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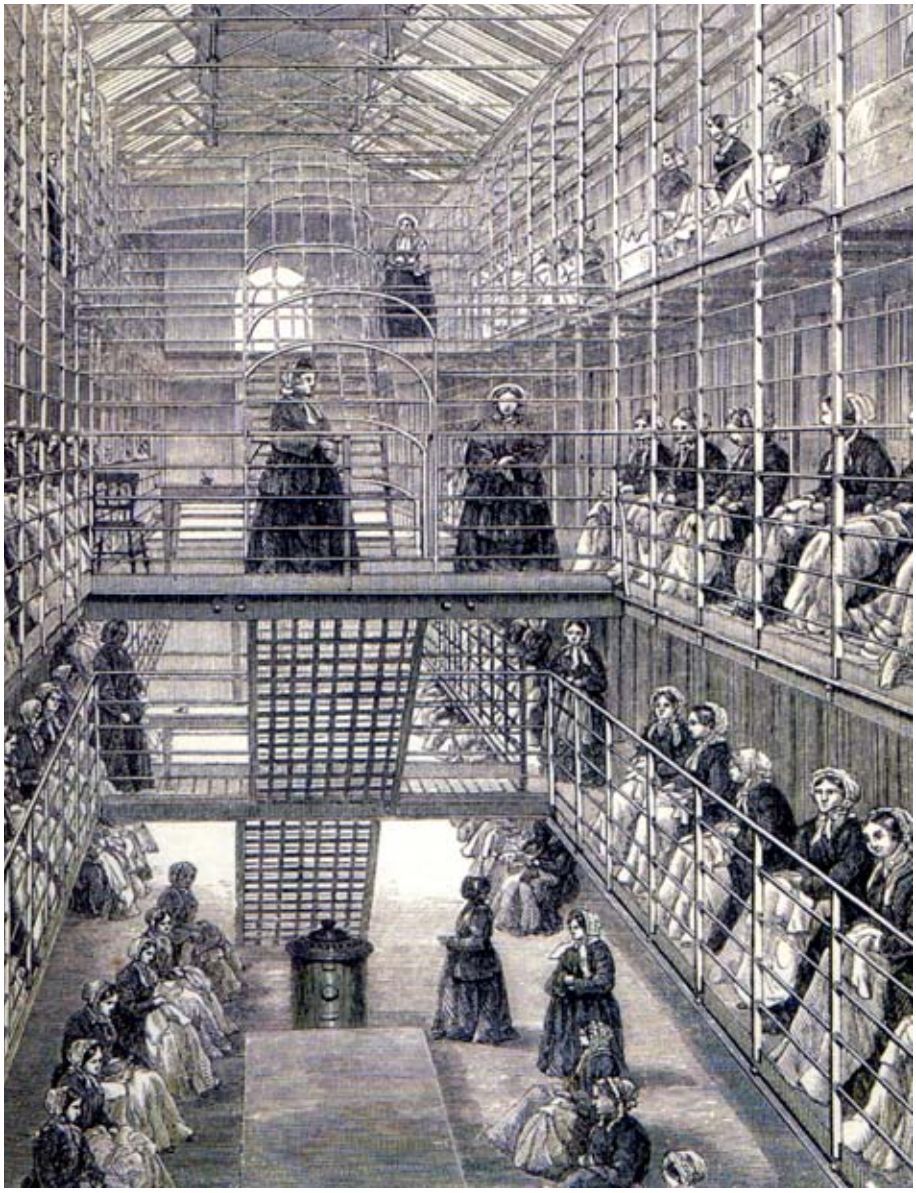
THE CHALLENGE OF PROVIDING PRISON HEALTHCARE

In the first article in his series on prison healthcare, **Stephen Ginn** looks at British prisons and at the unique difficulties of providing effective care to prisoners



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Prison is a difficult place in which to provide health services, and concerns about the health of prisoners and the quality of healthcare available to them are long standing.[1] In 2006 prison health services in England and Wales were transferred to the National Health Service. Scotland and Northern Ireland recently followed suit. In this first of a series of articles on prison health I examine the landscape of British prisons and the obstacles faced by prison health services.

Prison population

Imprisonment is a growing problem. During the past 20 years, the number of prisoners in England and Wales has nearly doubled (fig 1). The Scottish and Northern Irish prison populations have also substantially increased. Prison capacity has struggled to keep up, and 60% of prisons are officially overcrowded.[2] These increases are not explained by changes in criminal behaviour, as recorded crime is falling,[3] but by more frequent use of custodial punishment and lengthier sentences.

