

Improving the health and social outcomes of people recently released from prisons in the UK

A perspective from primary care

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The opinions and views expressed in this paper are those of the author.

Supported by a grant from

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Executive Summary

The following summarises the key findings and learning points from the research review:

- This paper has been commissioned in order to support the Sainsbury Centre for Mental Health in better understanding the health and social care and the physical and mental health needs of offenders upon release from prison.
- In addition the following questions were addressed; what development work is currently being undertaken or being planned in this area, what are the national policy drivers covering wider health care which may significantly relate to and affect prisoners, how are they enabled to access primary care services and what organisational issues affect this access? And what are the gaps which require research, training or service development?
- This review of the current primary care research about prisoner and offender health, shows that more is required, particularly looking at what works, in reducing mortality, morbidity and health related re-offending behaviour in the post release period.
- This work observes that prisoners are marginalised in society and tend to fall easily between care systems and structures as they attempt to have their multiplicity of 'never serious enough' needs met. Care should be taken to overcome this tendency.
- The provision of health care in prisons and for offenders upon release faces many uniquely difficult challenges e.g. high consulting rates, prisoner reliability as historians, poor prisoner concordance with treatment planning, prisoner personal health neglect and health damaging behaviours, poor clinical information and support systems, staff shortages, poor planning of service integration. This must therefore be considered when designing services.
- This paper shows that despite the relative lack of evidence much good work, appropriately designed and planned to deliver the objectives of improving offender health, can be effective in each unique prison and community setting. There is a move to multi-disciplinary and multi-agency models of care and such new modes of delivery require further evaluation.
- Imprisonment, the evidence repeatedly confirms, can be good for physical health and improving health intervention opportunities but is usually not good for mental health. The post release period is extremely dangerous in physical and mental health terms and for recidivism. Prisons, delivering good health and social care, can be seen as another, 'community based healthcare station'.
- Imprisonment rates are increasing especially amongst women and the elderly and alternatives, whenever possible, should be used to avoid the deleterious health effects of incarceration.
- Health and social care services need to be designed to be acceptable to and accepting of young people. Women and young prisoners have special needs. Other sections of the population, e.g. older men, should also be considered and their special needs identified.

- Researchers state that it is imperative that screenings for infectious diseases be conducted in prisons and/or treatment administered before detainees are released back into the general population.
- A number of studies have shown that for the clinical management of prisoner health problems, unless proven otherwise, the assumption should be that a normal approach will achieve normal outcomes. There is also no evidence that imprisonment per se prevents the successful application of any particular healthcare interventions however technological.
- The quality of post release planning is reported as variable and to be effective must be strengthened, particularly for prisoners with mental health problems who will require assertive outreach, and should become a key quality indicator to be performance managed.
- There are negative implications from the cumulative effects of engagement with the criminal justice system, and the process through which persons with mental illness and a criminal history, cycle through institutions. The multiple and diverse aetiologies driving behavioural disturbance in mentally ill offenders need to be better understood for individuals at sentencing and for populations in respect of service planning.
- There is an important role to be developed for therapeutic communities and group support methodologies as aids to personal future planning for prisoners.
- Investment in, monitoring, reporting and evaluation of, prison-based and community interventions is needed to help reduce substantially drugs-related, suicides and all cause deaths in recently released offenders.
- Services which aim to meet the needs of substance misusing prisoners will, because of the high prevalence of dual diagnosis, have to be effectively delivered in partnership with mental health providers.
- Integrated Inclusive Care Programme approaches work, but must be focussed, provide continuity from within the prison into the community, be multi-disciplinary and multi agency, well resourced and well integrated with mainstream services.
- Reduction in structured support and reduced autonomy both contribute to the risk of poor management of chronic conditions, or adherence to recovery programmes for more acute conditions, following release from prison.
- The key challenge for prison healthcare is to enable continuity of care, within, between, on admission and upon release. Using the prisoner journey from pre-arrest to post release as a template it will be possible for local health and social care, and criminal justice communities to better plan continuity of health and social care, alternatives to imprisonment and long term support services.
- Maintaining therapeutic relationships initiated with in the prison, into the post- release period are likely to reduce recidivism and improve health outcomes. Because it can be shown that prisons can be a place of relative safety and health promotion for some

prisoners, we should endeavour to make them more so for all.

- The direction of national strategy on prisoner and offender health is aligned with the evidence provided in this paper. Prisoner and offender health is to be provided by services commissioned by the NHS, and developed under guidance from regionalised development centres, with an aim to deliver better continuity and through care with improved integration between health, social care and criminal justice services. In taking forward this important agenda it will be necessary to ensure effectiveness and develop the evidence base.

Dr. Mark Williamson

I. Aims

The scope of this paper addresses the following questions:

- What is known about the health and social welfare and the physical and mental health needs of prisoners who have just been released from prison in the UK?
- What development work is currently being undertaken or being planned in this area?
- What are the national policy drivers covering wider health care which may significantly relate to and affect prisoners?
- How are they enabled to access primary care services and what organisational issues affect this access?
- What are the gaps which require research, training or service development?

Prisoner health and the health of released prisoners, covering physical health, mental health and primary care and social care issues is a relatively poorly researched field in the UK and worldwide. A recent Medline search using the key words – family practice, chronic disease, public health, primary health care, health promotion cross referenced with – prison, resulted in < 40 papers (personal communication). It is therefore important that we use knowledge and information from as wide a scope as possible both geographically and in terms of related population cohorts to try to learn about the key issues affecting prisoner health during incarceration and after release.

The purpose in writing this paper is to understand how released prisoners may be helped to better access primary care so that their numerous health problems can be addressed. It is limited to learning from predominantly westernised societies' experiences and will ensure that issues which are not transferable to the UK, such as those related to privatised medical systems, are identified accordingly. The paper attempts to consider issues in the sphere of primary care, notwithstanding the relative paucity of specific research. These include the management of chronic disease, substance misuse, communicable disease, mental health, and any other healthcare issues which most frequently impact on prisoner health. The paper also tries to avoid being too detailed on particular specialist areas such as secondary care mental health and public health and about other specific issues of detail such as the wealth of work focussing on substance misuse management in prisons, suicide prevention or TB in prisons. To do so would risk losing the primary care and service development focus which lays behind the purpose of the paper.

Wherever possible the focus is on the released prisoner but it has to be accepted that much of our knowledge comes from extrapolating what is known about the incarcerated to the freed.

2. Introduction

In the UK the prison population is increasing and the health problems of prisoners are being increasingly identified as important areas for research and service development. The NHS has recently become responsible for the commissioning of health care for prisoners, taking over this role from the prison service. This significant change, which now more closely aligns the UK with arrangements in the rest of Europe, followed the work of Reed et al¹ reporting the work of Her Majesty's Chief Inspectorate of Prison Team which identified significant variability in the quality of healthcare provided for prisoners in UK prisons. There then followed the publication in March 1999 of "The Future Organisation of Prison Healthcare"² which outlined the agreement between the Prison Service and the NHS on a formal partnership to secure better healthcare for prisoners. This important document spelled out a vision for healthcare in prisons:

"Healthcare in prisons should promote the health of prisoners: identify prisoners with health problems; assess their needs and deliver treatment or refer to other specialist services as appropriate. It should also *continue any care started in the community contributing to a seamless service and facilitating throughcare on release*. The majority of health care in prisons is therefore of a primary care nature. However, health care delivery in prisons faces a significant number of challenges not experienced by primary care in the wider community."

This paragraph nicely explains the need for continuity of care and the challenges of delivering an effective healthcare solution for prisoners within prison and on release. It states unequivocally the central role of primary care in providing the framework by which the solutions to the various issues can be addressed.

One of the unspoken realities of prison health is how issues or clinical problem areas overlap significantly, e.g. mental health and substance misuse; substance misuse and communicable disease; primary care, sexual health and public health; social exclusion with all. It is true in the experience of the author that the co-representation of these issues contributes in the marginalised of society to a tendency in care providers to allow them, including prisoners and the ex-prisoners, to fall between the stools of the care providing structures and systems. It must equally be credible that this reality will contribute to the recidivism and ill health of prisoners after release.

Prisons are designed for punishment, correction and rehabilitation to the community, these goals and the associated prison regimen, may conflict with the aims of health care. A literature review³ showed that the main issues in prison health care are mental health, substance abuse and communicable diseases. The team identified that women prisoners and older prisoners have needs which are distinct from other prisoners and that health promotion and improving the health of the community outside prisons are desirable aims of prison health care. They also found that the delivery of effective health care to prisoners is dependent upon a partnership between health and prison services and creative methodologies such as telemedicine may be usefully deployed.

Throughout the searching to provide the evidence for this paper it became clear that many of the research papers were simply describing the epidemiology and health care needs in the prison setting. Others were descriptions of one off service approaches which had been shown to be effective in a particular cultural or organisational setting. Very few indeed

focussed on the post release period and considered which interventions might be effective.

It is clear to all who work in prison health that every prison has a unique culture, does the same thing uniquely differently to others, and has a unique and small subset of the population. These realities confound research findings being easily generalisable. The reverse perspective on the two way street of this reality is that despite a relative lack of evidence much good work can be effective in each unique setting. Positive results have been shown from a variety of healthcare projects and approaches based as they are on reasoned logical planning and some evidence, even if it has had to be extrapolated from different settings, patient cohorts or prison systems. Hence the very difficulty inherent in trying to generalise should in fact encourage every prison health team to adopt and express a culture of creative solution building for each of the uniquely difficult healthcare problems of the environment.

The post release period can learn from prison based work and community based research but again the encouragement to be creative should apply.

3. What is known about the health and social welfare and the physical and mental health needs of prisoners who have just been released from prison in the UK?

General characteristics

The prisoner population has many important characteristics. Because of the small percentage of prisoners serving life sentences, it can be assumed that the recently released prisoner population predominantly retains these characteristics. There are 136 Prisons in the UK (126 public, 10 private) housing approximately 75 thousand prisoners (in 1992 the figure was 42 thousand) and the population is slowly rising. 5% are female and there are a small number of child prisoners, approximately 100 girls & 3 thousand boys. There are about 135 thousand prisoners incarcerated per year, (and logically) a slightly smaller number released, and about 50% serve less than 6 months. These figures mean that there are nearly a million relatives affected by imprisonment annually.

England and Wales has the highest imprisonment rate in Western Europe, though some others are notably increasing their use of this sentence, e.g. Netherlands.

The increasing use of the imprisonment sanction implies a successful approach but in fact it is relatively unsuccessful with an 80% recidivism rate within 2 years of release. The ex-prisoner population and their families are a significant part of the socially excluded population and they share similar issues of health, health care needs and difficulties in respect of accessing health and social care services.

