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Promoting health in prison

Prisons contain some of society's most disadvantaged people. In the last of his series **Stephen Ginn** looks at how prison provides opportunities to improve their health and asks whether earlier intervention could keep them out of prison in the first place

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Table 1 | Social characteristics of prisoners[5]

Characteristic	% of prison population
Taken into care as a child	24 (31 for women, 24 for men)
Experienced abuse as a child	29 (53 for women, 27 for men)
Observed violence in the home as a child	41 (50 for women, 40 for men
Regularly truanted from school	59
Excluded from school	42 (32 for women, 43 for men)
No qualifications	47
Unemployed in the four weeks before custody	68 (81 for women, 67 for men)
Never had a job	13
Homeless before entering custody	15
Have children under the age of 18	54
Having both anxiety and depression	25 (49 for women, 23 for men)
Have a physical disability	18
Used drugs in the four weeks before custody	64
Drank alcohol every day in the four weeks before custody	22

In previous articles I have set out the challenges of providing healthcare in prisons and have examined the problems in British prisons of elderly prisoners, women prisoners, and prisoners with mental disorders.[1-4] In this final article of the series I highlight how prison contributes to the treatment of people who are "hard to reach."

Many British prisoners come from the most economically deprived and socially disadvantaged groups within society. They share with these groups the experience of being raised in care, low educational attainment, unemployment, and homelessness (table 1).[5] Some minority ethnic groups are substantially overrepresented (table 2). Many prisoners have chaotic lifestyles and complex health and social problems. They may also have limited health aspirations and low expectations of health services, which may not have the flexibility to respond effectively to their needs.[7]

Prison can provide an opportunity for the orderly assessment and treatment of those whose lifestyle has previously prevented engagement. Prisoners can be encouraged to adopt healthier behaviours, and prison can provide an opportunity to address health inequalities.[8] However, prisons are not principally in the business of promoting health and some people argue that there is an inherent contradiction between the aims of care and control.[9] Prisons have values, rules, and rituals that enable prisoners to be observed, contained, and disempowered [10]; these are at odds with any notion that prisoners can be encouraged to take charge of their health.[9] In addition, any discussion about the health of prisoners cannot ignore the broader question of whether prison is the right place for many offenders.

Health promotion in prison

The first dedicated health promotion strategy for prisons in England and Wales was published in 2002.[8] Because few resources have been invested in evaluating it, its impact is largely unknown.[11 12] In 2008-09 Her Majesty's Inspectorate of Prisons and the Care Quality Commission examined a sample of 21 primary care trusts and found that all undertook health promotion in prisons. Although there was evidence of good practice, the information on provision was not always sufficiently detailed to allow proper appraisal.[13]

Around 80% of prisoners in England and Wales smoke,[14] four times the proportion of the general public.[15] Reasons for prisoners smoking include relief from boredom and stress.[16] Smoking in UK prisons has been restricted since 2007: prisoners may smoke in their cells but are not allowed to smoke in their workplace or during educational programmes or activities.[17] The government's 2010 tobacco control strategy for

England mentions prisoners as one of the vulnerable and disadvantaged groups whose high rates of smoking should be tackled.[18] An evaluation study of the use of nicotine replacement therapy in 16 prisons in north east England, found that quit rates similar to those in the community are possible.[19]

There are, however, no plans for British prisons to become smoke-free. This is in contrast to the United States, where 60% of surveyed prisons reported total tobacco bans, with 27% having an indoor ban on tobacco use.[20] Non-smoking prisoners have successfully sued several states for exposing them to second hand smoke.[21]

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Infectious disease

Prisons are vulnerable to infectious disease as they are often overcrowded, with poor ventilation, shared facilities such as showers, and high turnover of prisoners, staff, and visitors.[22] Outbreaks of seasonal influenza and gastrointestinal disease are common,[23] although prisons in England and Wales did not experience significant outbreaks during the 2009 flu pandemic.[24] Prisoners have higher rates of tuberculosis, hepatitis B, and HIV infection than a similar population outside prison.[25] A 1997 survey in England and Wales found that 0.3% of male prisoners and 1% of female prisoners were positive for HIV, and that 8% of adult males and 12% of adult females had hepatitis B antibodies.[26] Hepatitis C antibodies were found in 9% of men and 11% of women.[26]

62% of prisoners on directly observed therapy [for TB] were homeless on release, with less than half completing a full course of treatment