The prison population of England and Wales is nearly 87 000.[5] This is a rate of imprisonment of 154 people/100 000 population,[6] one of the highest in western Europe (fig 2). Scotland's prison population is just over 8200 (154/100 000)[7] and Northern Ireland's 1700 (99/100 000).[8] There are 131 prisons in England and Wales, 14 of which are privately run.[7] Women make up just 5% of prisoners, and there are 13 women's prisons in England, but none in Wales. Scotland and Northern Ireland each have one dedicated women's prison and there are also two Scottish male prisons with small female prisoner units. The prison budget was £2.18bn (€2.72bn; $3.50bn) for 2011-12

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Brixton Prison in 1853 (previous page) and Belmarsh in 2010: responsibility for prison healthcare lay with the Prison Medical Service from its creation in the 19th century until its abolition in 2006, when it was taken over by the NHS

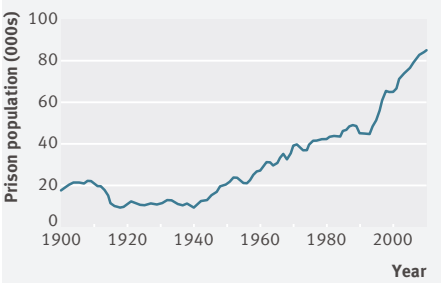

Fig 1 | Prison population England and Wales, 1900-2011[4]

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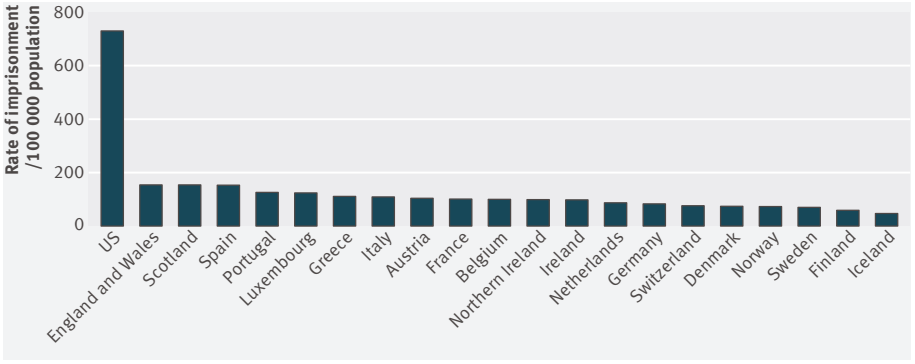


Fig 2 | Rates of imprisonment in western Europe and United States[10]

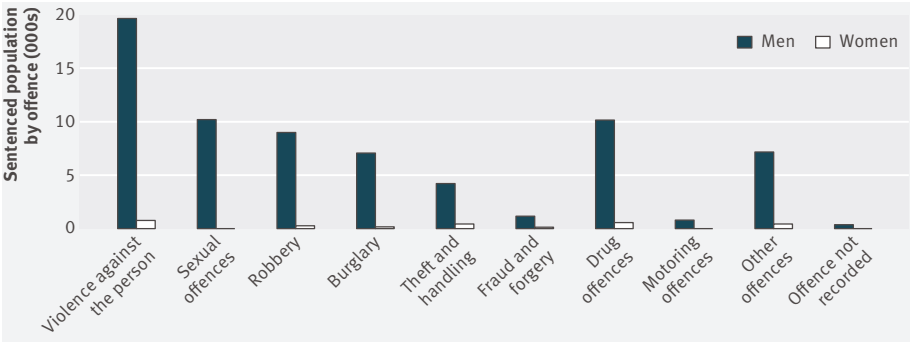


Fig 3 | Prison population by offence, March 2012[9]

in England and Wales, and it costs an average £39 573 for a prison place each year.[9]

Prisons are full of poor, disadvantaged, and vulnerable people. Compared with the general public, the average prisoner is considerably more likely to have been homeless, unemployed, and in social care as a child.[9] The level of educational attainment among prisoners is generally very low.[9] A typical prisoner is young and male,[9] and violence is the most common cause for detention, with acquisitive crime and sexual and drug offences also common (fig 3).

The turnover of prisoners is high. Nearly half of all people entering prison under sentence in 2011 were there for six months or less.[11] Around one in 11 prisoners is serving a life sentence, and just over 6000 prisoners are on indeterminate sentences.[11] With the exception of around 40 prisoners on a "whole life" tariff[9] every prisoner will one day be released.

A prisoner's movement through the prison system depends on his or her sentence and behaviour. Local prisons serve the courts in a particular area and detain both remand and sentenced prisoners. Training prisons accept sentenced prisoners from local prisons and, for men, have security categories of A, B, C, or D. Category A prisons hold prisoners thought to pose the greatest security risk, whereas category D (open prisons) hold the lowest risk offenders.

Challenging environment

Prison presents unique challenges for healthcare practitioners. Security is prison's principal concern and its main function is to detain people convicted by the courts. Effective healthcare comes second, but if good healthcare is not available to prisoners, they have no alternative. The notion that a successful prison also has a reforming role has a long history[12] but reoffending rates remain stubbornly high.[9]

Prisons are not nurturing places. They are foreboding from the outside, enclosed by towering walls topped with razor wire. Inside, the environment is grey and visually impoverished. Even short journeys are punctuated by multiple sets of heavy locked doors.