Prisoners have the following social exclusion characteristics (DH figures):

- Have been in local authority care 13 x (more likely than the non-prisoner population)
- 60 % are unemployed 13 x
- Played regular truant 10 x
- Suffered school exclusion 20 x
- Have a family member convicted 2.5 x
- 42% of released prisoners have no fixed abode
- 50% on release have no GP
- 50% re-offend within 2yrs
- 50% of prisoners have reading skills < 11 year olds
- 1/3 of offenders debt problems worsen in custody
- 125,000 children have a family member in prison

Of crime (National Offender Management Service figures):

- 70% is drug related
- 40% are alcohol related
- 55% is linked to thinking and behaviour problems
- 50% in the UK is committed by 100,000 offenders
- it is thought a 50% reduction is possible
- the cost of crime by re-offenders is approx. £11 billion per annum
- each prisoner costs the criminal justice system £65k per annum
- each prisoner costs £38k to incarcerate per year

The research evidence has hitherto tended to have a relatively short term focus after prisoner release and the post release period has tended to refer to the first year or 18 months. Very little relates to the long term post release and any work has tended to relate to military prisoners.

On admission to UK prisons 40% of people deny contact with a GP (DH figures). The reliability of offenders as historians must be considered because, as is stated in many studies, they will tend to deceive, or respond in the way they think researchers want them to, when it is perceived to be in their interests to do so. In Canada a recently reported⁴ issue is that imprisoned women are able, and see benefit to themselves, in using multiple identities and aliases. There is no published evidence of this in the UK.

Post release issues

The fact that the post release period is a key area for study and for action in terms of service development and improved coordination of care is well illustrated by the findings of Verger et al⁵ in France, reported in 2003. They noted that while the poor health status of prisoners has been highlighted in Western countries, the surveillance of their mortality has been neglected. They studied the mortality of 1305 prisoners released during 1997 from a French prison. Vital status after release was obtained for 86.4% of them. Compared with the general population, ex-prisoners non-natural mortality rates were significantly increased both in the 15-34 and 35-54 age categories (3.5-fold and 10.6-fold respectively) and the risk of death due to overdose was 124 and 274 times higher in the same categories respectively. Their key finding and opinion was that prevention and care should be reinforced in the pre-release period without waiting more epidemiological data.

This finding contrasts ironically, but is also partly explained, with Clavel et al⁶ who confirmed the benefits of incarceration in prison in relation to mortality. The mortality among a population of male prisoners between 1977 and 1983 was compared with that among the general French population. The overall mortality rate (for all deaths except external causes) was lower among prisoners (SMR = 84; p less than 0.05). Moreover, the risk of dying from all causes, as well as from malignant neoplasms, diseases of the circulatory system, and suicides fell significantly with increasing duration of imprisonment. These findings suggest that the lifestyle specific to imprisonment might overcome the prejudicial effect of risk factors such as alcohol, tobacco, or drug abuse that tend to be common among prisoners after release.

The key message, again confirming the purpose of this paper is that, surprisingly and no doubt setting dependent, to some extent prisons can be a place of relative health and safety for the prisoner population and that therefore prisoners may benefit in healthcare terms from imprisonment and that they are correspondingly extremely vulnerable on release.

In the UK there is a newly established prison health research network which has primary care and public health, mental health and substance misuse subgroups. These are developing planning for research programmes to try and improve our understanding of these issues and to ensure that system wide learning occurs and is implemented.

There are a wide range of NHS initiatives, to be discussed later, which will have an affect on the health and social care of this population in the community after release, and which are

coincidental with the current transfer of responsibility to the NHS from prisons of commissioning the health services in prisons in the UK.

Primary and community care issues

In the UK we can consider primary care to be that care provided by general practices and their health care teams, and the care provided by dentists, pharmacists and opticians. Community care extends this scope to that care provided by community nurses and doctors and social workers. Very little research has been done which looks at how released prisoners have their primary and community and social care and health needs assessed and provided for.

Consulting rates

In 1984 Martin⁷ compared the medical care of prisoners "declaring sick" to the medical officer and hospital officers in Bedford Prison with the medical care given to the medical officer's patients in general practice. The consultation rate of prisoners was higher than that of patients in the practice. It was considered that part of this increase was because household remedies were not available to prisoners except through the prison medical service and part may also have been due to the stresses of life in prison. Few psychoactive drugs were prescribed in prison, primarily to avoid the development of trading in such drugs and the bullying of patients. The problems that prisoners presented reflected the problems of violence and poor hygiene in prison. It was also considered that some problems that more commonly present in prison than in community based general practice may be related to stress of the circumstances of prisoners and of their environment.

Further findings from Martin et al⁸ showed that these issues persist beyond release, but that willingness of prisoners to access primary care in the community was low. The group of men studied had a high level of illness, neglected their health, and had a high alcohol intake. Fewer problems were found than in a survey in New York City. Many prisoners with active medical problems on discharge from prison were unwilling to take a letter to their own general practitioner.

In 1981 a review⁹ of the utilisation of healthcare showed that the annualized visit rate for men was 48 per prisoner per year, 2.6 times the rate for men studied in a long-term prison and almost 20 times the rate for men studied in the general population. The annualized rate for female prisoners was three times that of male prisoners. For all prisoners, the most common problems seen were skin conditions (9.7 percent), musculoskeletal (8.3 percent), and psychiatric (8.2 percent). An examination of practitioners' patterns in providing care demonstrated the primary role of registered nurses, who saw 70 percent of the patients.

Offender health seeking behaviour in UK prisons is many times that of the non prisoner population. This high demand has seen the development of wing based nurse triage schemes in a number of UK prisons (e.g. HMP Belmarsh) which have been shown to effectively manage demand for doctor appointments.

Models of service

A paper from Florida¹⁰ raises the question of the appropriateness of a purely medical model

of delivering primary care in the prison setting. 528 problems were identified in 333 inmates seen on sick call. The large number of psychosocial problems (194 out of 528) and the wide diversity of problems (125 in 333 inmates) were documented. The importance of considering alternative models of service delivery and the importance of health education were identified. Subsequent experience in the UK¹¹ has confirmed the effectiveness of expanding the roles of members of primary health care teams, e.g. pharmacists and dentists, and of using the skills, leadership and competencies of nurses more appropriately.

An important recent paper from South Carolina¹² nicely explains the benefits of both a supportive nurse patient relationship in the prison but also the key role of extending the partnership in to the community after release. The paper also takes the step of declaring significant benefits on criminal behaviours particularly those affecting health. They conclude that 'nursing is uniquely positioned to develop prevention, intervention, and treatment strategies for individuals involved in criminal activities before, during, and after incarceration.' This bridging model of services for the prisoner into the community is a theme which appears relatively frequently in the few programmes of care focussed on the post release period.

Wildbore¹³ in Manchester has demonstrated that community sentenced young offenders can benefit from nurse led health promotion. Forty years ago an increase in 'juvenile delinquency' led to a large prison-building programme for young offenders. Today, the emphasis is on community sentencing and a reduction in prison places. The secondment of nurses into youth offending teams makes it possible to offer primary health services to a group of mainly male, vulnerable people. The ability of health and social care services to provide such input before young people offend is challenging in view of the hard to reach nature of this sector of the population. The implication is that services need to be designed to be acceptable to and accepting of these young people.

Chronic diseases

Primary care is the main delivery model for care of the elderly and for providing chronic disease management. A paper by Fazel et al¹⁴ looked at the health of men aged 60 and over in English and Welsh prisons. 203 men were interviewed from 15 prisons, comprising one-fifth of all sentenced men in this age group in England and Wales. Assessment included semi-structured interviews covering chronic and acute health problems, and recording of major illnesses from the medical notes and prison reception health screen. 85% of the elderly prisoners had one or more major illnesses reported in their medical records, and 83% reported at least one chronic illness on interview. The most common illnesses were psychiatric, cardiovascular, musculoskeletal and respiratory. The group concluded that the rates of illness in elderly prisoners are higher than those reported in other studies of younger prisoners and surveys of the general population of a similar age. The increasing number of elderly people in prison poses specific health challenges for prison health-care services and for post release health care planning.

A paper in the US had similar findings. Colsher et al¹⁵ in 1992 describe the results of a health survey of 119 male inmates 50 years of age and older residing in Iowa state correctional facilities. The prisoners' disease histories included hypertension (40%), myocardial infarction (19%), and emphysema (18%). Most participants (97%) had missing teeth, 42% had gross physical functional impairments, and 70% smoked cigarettes. The importance of performing medical reviews with elderly male and female prisoner patients is reported from the Fazel et

al¹⁶ in Oxford

The structured regimen in the prison setting does lend itself to the delivery of the structured care required for many long term conditions. Diabetes, an archetypal chronic disease in the primary care sphere, has been shown by Braatvedt et al¹⁷ to be able to be well managed to a normal level of quality, in the prison setting despite the difficulties posed by prisoners, particularly in relation it seems to this condition, and their occasionally distracting and manipulative behaviours. The following description by McFarlane¹⁸ of the problems and solutions for this chronic condition can be usefully seen as a paradigm by which to address determinedly the approaches required for other chronic conditions.

“The Prison Health Care Service works under great pressure and difficulties and doctors have to deal with a large and ever-changing population, often with mental and physical disorders, who are frequently manipulative. This article highlights problems encountered in delivering diabetes care in prisons. Prisoners may self-induce diabetic ketoacidosis by refusing insulin injections, in order to be transferred to an outside hospital. On the other hand, prison staff may mis-interpret the symptoms of poorly controlled diabetes as 'acting up' by prisoners and inappropriate treatment can be given. If structured diabetes care is provided in prison, however, with close liaison between the Prison Staff and the local Diabetes Care Team, the basics of modern diabetes management can be provided. Good diabetic metabolic control can be achieved in the majority of patients, probably due to the rigid dietary regime, no alcohol and compliance with treatment. Imprisonment can ensure screening for diabetic complications and reassessment of treatment regimens. The British Diabetic Association guidelines for the provision of diabetes care in British prisons are outlined in this article.”

This approach combined with effective bridging of care following release, will be required to effectively manage many of the long term conditions suffered by the UK's increasingly older prison population, upon release. There is no published research on diabetes care for the recently released prisoner. Interestingly Petit et al¹⁹ show, as might be predicted, that unable to perform self testing and self injecting, diabetic patients tend to lose their autonomy in respect of self managing the disease. Again, a probable transferable learning point for other long term conditions, in relation to the post release period.

Sankaranarayanan et al²⁰ showed that ambulatory peritoneal dialysis, a relatively challenging self care for chronic renal disease, can be effectively achieved in the prison setting. As might be expected. This and any other technological healthcare intervention should not be withheld because of the fear of difficulties which may arise in prisons. The assumption should be that a normal approach will achieve normal outcomes. There were no studies found where this principle was disproved.