Resources available to prevent spread of blood borne viruses in prisons include disinfectant tablets to decontaminate needles, syringes, and tattooing equipment. Condoms, dental dams, and water based lubricants are available on request. A hepatitis B vaccination programme is in place. As injecting drug use is the most common risk factor for hepatitis B in the community, and 61% of injecting drug users are imprisoned at some point, vaccination in prison helps to protect this group.[27]

Tuberculosis is associated with drug use, incarceration, and homelessness,[28] and prison offers an opportunity for identifying people who are infected. A proposed national system in England and Wales to allow screening at reception is not yet in place, but eight prisons receiving prisoners from areas of high prevalence have x ray machines, and tuberculosis case finding in prisons has increased (46 cases in 2007 versus 91 cases in 2012).[23 29] However, ensuring completion of treatment is difficult. Pentonville prison found that in 2005 62% of prisoners on directly observed therapy were homeless on release, with less than half completing a full course of treatment.[30]

Drug misuse

Illegal drug use in prison is a substantial problem, with some prisons having very high levels.[31] In one study 48% of male and 38% of female sentenced prisoners reported using drugs during their current prison term.[14] Drugs may be posted into prisons, brought in by visitors or prison officers, or thrown over the perimeter.[31] Investment in prison treatment in England and Wales has increased from £7m (€8m; $11m) in 1997-98 to £80m in 2007-08 (not adjusted for inflation).[32]

In 2009-10, 60 067 prisoners received clinical treatment for drug addiction in prison in England and Wales.[33] Sixty per cent of these were entered on a detoxification programme and the remainder on a maintenance programme.[33] Individual care is planned using the integrated drug treatment system,[34] which aims to combine clinical and psychosocial approaches and to bridge prison and community care.

Standards of treatment vary greatly across the prison service.[35] Particular problems are recognised in addressing the needs of those serving short sentences, for whom serious drug or alcohol problems are an "abiding feature."[36] Continued support on release is also a problem,[31] and prisoners are at a substantially increased risk of death by drug overdose in the first month after release.[37]

Health on release

Release from prison can be a "health depleting experience."[38] For instance, one study of male probationers found the suicide rate to be nine times that of the local community population.[39] The operational guidelines for prisoner resettlement in England and Wales include consideration of the need for follow-up healthcare in the community,[40] but the quality of planning for post

Table 2 | Proportion of people (%) of different ethnic backgrounds at various stages of the criminal justice system compared with general population, England and Wales[6]

	White	Black	Asian	Mixed	Chinese or other	Unknown	Total No
Population aged ≥10 years, 2009	88.6	2.7	5.6	1.4	1.6	-	48 417 349
Stop and searches 2009-10	67.2	14.6	9.6	3.0	1.2	4.4	1 141 839
Arrests 2009-10	79.6	8.0	5.6	2.9	1.5	2.4	1 386 030
Cautions 2010*	83.1	7.1	5.2	—	1.8	2.8	230 109
Court order supervisions 2010	81.8	6.0	4.9	2.8	1.3	3.2	161 687
Prison population (including foreign nationals) 2010	72.0	13.7	7.1	3.5	1.4	2.2	85 002

*Data based on ethnic appearance and therefore do not include mixed category.

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release care is variable, and continuity of care can be poor.[41] Half of prisoners have no general practitioner when they are released.[41]

Former prisoners do not necessarily prioritise their health on release, instead focusing on basic needs such as accommodation .[38] In a 2003 survey in England and Wales only two thirds of adult prisoners said they had accommodation arranged for their release.[42] Broader determinants of health such as poor prospects for employment and lack of social support are also problems.[38]

The quality of planning for post release care is variable, and continuity of care can be poor. Half of prisoners have no GP when they are released

Is this the only way?

Prison clearly has a part to play in meeting the health needs of a marginalised group of people. However, it is ultimately not the best place to tackle poor health. Some newspapers delight in caricaturing prisons as "holiday camps,"[43] but even if prisons shared some of their characteristics, the harms of imprisonment would remain. Custody separates families, and former prisoners experience social disadvantages such as a high unemployment rate.[5] Prison's enforced passivity and conscious wasting of life also cause acute distress.[44]

The average yearly cost of a prison place in England and Wales is £39 573.[45] In 2012 UK total prison spend was £4.1bn.[46] Despite this expense, prison does little to deter offending and almost half of those sentenced to custody are reconvicted within a year.[5] It is important to ask whether the resources allocated to imprisonment could be spent more wisely, whether custody is the best way of dealing with people who offend, and how prison numbers can be kept to a minimum.