Prisoners themselves are a challenging population to treat effectively. Their health and social needs are extensive and diverse, and many have poor physical and mental health. Frequent relocations and short sentences make engagement with healthcare difficult. Exposure to illicit drugs, violence, and victimisation

Any successful health initiative runs the risk of being seen as too good for prisoners, who are portrayed as undeserving

in prison is commonplace. Prisoners are reliant on prison staff for almost every aspect of their existence and often have only a limited ability to influence the many factors that affect their health. Their accommodation, diet, and ability to exercise are all largely beyond their control.

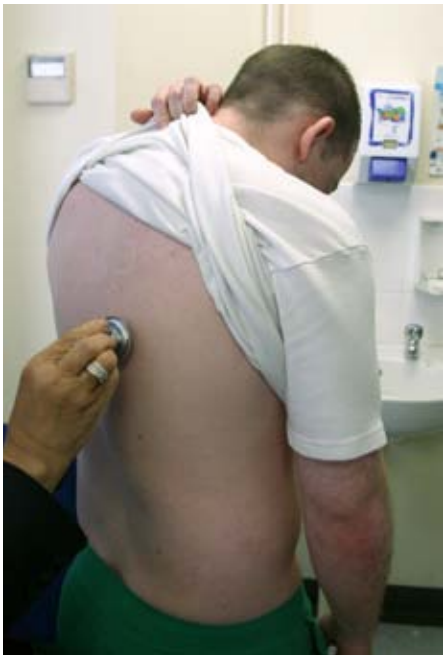
Another challenge is that prisons are politically sensitive places. Public views on the sorts of people found in prisons and the experience of imprisonment can be distorted by representations in the media,[13] which tend to concentrate on celebrity prisoners, stories of prisoners receiving undue privileges, and sentences deemed too lenient. Consequently, any successful health initiative runs the risk of being seen as too good for prisoners, who are portrayed as undeserving.

Evolution of prison health services

Specific provision for prisoner health began in 1774 when a law was passed requiring every prison to appoint a surgeon or apothecary in an attempt to stop typhus spreading from prison to the community.[1] Transportation to Australia ended in 1840, and 90 prisons were built between 1842 and 1877, many of which are still in use.[14] In 1877 the prison system was taken over by central government, and the Prison Medical Service came into existence at that time. The prison doctor became one of the most important people in a prison, along with the governor and chaplain.[15]

The Prison Medical Service remained a separate entity when the NHS was created in 1948, and its doctors were employees of the Home Office. Most secondary care took place in NHS hospitals, although some larger prisons employed a consultant psychiatrist.

Over the years concerns were raised about the quality of care this parallel system offered prisoners, and in 1996 Her Majesty's Chief Inspector of Prisons published an influential and highly critical report concerning the healthcare available to prisoners in England and Wales.[16] According to the report, prison healthcare staff were often inadequately qualified, lacked suitable training, and had low morale. Professional isolation and poor communication among doctors and nurses was common, and the standard of care varied enormously. Compared with people living in the community, prisoners did not have their health needs properly assessed or met. Many of these concerns were not new, but they had rarely been given such prominence.



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Inmate being examined in Pentonville prison

In 2006 the Prison Medical Service ceased to exist and the NHS in England and Wales assumed responsibility for prisoner health. The responsibility for healthcare in Scottish and Northern Irish prisons transferred to the NHS in November 2011 and April 2012 respectively.

Difficulties remain

Six years on, NHS prison healthcare remains a work in progress. Anecdotally, the transfer of responsibility for prison healthcare to the NHS is regarded as a success. The NHS has introduced community norms and expectations, and there are examples of new facilities, innovation, and investment. Prison doctors are now all qualified general practitioners, and professional isolation has been reduced as doctors often combine practice in prisons with work in the community. Primary care trusts now provide healthcare to both prisons and local communities, and the same standards of service can be offered to both.

But challenges remain within the service. In the following articles in this series I consider some of the most important: meeting the needs of the growing population of elderly prisoners, for whom Victorian era prisons are not suitable; treatment of prisoners with serious mental health problems; and the appropriateness of prison for women, who are arguably often victims as much as they are offenders and have high rates of self harm.

Prison healthcare and broader problems of imprisonment are not easily separated. The health of some prisoners improves after a prison sentence, and in my final article I will ask whether prisons can ever be "healthy" places.

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Contributors and sources: SG is an ST5 trainee in general adult psychiatry and was the 2011-12 Roger Robinson *BMJ* editorial registrar. Information for this series was obtained from an unsystematic literature review, prison visits, and discussions with prison doctors, prison nurses, prison and forensic psychiatrists, prison governors, prison reformers, prison health managers, prisoners, criminologists, sociologists, and prison inspectors.

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