Many diseases or treatment regimens require compliance with treatment. Seals et al²¹ show the benefits of pharmacy support, leaflets and compliance aide personnel in achieving better compliance. The benefits to be sustained, as they must be the case for chronic diseases, have to address the issue of reduced autonomy for self care, and balance this issue with the provision of bridging continuity of support on release in to the community.

The importance of effective health information systems and electronic clinical records in support of continuity of care in general and chronic diseases in particular, especially given the challenges of prisoner movements, within, between and on release from and admission

to prisons, is self evident but supported by at least one research paper. Anaraki et al²² found that prison healthcare staff in the South east Region record almost all clinical data on paper and do not have access to electronic clinical records nor to the internet. The main perceived barriers to implementing health information technology in prisons were concerns about potential breaches of security and discipline in prisons, anxiety about data security and a culture that gives low priority to health in prisons. They concluded that to provide 'equivalence of care' for prisoners, primary care trusts need to implement full electronic clinical records in prisons and ensure staff have access to resources on the internet.

Health issues for women prisoners

The number of women imprisoned in the United Kingdom is rising rapidly, but there is little research on their health and well-being. There are a number of papers²³⁻²⁹ from the United States identifying the need to better plan and provide for women prisoners. African American women are overrepresented in prisons and access to care was male biased. Women in the US who have been incarcerated are a high-risk group for criminal recidivism, and criminal justice statistics indicate that females are increasing in numbers more rapidly than the male detainee population. According to data from US epidemiologic studies, incarcerated women are often young, single, mothers from ethnic minority backgrounds who have little education and poor work histories. Mental illness, drug abuse, and risky behaviours relating to contracting HIV/AIDS are common problems among female detainees. Significant post release information is not available. Gynaecological diseases, and exacerbation of chronic health problems, particularly hypertension, diabetes and epilepsy, are also noted to be important issues. The US prison health care system is also being faced with management of an increasing number of pregnant and postpartum inmates. Health care needs of this group were identified as basic health care, teaching, counselling and supportive care. US researchers concluded that these were services that can be appropriately provided by nurse practitioners and other health care providers.

A study from Oxford³⁰ used measures of subjective health status to gain a picture of the health of imprisoned women. This self-completed questionnaire study aimed to explore the usefulness of the Short Form 36 (SF-36) in a general female prison population. The scores of imprisoned women for all but 3 of the 8 dimensions were significantly lower than those for women in the social class with the worst health in the United Kingdom, confirming the very poor mental and physical health of this population.

An interesting paper from Boston³¹ looked at how women were sometimes able to adapt positively to incarceration. Described as one of the "pains of imprisonment," separation was identified as particularly difficult for women in prison because most functioned in multiple relational roles, including mother, wife, girlfriend, daughter, sister, and friend, before incarceration. In the absence of consistent contact with family, friends, and other loved ones outside prison, incarcerated women may seek to develop connections with other inmates as a way to adapt to life in prison. Positive adaptation may allow incarcerated women to take advantage of educational/ vocational, parenting, and drug treatment programs offered in prison, thus facilitating their adaptation after release. That these findings may support a positive approach to release is interesting. It is also probable that these findings are not gender specific.

There is contention in regard to the concept of prison as an opportunity to improve health of prisoners, since imprisonment is so overwhelmingly punitive and damaging to individuals.

Plugge et al³² have demonstrated that women incarcerated for longer periods are more effectively screened for cervical cancer. It is self evident that longer spells of imprisonment will, in well run healthcare regimens, afford opportunity for health interventions.

Rogers et al³³ make the explicit call to consider correctional facilities as alternative health stations to improve community health. They afford “health professionals an opportunity to serve a segment of society that may not otherwise come into contact with the health care system.” The article illustrates why it is imperative that screenings for infectious diseases be conducted in correctional facilities and/or treatment administered before detainees are released back into the general population.

Imprisoned women are at higher risk of cervical cancer, and are less likely to have been screened than the general population. As Elwood and colleagues³⁴ have shown a purely nurse lead approach to addressing this need requires further evaluation.

Health issues in young prisoners

Young people are identified as having specific health issues, related to particular early life experiences. Brown³⁵ declared that from a health care point-of-view, the most needy adolescents in the United States are those who become incarcerated in the juvenile justice system. These youngsters have poor health care before incarceration. Their health problems range from the results of trauma to the consequences of sexual activity and severe psychological problems. Brown identified the health needs as:

- (1) prevention of health problems which contribute to behaviours for which youths are incarcerated;
- (2) comprehensive assessment and care;
- (3) continuity of care after discharge from the institutions;
- (4) comprehensive health education and health promotion;
- (5) professional, competent health care providers;
- (6) educated, sympathetic administrators and supervisory personnel;
- (7) adequate financing of health services. The conclusion being that concerned health providers must become advocates for these adolescents and for their health care in correctional and political settings.

This is an important list to consider when constructing the solutions required for meeting the health needs of released prisoners.

These findings and concerns are mirrored in the Australian experience with similar calls to better guide service development strategies using research and evolved expertise about the issue. As in the US, in Australia there is an overrepresentation in prisons of the black minority population. Fasher et al³⁶ found that of the 97 males and three females (mean age = 15.9 years), they studied, 30 were Aboriginal and 39 did not live with either parent at the time of admission. Respiratory illness, such as bronchitis and asthma were common. These diagnoses were overshadowed by histories of significant physical injury. The sample was at high risk of sexually transmitted disease. Forty-six per cent had prior contact with a mental health professional, 26% reported they had thought of suicide and 9% reported having attempted suicide. There was a high prevalence of substance abuse. They concluded that “the health of these young Australians was at risk from every perspective. Improving the quality of their health assessments was therefore an important issue for the clinicians who

attended them as individuals and for policy makers who aimed to reduce the considerable social and economic cost of juvenile crime. The discussion of these results from one centre revealed opportunities to make such improvements.”

These and other studies confirm the need to address the health needs of juveniles on discharge from prisons. Given their hard to reach status in primary care the proactive development of services tailored to meet such needs is indicated. Such services are unlikely to develop in an unplanned way in the increasingly market driven style of development of westernised health systems.

Mental Health

According to Department of Health figures³⁷ 90% of prisoners have a mental health or substance misuse problem or both. 7% suffer from severe & enduring mental health problems with approximately 1,000 p.a. transferred to secure NHS mental health facilities. The delay in such transfers has been a major problem but is rapidly improving. There were 94 UK prison suicides in 2003/04.

With respect to research there is a greater range of studies related to mental health issues in relation to prison health but again relatively little relating to follow up after release. We know from Reed et al³⁸ that the quality of services for mentally ill prisoners fell far below the standards in the NHS in 2000. Patients' lives were unacceptably restricted and therapy limited. They called for policy review and subsequently improvements in Care Programme Approach, mental health care in reach and improved transfer in to NHS secure hospitals has resulted.

Post release mental health issues

In 1998 Bisson et al³⁹ looked at the psychological health of British servicemen and their families who had been held prisoner in Kuwait following the invasion in August 1990. Their study investigated the mental health status of this group of individuals at 6 and 18 months after the final hostage was released. The Impact of Event Scale scores changed little over time whereas the General Health Questionnaire scores reduced significantly ($p = .001$) over the 12-month period suggesting that despite ongoing intrusive and avoidance phenomena levels of psychological distress did reduce. Those variables most strongly associated with a poor psychological outcome were witnessing physical violence and perceived deterioration in physical and mental health. Poor outcome at 6 months was strongly correlated with poor outcome at 18 months.

These findings might help to predict the group of released prisoners from UK prisons who may suffer most psychological harm and require proactive help. Clearly though the serviceman group and their experience are probably relatively unique.

Planning for the post release period for mentally ill prisoners is believed to be important and is self evidently something which should occur. Wolfe et al⁴⁰ found however that the quality of planning was variable, often absent and dependent on the presence of well functioning mental health units in the prison to be effective. In New Jersey there was an absence of release planning for most chronic conditions.

The cycling phenomenon

An important US study by McCoy et al⁴¹ from Chicago, shows the importance of assertive outreach for prisoners with mental health problems who are released. They knew that people with mental illnesses who are released from prison are at high risk of psychiatric decompensation and re-arrest. This paper describes an ACT jail linkage program for this population that won an American Psychiatric Association Gold Award (2001). Based on interviews with its first 24 participants, they illustrate how the released prisoners experience factors that contribute to recidivism and decompensation. Results suggest that it is possible to identify, engage, and retain people in treatment who struggle with many risk factors. They conclude that this program should be expanded and replicated. The learning from this highlights the risk for the mentally ill after release and the need to retain them in services.

The importance of a case based targeted support approach is highlighted by a number of other studies in the US and in Australia and NZ⁴²⁻⁴³.

The risk of the mentally ill cycling through prisons is a feature of the available research. Hartwell⁴⁴ in Boston USA, used data on 247 offenders with mental illness, to identify characteristics that distinguish those who are returned to prison or a psychiatric hospital with those who remain in the community. Socio-demographic, mental health, criminal history, and service variables were compared across a range of outcome categories with a focus on those re-institutionalized and those re-incarcerated. Those returning to institutions had somewhat different mental health service and criminal justice histories than the engaged/community group. In particular, the group that is re-incarcerated is more likely released from misdemeanour sentences, and the group being released from felony sentences is more likely to be found in a psychiatric hospital after release from correctional custody. They concluded that these findings have implications regarding the cumulative effects of engagement with the criminal justice system and the process through which persons with mental illness and a criminal history cycle through institutions.

Suicide and self harm

Suicide rates (standardised) are higher in prisoners than in the general male population by factors which range from 3.5 (Canada) to 6 (E&Wales), and in unstandardised studies by 2 (Poland) to 15 (Australia). (unpublished paper)

Roth⁴⁵ investigated parasuicide and the benefits of nursing approaches.

Parasuicide refers to the nonfatal, intentional, self-injurious behaviours, closely aligned to the UK self harm concept. These behaviours are frequently exhibited by individuals with features of a borderline personality disorder. In correctional systems, the rate of parasuicidal behaviour among incarcerated female offenders can be high and intertwined with complex behavioural and social issues. Nursing interventions in the management and treatment of parasuicidal behaviours incorporating the principles of dialectical behaviour therapy were developed and implemented at the institution. The treatment approach provided practical, effective nursing interventions including pre-treatment orientation, strategies for use with threats to self-harm and during self-harming episodes, and follow-up treatment. Again there are no studies which look at parasuicide post release and which investigate potential treatment modalities.

Mental health issues in women prisoners

A study by Gunter⁴⁶ in the US found that although women represent an increasing number of state prison inmates, they are studied less than their male counterparts. Incarcerated women have higher rates of depression than both community samples and incarcerated men. The diagnosis and treatment of depression in incarcerated women is complicated by the presence of substance abuse, psychosocial stressors, medical problems, and personality disorders. The paper showed how a primary care provider based in the community could provide an effective in reach service to fully meet the primary care mental health needs of the prisoners.