People who commit crimes often come into contact with health and social services because of their problematic behaviour. Management revolves around sanctions such as custody[47] rather than earlier assistance in the community that might prevent a prison sentence. Innovative thinking is required to allow resources currently allocated to prisons to be deployed more constructively and at all stages of the lives of people at risk of future imprisonment. Many of Britain's most vulnerable citizens now pass at some point through the criminal justice system.[48] People in the community with multiple needs and exclusions have not been a government priority, and there is no overarching strategy to tackle their health and social needs [48] with the explicit aim of avoiding custody.

Although recorded crime is falling,[49] the number of British prisoners continues to climb. Arguably, many of them should not be there. This is because of the relative harmlessness of their offences, the vulnerability of the offenders, and the harmful consequences of imprisonment. This is not to say that people who break the law should not be punished, but that prison and punishment should not be synonymous. Alternatives to prison may offer better outcomes and save money. One economic analysis found that community sentences save £3437 to £88 469 per sentenced offender, rising to as much as £200 000 if longer term changes to offending patterns are also considered. Community based drug treatment was found to be particularly effective at saving costs as offenders receiving treatment were 43% less likely to re-offend after release.[50] Court ordered community sentences are reported to be 8% more effective at reducing reoffending rates than custodial sentences.[5]

Continued and increasing reliance on imprisonment is a moral and political choice, a path that politicians choose and society implicitly condones. During 1997-2009 the British government introduced 1036 new offences punishable by imprisonment[51] and the prison population in England and Wales has almost doubled since the early 1990s.[1] Electorally, no major political party seems able to abandon a populist stance of being "tough on crime." Yet everyone is affected by the increasing human and economic costs of an ever more punitive criminal justice system.[52]

Stephen Ginn Roger Robinson editorial registrar, BMJ, London WC1H 9JR, UK
mail@stephenginn.com

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BMJ BLOG **Peter Bailey**

Galley slaves, rebel!

Jeremy Hunt's speech to the King's Fund on 23 May made me wonder if someone in the Department of Health had had an "Oh my God!" moment. His speech seemed to suggest a dawning understanding that those working in the front line of medicine in general practice, the out of hours service, and emergency departments are the good guys, not the enemy. Slagging them off, starving them of funds, setting impossible targets, and beating them about the head with lurid stories of failure has not, after all, improved the NHS. The effect has instead been an erosion of morale, a steady increase in morbid cynicism, and a haemorrhage of talent away from the beleaguered work places. Small wonder that emergency medicine vacancies cannot be filled and 50% of trainees leave the speciality. Who is surprised that general practitioners over 50 are eyeing up the prospects for early retirement?

So, with this dreadful awakening to reality, what is Jeremy Hunt actually saying? Is he proposing a significant increase in the workforce in primary care and emergency medicine? Is he calling for longer appointments in general practice?

No. Once again, the Department of Health is asking for the impossible. Hunt said that "Every patient is the only patient." Is the man mad? It is no longer possible to practice good medicine in 10 minute slots. The "quick" patients are now seen by nurses, making the case complexity of the people who consult the doctors much greater.

He says that there has been a betrayal of general practice ideals. The effrontery of this is breathtaking. Is he trying to make *us* feel guilty? Who exactly has committed this betrayal? Who forced general practitioners to give up in-house out of hours care by imposing regulations that made it impossible for individuals to meet targets designed for corporate care providers? Who was it who said that front line staff are "coasting." Who erodes practice income year on year while imposing ever more onerous targets, slicing chunks off resources and expecting us to run faster to stay in the same place? We already feel like galley slaves chained to the rowing bench, out in all weathers, unable to attend to bodily functions, whipped by the slave master, and working endlessly to the beat of a merciless target drum.

So here is my advice to Mr Hunt: fund the front line. Give us your support to give patients more time. What we really want to do, Mr Hunt, is to listen to the dying, the sick, and the frightened and meet their needs. And we want to be left alone to get on with it.

Peter Bailey is a freelance general practitioner, Cambridge.

https://www.gov.uk/government/speeches/primary-care-and-the-modern-family-doctor