The Children Act 1989: Section 31(9) covers both actual and likely harm. Harm includes both ill-treatment (including sexual abuse and non-physical ill-treatment like emotional abuse) and the impairment of health or development.

- 'Health' means physical or mental health.
- 'Development' means physical, intellectual, emotional, social or behavioural.
- **Physical abuse** implies a physically harmful action directed against a child, eg any inflicted injury such as bruises, burns, head injuries, fractures, abdominal injuries or poisoning.
- **Sexual abuse** implies the involvement of dependent, developmentally immature children and adolescents in sexual activities they do not fully comprehend and to which they cannot give informed consent, or that violate the social taboos of family roles.

What is 'significant harm'?

- Physical injury needing prompt medical attention that could incur criminal charges under Sections 18, 20 or 47 of the Offences Against the Person Act 1861.
- Sexual abuse includes direct (eg touching) and indirect (eg exposure) sexual acts in which the young person was exploited because the activity was unwanted when it first began and involved differences in age, authority or gender (ie coercion by an older person or one in a position of authority). The young person's degree of physical and personal maturity may be relevant in deciding the seriousness of the abuse.
- Emotional abuse covers actual or likely persistent or severe psychological ill-treatment, eg persistent verbal denigration, humiliation in the absence of any positive interest, concern and action, or intimidation.
- Neglect covers actual or likely persistent or severe neglect or the failure to afford protection to a young person against any kind of foreseeable danger, including a failure to address needs that result in significant impairment of a young person's health or development.

Which children are healthcare workers responsible for protecting?

The requirement to protect children from significant harm extends beyond current patients (eg a young offender), other inmates (eg other young offenders) and beyond children visiting the prison. If you have reason to believe that another child (eg a younger sibling or the patient's own children) are at risk or are suffering significant harm, you have a duty under the Children Act 1989 to take steps to protect them. Consideration should also be given during a prisoner's pregnancy to possible risk of significant harm to her unborn child after it is born. Examples include a pregnant mother who has previously been convicted or suspected of abusing children, or whose children have been removed from her care via a court order because of significant concern about her care of them.

Patient confidentiality and child protection

The guidance accompanying the Children Act 1989 is clear about the obligations of all agencies to report concerns about child protection. In child-protection cases, the overriding principle is to secure the best interests of the child.

Common law

The common law duty of confidence enjoins on healthcare professionals the duty to keep personal information about children and families confidential, except where the individual patient has given consent. However, the law permits disclosure of confidential information necessary to safeguard a child or children in the public interest. The Caldicott principles for disclosure of medical information, which will soon become law, go further and state that the duty of confidence is superseded by the principle of duty of care for the child, making disclosure to safeguard a child an ethical requirement. Where the patient is a child, they are also entitled to confidentiality, provided that, in the case of those under 16, they have the ability to understand the choices and consequences relating to treatment. However, again, where it is believed that the child is being exploited or abused, confidentiality may be breached following discussion with the child.

The guidance of the General Medical Council, the Royal College of Psychiatrists and The United Kingdom Central Council for Nursing, Midwifery and Health Visiting (UKCC) is set out in the section on confidentiality in **Ethical issues** (page 300).

What action should be taken?

Young offenders who allege that they have been abused recently

Recently remanded or sentenced young offenders may claim that they have recently been abused in the establishment, at home, school or in a children's home. They may fear that a younger sibling, relative or other child is at risk or is suffering abuse.

- Ensure that the young person is safe and does not return to the situation or people where the alleged abuse occurred.
- Document what is said and any physical evidence meticulously, with due regard to confidentiality. Do this as soon as possible, and no later than 24 hours after the event. If a court case is considered, the courts will require evidence of the abuse, whether non-accidental injury, sexual or emotional.
- Discuss the situation with the patient and, if he/she or another child is at risk of serious harm, encourage them to report it. If at all possible, offer to help or accompany him/her, even if only to report it to the prison CPC or a social worker.
- Sometimes a patient may be reluctant to report abuse, especially if it has occurred within the family, as they may not want to prosecute the abuser. Reassure them that the priority in child protection is always the protection of any children at risk, not the prosecution of perpetrators. Disclosure need not lead to prosecution if the victim does not want this.