In a descriptive, correlational study Fogel⁴⁷ explored the stressful life event of incarceration for women prisoners and examined its relationship to selected health outcomes. Interviews with 55 women during their first week of incarceration and after 6 months in prison provided the data for analysis. Specific stresses of incarceration identified by the women included separation from families, worry about their children, and loss of control of their own lives. Psychological stress at time of incarceration was found to be positively related to depression and weight gain after 6 months of incarceration. Strategies to decrease the stressful nature of incarceration and improve the health status of incarcerated women are recommended by the author. Again the gender specificity of these findings is likely to be relatively minimal as male prisoners often identify similar psychological stressors, (personal observation).

Mental health issues in young prisoners

For young people the experience of bereavement seems to complicate the negative mental health effects of imprisonment. A study by Finlay et al⁴⁸ aimed to pilot a grief awareness programme as a health promotion project for young offenders with complicated grief. Seventeen young offenders in custody at HM Prison, Cardiff were opportunistically recruited, interviewed about their bereavement, and offered entry to the programme. Young offenders who reported coping poorly with bereavement were more likely to have used drugs to cope with their emotions, to have had suicidal thoughts, and reported more depression and anxiety. They were also more likely to have been bereaved in late adolescence and to have lost a first degree relative, with death being sudden, violent or by suicide. Once again it is reasonable to assume that young adult offenders, male or female might show similar findings.

Such findings highlight the need to consider such aetiologies of behaviour so as to contribute to the use of mitigation and the provision of alternatives to imprisonment in affected young people. The interventions which might be effective in the post release period appear not to have been studied so a degree of extrapolation is required. The effects of a primary care mental health approach for general patients in the community is effective in significantly reducing referrals (by up to 50%) to secondary mental health care (personal communications). In addition there is evidence from a high secure prison in the UK (personal communications) of an effective primary care mental health approach, again measured by reduced referral to secondary services, and from Brazil⁴⁹ a paper promotes the efficiency of the primary care approach reducing referrals by 36%.

Substance Misuse

Post release mortality

The key issue for the post release period which has attracted research interest is drug related death following release from prison. Bird et al⁵⁰ looking at released prisoners from the Scottish jails and young offender institutions confirmed the theoretical fatal risk to addicts of reduced tolerance following incarceration and the combination of a 'celebratory' fix. It is estimated by the Home Office that there are approximately 160 ex-prisoners who die from drug overdose in the UK, accidental or intentional, in the first week of release, per year.

Drugs-related mortality in 1996-99 was seven times higher (95% CI: 3.3-16.3) in the 2 weeks after release than at other times at liberty and 2.8 times higher than prison suicides (95% CI: 1.5-3.5) by males aged 15-35 years who had been incarcerated for 14+ days. They estimated one drugs-related death in the 2 weeks after release per 200 adult male injectors released from 14 + days' incarceration. Non-drugs-related deaths in the cohort, in the 12 weeks after release were 4.9 times (95% CI: 2.8-7.0) the 4.3 deaths expected confirming the French findings on mortality. They concluded that investment in, and evaluation of, prison-based interventions is needed to reduce substantially recently released drugs-related deaths.

Seymour et al⁵¹ also confirmed this finding and the aetiology of the problem. Harding-Pink⁵² in 1990 also confirmed the high mortality rate post release, 4x the age adjusted rate for the normal population. Likely risk factors included loss of tolerance to opiates while in prison, and psychological and social stresses following release.

Dual diagnosis is not uncommon in prison. The 1997 ONS Psychiatric Morbidity Study³⁷ identified 5 main mental health disorders. 54% of male remands, 44% male sentenced, 61% female remands and 42% of female sentenced substance misusers had 3 or more of these disorders. Services which aim to meet the needs of substance misusing prisoners will have to be effectively delivered in partnership with mental health providers.

Benzodiazepines

The use of benzodiazepines in prison as medication for insomnia has been shown to be a problem which extends in to the post release period and is associated with chronic addiction, mental illness, communicable diseases, criteria of social exclusion, and recidivism. Lekka et al⁵³ showed that the history of psychiatric hospitalization, history of illicit drug use, history of unemployment, symptoms of anxiety, and anti-HCV positivity in their prisoner cohort were independently associated with benzodiazepine use in the prison. Therefore they concluded, medical and psychiatric interventions focusing on anxiety problems, depression, drug addiction, and HCV in this group of benzodiazepine users are warranted.

A paper from Elger⁵⁴ in Switzerland advocates the need for better assessment of insomnia and less reliance on benzodiazepines. Her results confirm that insomnia is a frequent complaint among prisoner patients and that at least half of insomnia patients are substance misusers. In non-substance misuse patients, insomnia did not seem to be only a transitory problem of adaptation to incarceration, but a more chronic problem lasting more than 3 weeks, related to a higher degree of medical and psychological problems before and during incarceration.

Methadone maintenance

A study in Sheffield⁵⁵ confirms the benefits of retention in methadone maintenance programmes on criminal activity (which is the main finding of the larger national treatment outcomes study (NTORS)⁵⁶). De facto this small study is looking at many post release prisoners. A retrospective analysis was made of the criminal records of 57 patients successfully retained in methadone maintenance at two general practices in Sheffield. Their criminal conviction rates and time spent in prison per year were compared for the periods before and after the start of their methadone programme. Overall, patients retained on methadone programmes in the general practices studied had significantly fewer convictions and cautions, and spent significantly less time in prison than they had before the start of treatment.

These findings on drug related deaths and the importance of the continuity of care principle in methadone maintenance programmes are key factors supporting the establishment of effective handover of care processes and also point to the benefits of bridging services.

Communicable disease

Prevalence

Again there is sparse research evidence in the UK. A major concern about the impact of AIDS and TB in the USA has resulted in a number of important studies, in addition to a major investment in infectious diseases facilities in US prisons (New York Study Tour). In the UK most attention has been paid to blood borne viruses, Hepatitis C, B and A, (in order of research volume), and including HIV. These may be acquired sexually or through substance misuse and are diseases which will subsequently be a risk to the health of the prisoner and his/her family or other sexual or drug using contacts.

A review in Irish prisons⁵⁷ identified high drug use in prisons and tattooing as risk factors for infecting newly committed prisoners, in particular with Hepatitis C virus. High rates of using injected drugs, initiation of use of injected drugs, and sharing injecting equipment occur in Irish prisons. Injecting drug users have high rates of infection with hepatitis B and C viruses, and hepatitis C is endemic in injecting drug users and in Irish prisoners. These findings confirm the need for increased infection control and harm reduction measures in prisons. It also confirms the risks to others of needle sharing and unprotected sex with released prisoners. Though not UK based the findings are likely to be generalisable to the UK.

Health promotion programmes

A US study by Wexler et⁵⁸ al in the early 1990s did show the benefit of an educational model to protect against infection. An AIDS prevention training program for parolees recently released from prison with histories of drug injection was developed and evaluated. Key program elements included: a social learning approach to prevention which emphasized resistance skills training; a self-help orientation stressing individual responsibility; therapeutic community principles such as credible role models and community building; and job readiness training for the AIDS prevention/outreach field. A total of 394 eligible parolees (81% male, 19% female) were recruited, of whom 241 attended the program, including 164

completers. One year follow-up results showed that ARRIVE participation significantly decreased certain sexual and drug-related risk behaviours and improved parolees' community adjustment.

A further study by Seal et al⁵⁹ in 2003 has suggested the ongoing need to focus on the support of recently released prisoners particularly in relation to avoiding or passing on STDs or HIV. Ninety-seven service providers, representing 83 agencies, were interviewed about sexual and drug use HIV/STD risk behaviours and their determinants among young men who have been released from prison. Providers believed that men frequently practised sexual risk behaviour, often in conjunction with substance use. Individual determinants of risk behaviour primarily focused on "making up for lost time," being a man, degree of HIV/STD knowledge and vulnerability, desire to escape, and future orientation. Peers, partners, and family were portrayed as strong interpersonal influences on risk behaviour, both positively and negatively. The dominant contextual determinant of risk behaviour was the co-occurrence of sex and drug use. Structural determinants of reduced risk included stable housing, economic sufficiency, and positive community support for safer behaviour (e.g., drug treatment access, needle exchange). The findings highlight the need for comprehensive, transitional case management for young men as they reintegrate into the community, including HIV/STD prevention.

Vigilante et al⁶⁰ describe a very important programme. Prior to release from the Rhode Island state prison, women at the highest risk for re-incarceration and HIV infection are assigned to the Women's HIV/Prison Prevention Program (WHPPP), a discharge program designed to reduce the likelihood of re-incarceration and HIV infection. Candidates for the WHPPP must meet at least one of three criteria: intravenous drug use or crack use, commercial sex work, or a history of prison recidivism with poor educational history and poor employment prospects. While incarcerated, the program participant develops a relationship with a physician and a social worker and establishes an individualized discharge plan. After release, the same physician and social worker continue to work with the client and assist an outreach worker in implementing the discharge plan. Data were collected from questionnaires administered to 78 women enrolled in the WHPPP between 1992 and 1995. The population in this program was primarily composed of ethnic minorities (55%), 25-35 years of age (55%), unmarried (90%), had children (72%), and displayed a variety of HIV risk behaviours. The WHPPP recidivism rates were compared with those of a mostly white (65%), similarly aged (51% were between 25 and 35 years of age) historical control group of all women incarcerated in Rhode Island in 1992. The intervention group demonstrated lower recidivism rates than the historical control group at 3 months (5% versus 18.5%, $p = 0.0036$) and at 12 months (33% versus 45%, $p = 0.06$). Assuming that recidivism is a marker for high-risk behavior, participation in the WHPPP was associated with a reduction in recidivism and in the risk of HIV disease in this very high risk group of women.

Once again we see the benefits of continuity of care, case based approaches, ongoing therapeutic relationships with patients, and a programme aimed at achieving the outcomes it achieves. Who was it said – "Every organisation (or endeavour) is perfectly designed to achieve the outcomes it achieves" - ?

In an important grounded theory study in the south eastern United States Leenerts⁶¹ identified incarceration as a turning point in personal approaches to improved self care in women prisoners with HIV. That prison is seen by prisoners with health problems as an opportunity for them to address important health and lifestyle issues, such as an approach to

chronic disease or addiction, is the importance of this work. This does not imply that those responsible for sentencing policy should imprison on the basis that it might be good for the individual's health, i.e. a form of therapeutic intervention. There is a danger it might so influence.

Public health

Department of Health figures show the following public health characteristics, public health issues & opportunities:

- 38% drug users on admission to prison
- 24% injecting drug use – of which:
 - 20% Hep B (N= 3,600)
 - 30% Hep C (N= 5,400)
- high opiate & rising crack dependency
- 50k prisoners per year access drug detoxification sessions
- 80% prisoners smoke (40% general population)
- there is a growing elderly population with chronic disease.....

Literature reviews show a predominance of papers looking at the morbidity profiles of new prisoners, with no papers assessing how the health issues are continued after release or particularly focussing on the public health of the post release prisoner population. The findings of these papers utilising the captured nature of the cohort of newly admitted prisoners are very constant across the westernised world. There is a “high prevalence of chronic medical and mental health issues, limited access to health care, high rates of infections and sexually transmitted diseases, substantial substance abuse, other unhealthy behaviours and violence, and a strong desire for help with health-related problems”⁶².

TB

TB is an important disease worldwide for prisoners, and is relatively common because of the effects of close proximity in incarceration, poor nutrition, chronic poor health and HIV. Again the US leads the way in terms of seeking to develop more effective interventions. Because of the NHS, the issue of medication follow up after release is not so problematic in the UK as it is in the US. White et al⁶³ in San Francisco again demonstrated the importance of an educational approach to improving health outcomes for the released prisoner. The Tuberculosis (TB) Prevention Project was designed to improve completion of care for latent TB infection in released inmates. As part of an ongoing clinical trial to improve rates of completion, educators provided TB-focused educational sessions to 1,027 inmates. The nature of the jail itself, inmate characteristics, the characteristics of educators, and the educational sessions themselves interacted in different ways to enhance or impair the interaction. They concluded that prison is a setting in which the population is at high risk for a number of health problems and health education is increasingly important.

Health promotion

Promoting health is most likely to give long term results in the young and though efficacy is yet to be shown such approaches are being delivered to the imprisoned with the hope of improving lifestyle choices after release. The educational approach is most commonly adopted. At a recently opened unit housing over 300 young inmates, a proportion of whom cannot read and write, nursing staff at the unit have cooperated with colleagues in other

settings to produce an innovative programme designed to promote healthy lifestyles. Courses are available in areas ranging from parenting skills to sexual health. More importantly, perhaps, the unit is fostering an ethos that discourages bullying--arguably an experience which makes victims' lives so miserable that they would be unreceptive to health promotion initiatives⁶⁴.

The benefits of an educational approach in promoting the health of women prisoners were shown by Lehman⁶⁵ in Texas. One percent of the population of the United States consists of women offenders, who are at-risk for numerous preventable diseases. Since health promotion is not a high priority when women are incarcerated, the author used group education as one way of increasing participants' knowledge and self-efficacy. Results indicated that a group health education program is an excellent way to change participants' knowledge and self-efficacy in a women's prison population.

The following year another Texan group⁶⁶ looked at formerly incarcerated women and showed that improvements in health could be achieved through participation in an action research programme. This work further supports the effectiveness of women working jointly to plan future health strategies upon release.

More US work this time based in New York⁶⁷, demonstrated the effectiveness of a programme which had specific focus, specific aims, an approach of bridging support from within the prison into the community, and a multidisciplinary, multi agency approach which was well resourced. They identified that most women return to their communities within a few weeks of arrest, and few receive help for the substance abuse, health, psychological or social problems that contribute to incarceration. They describe a model programme, Health Link, designed to assist drug-using jailed women in New York City to return to their communities, reduce drug use and HIV risk behaviour, and avoid rearrest. The program operates on four levels: direct services, including case management for individual women in the jail and for 1 year after release; technical assistance, training, and financial support for community service providers that serve ex-offenders; staff support for a network of local service providers that coordinate services and advocate for resources; and policy analysis and advocacy to identify and reduce barriers to successful community reintegration of women released from jail.

The fact that these approaches are tailored for women, like many of the health promotional programmes for released prisoners, presumably because of their increased vulnerability relative to men, does not in itself deny the likelihood that such an approach also targeted at men would not be equally effective. Intuitively this important programme approach should be effective and probably represents a model for future service design.

Housing, employment, social care and leisure

There is little evidence from the UK. In a recent paper from San Francisco Kushel⁶⁸ et al describe some of the characteristics and risks associated with homelessness and the links to imprisonment. The USA imprisons approximately ten times the number pro rata of the population as in the UK with a significant non-white racial bias so again the findings may not be particularly generalisable to the UK.

Characteristics

They studied a large sample of homeless and marginally housed adults to examine whether a history of imprisonment was associated with differences in health status, drug use, and sexual behaviours among the homeless. Almost one in four of participants (23.1%) had a history of imprisonment. Models that examined lifetime substance use showed cocaine use (odds ratio [OR]=1.67; 95% confidence interval [CI]=1.04, 2.70), heroin use (OR=1.51; 95% CI=1.07, 2.12), mental illness (OR=1.41; 95% CI=1.01, 1.96), HIV infection (OR=1.69; 95% CI=1.07, 2.64), and having had more than 100 sexual partners were associated with a history of imprisonment. Models that examined recent substance use showed past-year heroin use (OR = 1.65; 95% CI = 1.14, 2.38) and methamphetamine use (OR=1.49; 95% CI=1.00, 2.21) were associated with lifetime imprisonment. Currently selling drugs also was associated with lifetime imprisonment.

They concluded that despite high levels of health risks among all homeless and marginally housed people, the levels among homeless former prisoners were even higher and that efforts to eradicate homelessness must also include the unmet needs of inmates who are released from prison. The study also confirms the relative similarities of the homeless or marginally housed population and of prisoners.

Therapeutic communities

The use of therapeutic communities to address the problems of released prisoners has been attempted in the US with positive results in particular related to better managing substance misuse. The work of Martin et al⁶⁹ shows the benefits also in relation to reduced recidivism rates.

A multistage therapeutic community (TC) treatment program was instituted in the Delaware correctional system. Components in place long enough to provide follow-up data consisted of a TC in prison and a "transitional" TC outside the prison for parolees. Baseline data at release from prison, and outcome data six months after release were analyzed for 457 respondents. A group who had participated in neither of the TCs was compared to groups who had participated in the TC in prison only, the transitional TC only, or both TCs. The latter two groups had significantly lower rates of drug relapse and criminal recidivism, even when adjusted for other risk factors. There was also a reduction for the prison TC group, although more modest and statistically significant only when adjusted for baseline differences. Outcome benefits of the TC participation were also found for behaviours affecting the risk of HIV infection. The results support the efficacy of a multistage TC program and the importance of the transitional TC as a component.

4. Key policy areas and developments

It is increasingly apparent, and the evidence and proposed developments in this paper add to the impression, that co-operative working between service users and a range of systems of care and support, health, social and criminal justice, are necessary to deliver the best outcomes. The national policy makers have accordingly been constructing a number of strategic structures and policy directions which endeavour to facilitate effective partnerships and joint working in the interests of delivering these outcomes. The following is a sketch of the NHS policy changes currently underway, the Department of Health structural and policy area arrangements which are also currently being put in place, and the new criminal justice structures and policy which have also just commenced.

NHS Policy

It is impractical to detail the full range of NHS policy or other policy areas which will impact on prisoners, they are after all for the NHS, just people at a prison address. Many of the policy issues relating to quality, such as the National Service Frameworks and National Institute for Clinical Excellence are so ingrained as to be not new to the NHS or for prisoners, but are of course critical in determining the nature of care provided. A key question, addressed by some of the evidence to the affirmative, is whether community best practice can transfer in to the prison setting. However, it may be the case that for issues such as substance misuse, mental health and communicable disease and primary care, special attention should increasingly be given to considering the special needs, in terms of health care and health care design, of offenders, and the socially excluded, in the creation of this best practice guidance.

Some of the key Department of Health and National Health Service policy areas which will contribute to the direction of a policy for prison primary care are:

The new General Medical Services (nGMS) contract

A more quality and outcomes based contract, by which general practitioners are paid to deliver primary care to patients in the community. The quality and outcomes framework will evolve overtime and may offer the opportunity of funding and incentivising GMS provision to socially excluded groups and prisons. The contract has been in place for 2 years and has certainly enhanced the delivery of chronic disease management in primary care. A similar outcomes focussed approach has been developed and is being presented to dentists and pharmacists to broaden the range of services they provide. The recently released offender will have choice to access primary care from a range of providers who will have subtly different priorities and approaches. To make appropriate choices to support a long term relationship with a practice will require appropriate information which should be provided to prisons and be used to forward plan.

The new strategic direction for the NHS, “Creating a patient led NHS”

The new rearrangements of the NHS have the main features of larger PCTs and SHAs, less health care services provision by PCTs, a freeing up of the market and inclusion of the private sector in health care provision, and the greater involvement of clinicians in commissioning through practice and locality based commissioning. The main concern is that

the organisations mentioned might inadvertently take their eyes off the offender health ball during the period of transition.

The new White Paper for non hospital health care, “Your health, Your care, Your say” due for launch in early 2006

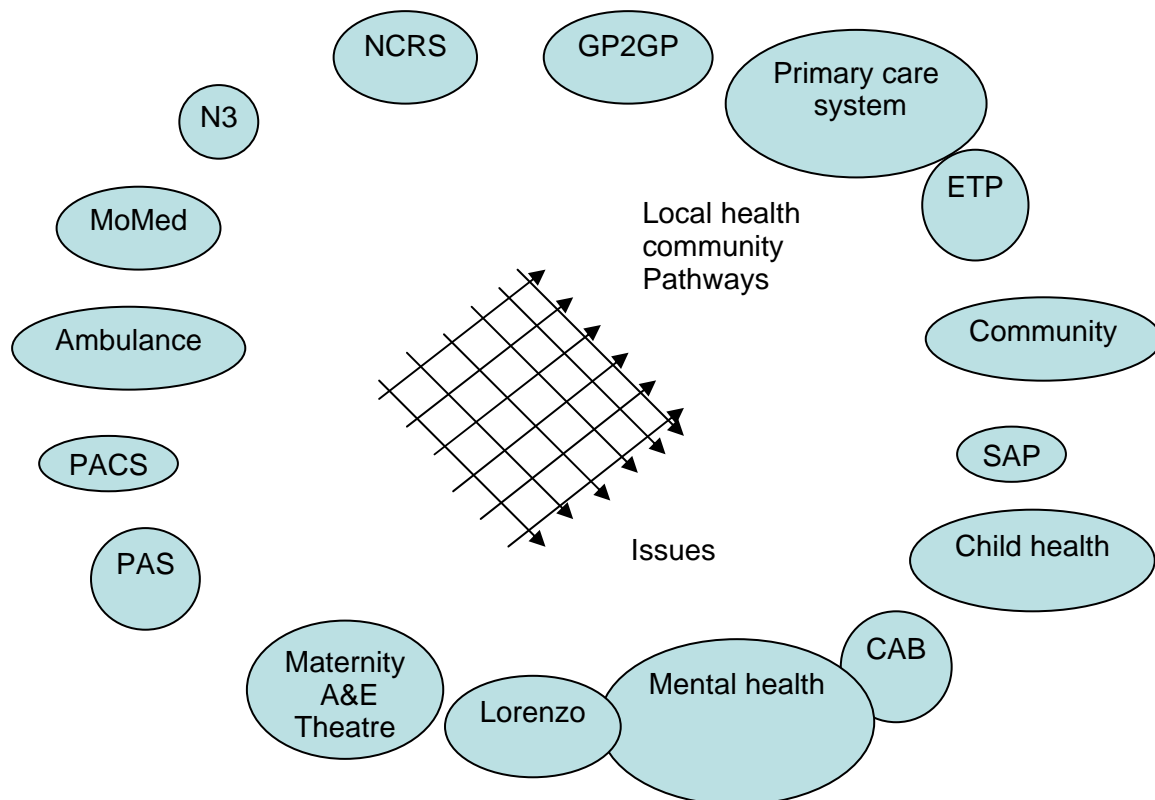
A large consultation exercise has taken place, albeit over a short period of time and this paper is awaited. The Health and Offender Partnerships structure of DH will contribute to this exercise. Clearly the most important phase will be the implementation of the new policies as they apply to primary care and how services for prisoners in prison and after release. This paper will hopefully inform some of the policy direction and ensure that its key principles of continuity, integration of services, and effective outreach to the social exclusion population in the community can be achieved.