- If consent is refused, discuss the situation with an experienced colleague or, anonymously, with the prison CPC, local social services, the designated doctor or nurse in the local Health Authority or your professional body.
- If the patient continues to refuse consent, if there is reason to believe that serious harm may occur and it is in the best interests of the child, inform the appropriate person and ask that, if possible, the identity of the informant is concealed from the alleged perpetrator.

Advice on responding to an individual who discloses abuse appears in **People who disclose abuse** (page 271). If the young person has been the victim of a very recent sexual assault, **Victims of sexual assault** (page 260) may also be relevant.

Young persons who are themselves abusers

In a YOI or Young Offenders Unit, the abuser may be an inmate, themselves under 18. A complaint against a fellow inmate should be taken seriously, although care has to be taken that this is not a malicious lie to bring trouble upon another inmate. Young people who have been victims of sexual abuse or who have grown up in a culture of domestic violence are more likely to become abusers. Awareness of a young person's history of abuse might make one alert to the possibility that he/she may abuse a weaker young person. If you suspect that a young offender is an abuser of others do the following.

- Consult an experienced colleague — perhaps the healthcare representative on the prison Child Protection Committee.
- Discuss your concerns with the prison CPC.
- If the CPC is not available, the duty governor should be informed as the alleged abuser may need to be relocated within the establishment. The local Social Services' Child Protection Unit may be also helpful.
- An assessment of the needs of the alleged perpetrator and of why he/she is abusing others should be arranged.

Adults talking about past abuse

During the course of treatment, a young person or an adult prisoner may admit to having been abused as a child. Unless there is reason to believe that the original perpetrator is still committing such offences against children, there are no legal child-protection implications. If the young person or adult prisoner wishes to discuss possible prosecution of their former abuser, they will require legal advice. **People who disclose abuse** (see page 271) gives more advice on responding to a disclosure of abuse.

Mother and Baby Units (MBU)

Staff need to be alert to the possibility of babies suffering significant harm. For more details, see **Problems in the mother-baby relationship** and **Postnatal depression** (pages 144 and 134). Each MBU has a child-protection procedure endorsed by the area CPC within which the prison is located. You should ensure that you have access to a copy of this procedure. If harm to the baby is suspected do the following.

- Express care and attention for the mother. Such mothers frequently have unmet emotional needs and/or are immature. If concern for the baby appears to neglect the mother's needs or fears, this could lead to serious resentment of the baby. However, be aware that the child's welfare is paramount.
- Arrange additional practical help with childcare, offered non-judgementally. For example, a nursery nurse assisting the mother to care for the baby may model good care. She would ideally spend considerable periods with both mother and baby. The health visitor or the MBU governor may trigger a review of the infant's care plan and arrange additional help.
- If possible, involve the mother in making decisions about who should see the baby. However, if she refuses to have the baby examined or given medical treatment or to cooperate in good baby care, so that the baby is at risk, then inform the Liaison Department at the local social services. The principal duty of care is to the baby and this, as a last resort, may override patient confidentiality and the mother's wishes.
- If you become aware of actual harm to the baby, eg a non-accidental injury, activate the prison's child-protection procedure immediately. Involve the mother in this process if possible, but give priority to protecting the baby from the risk of further harm.
- Record all actions and decisions taken clearly. Describe fully the reasons for concern, the agreed plan, and the names and designations of all who are involved in the care plan. Each person must receive a copy of the plan.

Who should be informed?