Practice based commissioning (PBC)

As part of creating a patient led NHS PBC is emerging more in to a locality commissioning model. It is interesting to speculate how prisons might be affected. Certainly the risks, mostly financial and competency based, attached to a single practice commissioning model is clear to many so collaboration, sponsored by PCT commissioning managers seems to be the favoured approach. A prison may therefore seek to collaborate with other prisons as part of an inter PCT approach or with neighbouring practices as part of an intra PCT approach. Certainly this paper and its principles would demand that the local prison is seen as part of a group of primary care services for the socially excluded/ vulnerable population of a PCT area or local health community. Involvement, support and oversight by, the new CSIP regional development centres structures will be essential in maintaining cohesion of this proposed strategic approach.

The National Programme for IT in the NHS (NPfIT)

The elements of NPfIT are complex, are acronym rich and are currently suffering from a failure of clinician buy in and difficulty in integration between; products, sectors of the NHS and social care structures, and the NHS and its multinational provider companies. The following diagram shows how the various products are currently being developed in isolation but are all related to a local health community with its patient pathways, (including offender and the socially excluded), and the cross cutting issues such as financial balance and clinical governance.



Acronyms are: NCRS = national care records service; GP2GP = GP to GP transfer of records; ETP = electronic transfer of prescriptions; SAP = single assessment process, supports community health and social care; CAB = choose and book, of primary to secondary care referrals; Lorenzo = the final clinical system solution spanning primary and secondary care; PAS = patient administration system, hospital system; PACS = picture archiving and communication system, the NHS using digital pictures and moving them around; MoMed = map of medicine, a clinical decision support programme; N3 = the new national network, the IT infrastructure, fast and secure.

The prisons are to have a single server, single tailored clinical information system, limited choose and book functionality, structure as mainstreamed as security issues will allow with NHS structures.

The national public health strategy “Choosing Health”⁷⁰

This is a large and detailed document with a broad remit of improving the health of the nation. It ranges across; health in a consumer society, children and young people, a focus for local communities, the NHS as a health promoting organisation, work and health and implementation.

One of the big ideas is ‘health trainers’. In prisons and especially in relation to the post release period support by a peer is likely to be very helpful for individuals in supporting them in continuing to avoid health damaging behaviour decisions. Accordingly prison health at the DH is leading on a programme of health trainers supporting released prisoners and secondly on training current prisoners to become health trainers. The impact of this policy is likely to be very positive, especially integrated with the model of care described later in this paper.

Medical care practitioners

Only just released this paper from DH initiates a consultation on what are called 'Physician Assistants' in the USA. American correctional facilities and jails are heavily staffed and dependent on physician assistants for the delivery of medical care, able to do everything up to prescribing and operating. This policy is likely to become important for UK prison health services and for providing medical care in the community in services which are for many reasons seen as less attractive by many doctors.

Patient and public involvement

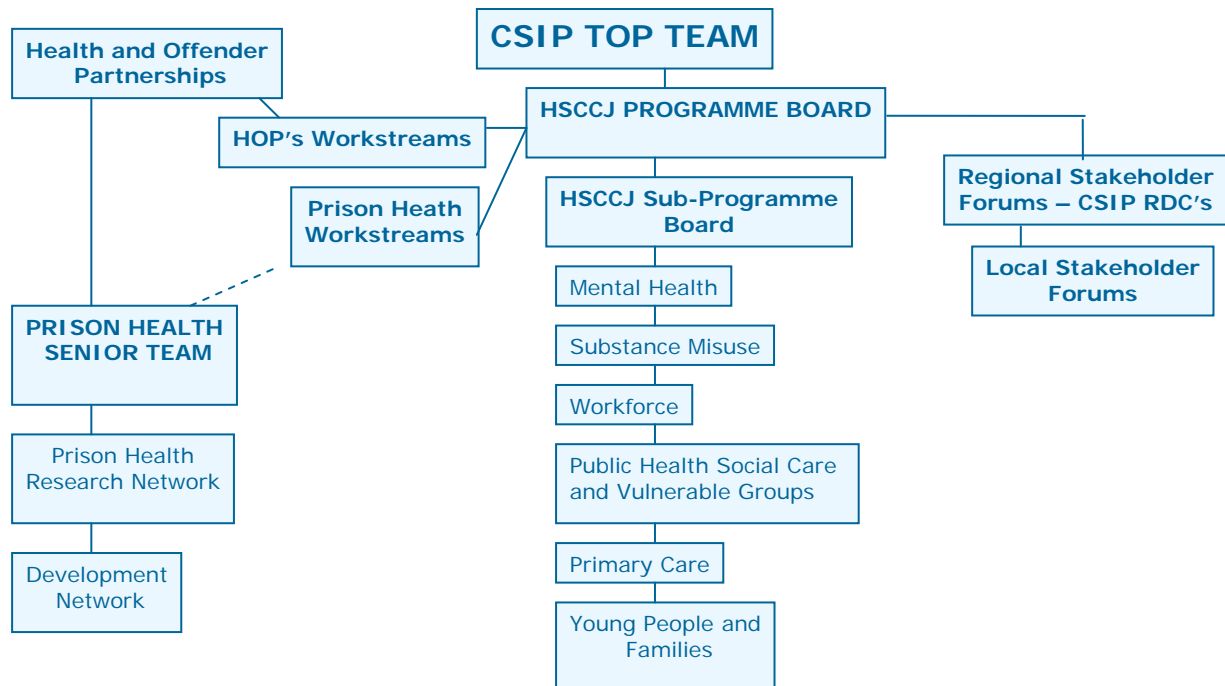
It is true that prisoners and their families have to date had relatively little say in determining the direction of policy and how services are delivered locally. That PPI improves the quality of health care has been evidenced by the NHS in 2004, and has resulted in NHS policy in involving patients in how healthcare is provided in their communities, the copying of letters to patients, and patient advice and liaison services (PALS), which support patients in navigating through and complaining about NHS care. The role out of these processes and rights to prisoners is just underway.

Performance

There is a strategic direction of policy which is seeking to join up performance management and statistical surveillance of health and social care services in the UK. For prisons the current debate relates to how, following the beginning of commissioning by the NHS of prison based healthcare, the care of prisoners might become part of mainstream; in statistics, for health and social care, complaints services, patient surveys and performance rating procedures of the Health Care Commission. Prisoners have the same rights as all other NHS patients and can expect the same levels of performance in respect of waiting times, choice and outcomes. However the choice issue is slightly affected by security considerations which limit the awareness of prisoners about when and where and by whom they are to be seen in the secondary sector.

Department of Health policy

Prison health and health and social care in criminal justice policy, (HSCCJ), Health and Offender Partnerships and the Care Services improvement partnerships, (CSIP)



The above diagram is essential in attempting to understand the challenging complexity of the new Department of Health strategic policy structures in health and criminal justice. The following narrative may also be helpful. To support the clarity and accuracy of the following explanation much of this section's text is taken from the recently published CSIP/HSCCJ explanatory CD. It should be understood that these structures and relationships are currently settling and gaining credibility. The CSIP regional development centres, (RDCs), are currently launching their health and social care in criminal justice teams and partnerships.

Following consultation, CSIP commenced work from 1 April 2005. The scope of the partnership is to support change in a whole range of care services for people, families and communities including:

- Children
- Learning disability
- Mental health
- Older people
- Physical disability
- Health and Social Care Criminal Justice

The CSIP initiatives are a collation of mostly established programmes now co-ordinated by CSIP and their regional outposts the RDCs.

- Change for Children
- Health and Social Care Change Agent Team

- Integrated Care Network
- Integrating Community Equipment Services
- National Child and Adolescent Mental Health Support Service
- National Institute for Mental Health in England
- Valuing People Support Team
- Health and Social Care in Criminal Justice Programme

The largest of the above are the well established NIMHE structures the next largest are the rapidly developing structures and partnerships in the HSCCJ programme. CSIP will have a strong regional structure, based on the existing eight NIMHE regional development centres (RDCs), with a new remit that reflects the full range of care services needs. Each RDC will be accountable to local stakeholders with national reporting and feedback. Helping the organisation to:

- Join up service improvement support where this makes good sense
- Reduce duplication between initiatives
- Work across Government and sectors to help services for those with health and social care needs

The nature of these relationships, up to the centre and down to the localities and communities is yet to evolve; the culture and operational arrangements of each RDC will be locally determined and inform these relationships. Essentially policy will flow from the Department of Health and at the RDC will impact and undergo local tailoring and implementation. At some point, in time and in the system, there will be a requirement for performance management which will similarly affect the nature of the relationships.

The overall aim of the 'Health and Social Care in Criminal Justice' (HSCCJ) programme is to work with key national, regional and local stakeholders to ensure that the health and social care needs of those who are "offenders" in all parts of the Health and Criminal Justice and Social Care system are met. HSCCJ builds on the work of Prison Health, the joint unit established between the Department of Health and the Home Office to modernise and integrate Prison Healthcare services into the mainstream NHS.

The programme is also influenced by Health and Offender Partnerships (HOPs), the new unit established between the National Offender Management Service (NOMS) and Care Services Directorate of the Department of Health. HOPs has been established to 'improve health, address health inequalities and reduce crime by maximising the opportunities provided by better integration of health, social care and criminal justice systems'.

The objectives of health and social care in criminal justice are:

- Help to improve the quality of life for people of all ages who experience mental or physical distress or learning disability across the criminal justice system.
- Support organisations to implement National Service Frameworks, the NHS Plan and the Social Exclusion Unit report
- Work to improve the quality of planning and commissioning of services

The focus for the next year is on:

- Mental Health
- Substance Misuse
- Workforce
- Public Health, Social Care and Vulnerable groups

- Primary Care
- Children, young people and families
- Research and Development

Hence the sub programme boards working in these areas.

The national HSCCJ Programme Board has been established to advise the National Director of HCJP, Richard Bradshaw, also the head of Prison Health, and the National CSIP Top Team on progress against delivery targets identified in the Service Level Agreements (SLAs) with each of the eight CSIP Regional Development Centres (RDCs). Each of the key service deliverables (or 'sub-programmes') is governed by a separate Sub-Programme Board:

- Mental Health
- Substance Misuse
- Workforce
- Public Health and Vulnerable Groups
- Primary Care
- Children and Young People

So the areas of policy development are clear, each led by a sub-programme board, linked to key leadership structures with key relationships with relevant strategic partners, able to reliably disseminate the policy to regional structures with power and effective locally developed partnerships. This policy will be further achieved by:

- Identifying regional stakeholders
- Scoping existing programmes, service structures, ways of working to identify a common agenda and opportunities for greater collaboration and joint planning
- Identifying resources – what exists? Pooling of budgets? Accessing new forms of funding?
- Regional and local governance arrangements – how will collective decisions be made? What will be the roles and responsibilities of partner organisations?

The NHS and social care and criminal justice systems in local communities need to now learn how this policy is created, contribute to it and effectively implement the new service developments for the benefit of the service users.

It is clear from the policy structures and key areas of work, that there is a national strategic determination to join up the care and support structures for offenders before during and after periods of incarceration by connecting the criminal justice and health and social care systems, with the offender/patient/service user throughout the offender pathway. The focus for these systems of support and care on the post release period, perhaps, for some, extending to the next pre-incarceration period, will almost certainly be more effective in delivering improved health and social outcomes than previously.

The structures outlined and the flows and relationships may not seem immediately clear but make increasing sense with time, and perseverance!

In order to gain a detailed history and understanding of Prison Health related developments lead by the Prison health team at the department of health, the reader is asked to view the website <http://www.dh.gov.uk/policyandguidance/healthandsocialcaretopics/prisonhealth/fs/en> Though suffering from a relative lack of searchability this website is regularly updated and

keeps the prison health community apprised of all significant recent developments.

Prison and probation – National Offender Management service (NOMS)

NOMS is often described as a merger between Prison and probation management structures, but is perhaps better thought of a de novo structure with aims and objectives of the two prior structures but with a more strategic focus on reducing re-offending. It has been a very challenging re-structuring and is now starting to settle in to its new role.

On their recent website update the following issues and activities are being taken forward:

- Organisational development at the same time as the maintenance of operational performance in prisons and probation,
- Working with the sentencing guidelines council to stabilise sentencing practice,
- Establishing the ten Regional Offender Managers (ROMS) and applying offender management to offenders,
- Establishing the new commissioning system with SLAs between ROMS and prisons and probation services,
- Building the IT infrastructure to support offender management,
- Providing an offender manager for every sentenced prisoner supporting sentence planning and discharge planning,
- Greater control applied to the offenders who pose the highest risk,
- Introducing contestability in to the commissioning process.

In respect of health issues NOMS works with Prison Health at a DH departmental level in Health and Offender Partnerships (HOP).

World Health Organisation and the developing WHO Health in Prisons Project

The NHS and DH collaborate with WHO in the Health in Prisons Project, led by Paul Hayton as project lead officer. The main activities are the hosting of an annual meeting and conference of the WHO European network for Prison Health, and the production of policy guidance documents. The key output to date has been the 2003 'Moscow declaration' which has since guided policy direction in a number of countries.

The key issues summarised are:

- Closer links at government department level between health and penitentiary systems to drive forwards mainstreaming of prison health care and public health and improved standards and better continuity,
- Prisoner health care to be free of charge,
- Improved harm reduction policy in prisons in respect of HIV/AIDS and hepatitis,
- Better management of the threat from tuberculosis in prison populations,
- Working holistically in society to mitigate against the threat from HIV/AIDS and TB,
- A general working together to improve the quality of psychiatric and psychological treatments for prisoners,
- A move towards improving the quality of the environment of prisons,
- A role for WHO to support improvements in health care for and the health of detainees.

5. Summarised key national prisoner health related policy documents

The following list of key policy areas and documents are briefly summarised where appropriate, in order to guide further reading and indicate policy direction.

1. **Death in Custody Investigations -Letter from Steven Shaw, Prison and Probations Ombudsman**⁷¹.

This initiated the new process for investigating deaths in custody, explaining the roles of PCTs and the ombudsmans team. In particular the relationship with coroners and the non-legal nature of the investigations is explained.

2. **Clinical Governance for Prison Health: Getting Started**⁷².

This introduced the NHS quality assurance processes in to prison health services, linked the prison with the PCT for improving the quality of health care provision and reinforced the role of the prison governor and PCT chief executive.

3. **The future organisation of prison health care**²

This Report sets out the key findings and recommendations of a Working Group of Officials from the Prison Service and the NHS Executive, jointly established by the Home Secretary and the Secretary of State for Health to consider the future organisation of, and ways of improving, prisoners' health care. The key findings and recommendations were:

- That the quality of prison healthcare was variable.
- Established health authorities and prisons working together to create prison health improvement plans.
- Established the prison health policy unit and prion taskforce and regional health development teams.

4. **Health Promoting Prisons: A Shared Approach.**⁷³

This report is aimed at those working with prisoners, and who have a role in promoting health education in prisons. The report acknowledges that prisoners suffer from health inequalities and social exclusion. An action plan is identified, outlining targets to be achieved by 2005. This action plan is underpinned by five key aims:

- the development of a whole prison approach;
- improved information communication and good practice;
- the agreement of a Health Promoting Prison standard in England and Wales;
- monitoring of progress in the area of health promotion in prisons;
- the benefits of a multi-disciplinary approach within prisons.

5. **Health Services for Prisoners Prison Service Performance Standard 22. Issued May 2004**⁷⁴

An absolutely key document which seems not to have received the attention it deserves. It explicitly states and guides the range and type of services, and quality assurance processes which should be provided in prisons. The development of these standards is key to both improving standards over time but also supporting the performance management of services. Importatly related to PSI 36/2002 Developing and modernising primary care in prisons⁷⁵

6. Good medical practice for doctors providing primary care services in prisons⁷⁶

This document issued under a PSI but created by the RCGP and Prison Health complements the General Medical Council's and Royal College of General Practitioners documents 'Good medical practice' and 'Good medical practice for General Practitioners'. There are clearly issues that confront doctors providing primary care services in prison and this document contains added text enlarging on but not replacing the original text of 'Good Medical Practice for General Practitioners'.

7. Strategy for modernising dental services for prisoners in England⁷⁷

This document, through a planning approach, aims to help prisons, working with their NHS partners, to:

- Improve the quality of dental care in prisons by ensuring high quality standards are in place based on the principles of clinical governance and robust audit trails.
- Work to raise the awareness of good oral health throughout the prison, amongst prisoners, prison staff and voluntary agencies working in prisons.
- Identify resources and operational issues specific to prisons that are required for each prison to meet the dental needs of prisoners.
- Ensure that cost effective dental services are commissioned to meet the oral health needs of prisoners including appropriate performance measures.
- Develop a model service specification for the provision of dental services in prisons that will enable prisoners to have access to dental care appropriate to their needs.

8. Pharmacy services for prisoners⁷⁸

The management of drugs in prisons is challenging in particular in relation to controlled drugs. The integration of systematic pharmacy services with the prison regimen and the normalisation of in possession issues is particularly difficult. This paper is therefore extremely important.

The principal conclusions of the report are as follows:

- Pharmacy services to prisoners should be patient focused, be based on identified patient needs, and support and promote self-care.
- Developments in medicines management in the NHS, including repeat dispensing and medication review, should be reflected in pharmacy services provided to prisoners.
- All prisoners should have appropriate access to a pharmacist or pharmacy staff.

Importantly the report establishes that; in possession medications are the norm, the requirement to have drug and therapeutic committees and regional pharmacy leads. The need for IT systems, Training & Continuing Professional Development (CPD) planning linked to the NHS, the development of the pharmacy workforce, and a process of modernisation linked to the NHS developments, were also affirmed.

9. Clinical Appraisal for doctors employed in prisons⁷⁹

Through the appointment of regional prison medical leads to support and oversee the process, the prison doctor workforce became subject to the need for annual appraisal. For many working in the community and prisons a single appraisal was maintained by ensuring the prison sessions were appropriately considered in the appraisal.

10. Rationalisation of doctors' duties in prison⁸⁰

Part of the ongoing process to modernise the role of doctors working in prisons. The term medical officer is used less and doctors have less specification of roles enabling them to be done by other professionals in the healthcare teams.

11. Guidance for the introduction of healthcare assistants⁸¹

This again is important guidance in support of modernisation and skill mix of the prison health care workforce. The Prison Officer Association and Royal College of Nursing were involved in the production of the guidance which demonstrates the strategic nature of the proposed changes and the sensitivities of the role changes. As mentioned earlier a further development of skill mix is the recently disseminated proposal to develop the medical care practitioner role. Physician assistants, performing doctor type roles up to, but excluding, prescribing, are fundamental to delivering prison healthcare in the United States.

12. Guidance on developing prison health needs assessments and health improvement plans

There have been a number of papers from Prison health and the University of Birmingham all with three objectives. Firstly to describe the main health problems that exist in the prison population in England and Wales today. Secondly to identify health care interventions which help meet these health problems. Thirdly to make recommendations about which health care interventions should be provided in prisons to meet the health care needs of prisoners. Toolkits have been produced to be used in conjunction with these documents helping local PCT and Prison partnerships to identify health care needs and plan services for their prison population. The University therefore hosts the prison health development network.

This paper seeks to take forward this work by linking to the post release period, and will be fed in to this network.

13. Patient advice and liaison services (PALS) for prisoners

That prisons are a challenging environment to manage patient advice and liaison is clear to all that work in them. The mainstreaming of prison healthcare with this key service for patients is now underway following the establishment of the principles of normalising PALS in to prison healthcare.

14. Offender mental health care pathway⁸³

This pathway is intended to guide the practice of people who directly deliver services, and support decision making for those who commission them. It contains a large number of templates based on best evidence and good practice. It acknowledges the key issues presented with this paper of the importance of primary care mental health services and the continuity of care between prisons and upon release. This is a key and well evidenced piece of work which must now be utilised to improve services to prisoners.

15. Mental Health In-Reach Collaborative Launch

The in-reach project is a fundamental component of the prison mental health modernisation agenda and is crucial in the implementation of the strategy set out in the document "Changing the Outlook, A Strategy for Developing and Modernising Mental

Health Services in Prisons” (December 2001). The mental health in reach concept has been delivered through the use of a national collaborative approach first pioneered by Don Berwick in the US. The focus on delivering best clinical practice makes collaboratives a useful vehicle to potentially take forward the main principles of this paper.