The principal responsibility for child protection rests with the local Social Services' Child Protection Unit. Additionally, prisons containing an MBU all have a liaison social worker and a written child-protection procedure. YOI have a prison

CPC, a prison CPC on which a representative of healthcare sits and a written child-protection procedure. The procedure usually involves the following.

- Referring child-protection issues to the duty governor or the CPC.
- The duty governor making an assessment as soon as possible and certainly within 12 hours in consultation with the prison CPC, and then taking action as necessary. Action taken may include:
 - ensuring that the individual does not return to the place or people where he/she could be harmed again and
 - informing the parents or a guardian and local social services and organising a child-protection conference.
- In other prisons, it may be necessary to report the matter directly to local social services. It is important that all healthcare staff are aware of the name and contact details of the relevant department of local social services.
- Where there is reason to believe that another child in another area is being abused or is at risk of being abused, the appropriate person to inform is the local Social Services' Child Protection Unit where the alleged abuser and child victim live. If it is not local, obtain help from the prison's local social services. The Local Authority, via social services, has a responsibility under Section 47 of the Children Act 1989 to make enquiries where it has reasonable cause to suspect a child is suffering or is likely to suffer from harm.
- Others who may be helpful include: the health visitor, probation staff and the National Society for the Prevention of Cruelty to Children (NSPCC).

Further information

- The prison's child-protection policy (for YOI and prisons with an MBU).
- Any publication or policy of the local area CPC.
- Department of Health. *Protecting and Using Patient Information: Caldicott Report*. London: Department of Health, 1997.
- *Working Together under the Children Act 1989*, 2nd edn London: HMSO, 1999.
- Howard League Report. *Banged Up, Beaten Up, Cutting Up*. London: Howard League, 1995.
- Birchall E, Hallet C. *Working Together in Child Protection*. London: HMSO, 1995.
- Royal College of Psychiatrists. *Good Psychiatric Practice: Confidentiality*. Council Report CR85. London: Royal College of Psychiatrists, 2000.
- General Medical Council. *Confidentiality: Protection and Providing Information*. London: GMC, 2000.
- United Kingdom Central Council for Nursing, Midwifery and Health Visiting. *Guidelines for Professional Practice*. London: UKCC, 1996.

Resources for young people and primary support groups

Childline: 0800 1111 (24-hour freephone helpline)
(For children and young people)

Children 1st: 0131 337 8539
(Offers help and advice on child abuse in Scotland)

Children's Law Centre Northern Ireland: 0808 808 5678 (Monday, Tuesday and Friday, 10 am–4:30 pm; Thursday, 10 am–5 pm)
(Free legal advice and information about children and young people in Northern Ireland)

The Children's Legal Centre: 01206 873820 (Monday–Friday, 10 am–12:30 pm, 2 pm–4:30 pm)
University of Essex, Wivenhoe Park, Colchester CO4 3SQ. E-mail: clc@essex.ac.uk; URL: <http://www2.essex.ac.uk/clc>
(Free legal advice and information about children and young people)

Family Rights Group: 020 7923 2628; 0800 731 1696 (freephone advice line: Monday–Friday, 1.30 pm–3.30 pm)
The Print House, 18 Ashwin Street, London E8 3DL. E-mail: office@frg.u-net.com
(Offers advice, advocacy and publications to families whose children are involved with social services)

Kidscape: 020 7730 3300
2 Grosvenor Gardens, London SW1W 0DH
(Provides booklets, leaflets [some free], videos and other materials to help teach children and young people practical strategies for keeping safe, coping with bullying and preventing child abuse)

National Society for the Prevention of Cruelty to Children (NSPCC):
0808 800 5000 (24-hour helpline)

(For children and anyone concerned about child abuse)

Scottish Child Law Centre: 0131 667 6333

(Gives advice about how Scottish law relates to children)

Youth Access: 020 8772 9900

(Provides information on and referrals to agencies around the country providing advice, support and counselling to young people)

See **People who have been abused as children** (page x) for details of resources for this problem