16. Changing the outlook: a strategy for developing and modernising mental health services in prisons⁸⁵

Produced in 2001 this very important document set out a joint Department of Health and Prison Service approach to far-reaching development and modernisation of mental health services in prisons over the next 3 - 5 years, in line with, and ensuring that prisoners benefit equally from, the National Service Framework for Mental Health and the NHS Plan.

The aims of the document are stated as:

- a reduction in the number of prisoners located in prison health care centres, with resources re-deployed to provide day care and wing-based support;
- a reduction in the average length of time mentally ill prisoners spend in those prison health care beds that remain;
- a more appropriate skill mix among those providing mental health care, so that prisoners have access to the right range of services to NHS standards;
- increased numbers of day care places;
- improved wing-based services;
- better integration between Prison Service and NHS staff, to encourage skills transfer among staff and reduce professional isolation, and to facilitate exchange of information;
- quicker and more effective arrangements for transferring the most seriously ill prisoners to appropriate NHS facilities and receiving them back;
- increased collaboration by NHS staff in the management of those who are seriously mentally ill, including those vulnerable to suicide or self-harm whilst they are in prison;
- improved health and social functioning for patients.

17. Developing and modernising primary care in prisons⁸⁶

The strategy for improving primary care in prisons is to increase integration with primary care planning and development through the local Primary Care Trusts (PCTs). The four key areas of developing primary care teams, primary care services, primary care partnerships and primary care infrastructure, is described. The document essentially took prison health from a Prison Service primary care service, full of variation and isolation, to the present situation of being still variable but now linked to PCT planning and awareness. The initial waves of prison health care improvement were, health needs assessments, linking to health improvement programmes and quality assured through the introduction to prisons of the concept of clinical governance. Developments are progressing but there is a current stalling of leadership drive as the previous structures of regional prison health development teams hand over to regional development centres of Care Services Improvement Programme (CSIP) and emergent Strategic Health Authorities teams. The transfer to PCT commissioned care and the changes in structure in the DH leaves prison primary care expectant and poised to take more exciting steps. The department of Prison Health, in the Care Services section of

the Department of Health, is now developing the next phase of policy.

18. Safer Prisons report - A National Study of Prison Suicides 1999-2000 by the National Confidential Inquiry into Suicides and Homicides by People with Mental Illness⁸⁷

A very important and detailed paper looking primarily at current prisoners rather than the recently released. A brief summary will inevitably miss major issues. The following notes only the recent release period and the key recommendation for post release:

- In a 4-year study period (1996-2000), 354 people were found to have committed suicide within 1 year of release from prison, i.e. 88 cases per year.
- These deaths clustered immediately after release with 80 (23%) in the first month and 40 in the first week.

This concurs with a recently produced unpublished paper giving a 35x more likely to die from suicide than the normal population in the first week following release and a risk of 5x in the first year.

The release of prisoners with mental health problems should be co-ordinated with mental health teams outside prison. Care plans should be jointly reviewed by prison and local staff prior to release. Those “at risk” of self-harm should be followed up within a week of release.

19. The HR in the NHS Plan: A Prison Health Workforce Perspective and Briefing⁸⁸

Formulated as best practice guidance to give prisons and their partners in the NHS information to assist in the production of the workforce planning elements of their Prison Health Delivery Plan (PHDP), alongside case studies and examples of good practice. It outlines the key initiatives, originating from the *HR in the NHS Plan* under the headline of ‘More staff, Working Differently’.

Pillar One – Making the NHS a model employer – embracing ‘best policies, practice and facilities’ incorporating ‘Modernising Pay’ and introducing the principles later to impact under the NHS Agenda for change initiative.

Pillar Two – Ensuring the NHS provides a model career – ‘one in which there is an expectation of lifelong learning and development with opportunities for advancement and progression’, incorporating ‘Modernising Learning and Personal Development’ and ‘Modernising Workforce Planning’

Pillar Three – Improving staff morale

Pillar Four – Building people management skills

These incorporate the key national workforce objectives:

- “Increase workforce numbers to meet NHS Plan, workforce and service delivery commitments”
- “Implementing national policies and local activity to make the NHS a model employer”
- “Modernising processes and roles and the development of skill mix to increase productivity and capacity”
- “Modernising learning and personal development to facilitate skill mix”

- Developing Human Resource Management capacity and capability

20. National Health Service and Agenda for Change

The workforce issues relating to the new commissioning arrangements by the NHS for prison based health services, came to a head as nurses and others employed by prisons were concerned that they might be transferred to NHS employment against their will. Reassurances and national union negotiations have stabilised the position. Transfers are by choice and are dependent on who is providing the care.

21. Prison nursing network launch and the beginning of clinical supervision in prison nursing.

Self explanatory.

22. Nursing in prisons: report by the working group considering the development of prison nursing, with particular reference to health care officers⁸⁹.

This key document acknowledged the lack of clarity about the role of nurses and health care officers within the prison health care team. It set out a programme of work which recognised and built upon the expertise of nurses and health care officers working in prisons and which pointed the way towards the development of fully integrated nursing teams. The recommendations within the report aimed at modernising the role of nurses and health care officers, their training and development to keep the Prison Service abreast of developments within the NHS. The report recommended further strengthening of the link between prison health care centres and local NHS services to reduce professional isolation and to increase the sharing of good practice. It also recognised the importance for prison health care services of adopting the standards and practice of those found within the NHS, while taking account the special nature of the prison setting and the high rate of morbidity within the prison population. The Department of Health's nursing strategy – *Making a Difference* – set an ambitious programme for nursing in the NHS. This report committed the Prison Service to working in partnership with the NHS on the implementation of the recommendations of *Making a Difference* to better support staff working in prison health care.

23. Report of the Working Group on Doctors Working in Prisons⁹⁰

Another key modernising document, of a landmark nature, with no going back. The importance of this element of the workforce is acknowledged and the importance of improving the quality of their performance is made emphatically. The key recommendations taken from the document are as follows:

Pay, Terms and Conditions

- rationalise the recruitment and selection process for employing doctors
- review the recruitment policies regarding the employment of doctors within the women's estate and devise a strategy to attract more women doctors so that women prisoners are able to see a female doctor if they so choose
- determine a competency checklist for doctors
- mirror initiatives used in the NHS for tackling poor performance
- review the current pay scales for doctors

- draw up a series of model contracts that offer guidance about the structure of work that can be reasonably expected of a doctor working in a prison
- review the out of hours requirements for medical staff

Training and Continuing Professional Development

- Facilitate or strengthen links with outside bodies that offer relevant training to enable doctors to maintain and develop existing skills
- Develop and provide appropriate induction, tailored to the needs of the groups with whom doctors will be dealing
- One session a week to be spent in a relevant NHS facility
- Two academic posts to be funded at Senior Lecturer level in Universities which have a successful record of research which relates to the health needs of prisoners and a medical school

Structure

- The development of a series of medical lead posts across the prison estate
- The development of a series of medical networks across the prison estate
- Health care manager posts to be open to people from all professional backgrounds and these posts to mirror best practice in the NHS
- An appropriate balance between the interface of primary and secondary care within prisons
- Proper partnership arrangements/service level agreements between the prisons and their respective local NHS Trusts

Qualifications

- all doctors working in primary care must hold a certificate from the Joint Committee on Postgraduate Training in General Practice (JCPTGP) or have an Acquired Right to practice
- There must be effective clinical appraisal and revalidation in line with the NHS model

IT

- doctors should have the necessary IT in order for them to deliver services more effectively and quickly
- The development of clinical audit within prison healthcare centres should be encouraged.

24. They're Not Just Patients or Prisoners. They're People (leaflet)⁹¹

Aimed at encouraging recruitment of healthcare professionals in to the prison sector.

25. An education and training framework for staff providing healthcare in prisons⁹²

This document provides a detailed description of the professional and vocational qualifications that are a pre-requisite for all people who work in or interact with health care services in prisons.

26. National strategy for the clinical management of drug dependence in prisons – expected soon

The drivers behind the imminent publication of the new national strategy for the clinical management of drug dependence in prisons are the high rates of suicide on admission to

prison and the concern about drug related deaths post release. There has also been legal challenge to the variability of services available in prisons and the lack of equivalence with national and international community based services. Many prisons have attempted to address these issues but have faced difficulties working with the prison regimen, providing continuity with other health and criminal justice based services and community teams, and in particular the difficulties arising from the Home Office originated and restrictive remit of the CARATs (Counselling, Assessment, Referral, Advice and Throughcare) teams. Particular problems remain in respect of dual diagnosis patients, and those with mostly alcohol problems which will be the subject of future guidance.

The expected key elements of the new strategy (currently in draft) are:

- opiate substitution therapy for stabilisation of all and maintenance of some, heroin addicted prisoners,
- approximately £60m of new funding from the Home Office and Department of Health,
- a treatment framework for clinical management

The key treatment options which are likely to be included within the policy include:

- doctor prescribed management of withdrawal in first night reception,
- stabilisation for five days converting to detoxification, extended, detoxification, or maintenance therapy,
- safe alcohol detoxification,
- managed benzodiazepine withdrawal,
- clinical monitoring of stimulant withdrawal,
- linkage in the prison between CARAT teams and substance misuse teams, and with services before admission and after release,
- joint management between substance misuse teams and mental health teams for patients with dual diagnosis,
- regular drug testing for prolonged treatment regimens,
- psychosocial support

27. Social exclusion unit – Reducing re-offending by ex-prisoners prisoners⁹³

There is now considerable evidence of the factors that influence re-offending. Many of the statistics from this report inform this paper. Building on criminological and social research, the SEU has identified nine key factors:

- education;
- employment;
- drug and alcohol misuse;
- mental and physical health;
- attitudes and self-control;
- institutionalisation and life-skills;
- housing;
- financial support and debt; and
- family networks.

The evidence shows that these factors can have a huge impact on the likelihood of a prisoner re-offending. For example, being in employment reduces the risk of re-

offending by between a third and a half; having stable accommodation reduces the risk by a fifth.

That drug and alcohol and physical and mental health issues are highlighted enhance the importance of the development of services and personal strategies and plans for offenders, in order to better manage these malign influences. The focus on re-offending helps to strengthen the imperative which is a major theme of this paper for better partnership building and joint working between government departments, regional agencies and the health, social and criminal justice systems.

6. Practical issues of access for health and social care

The following may be criticised as being theoretical and poorly informed. Prisoner experiences are variable and there is little published analysis in relation to prisoner journeys. However this approach may guide future approaches to better understanding the needs of prisoners at different phases through the health and criminal justice system in the UK.

| The prisoner journey | Issues arising from the health and social care system |
|---|---|
| The future prisoner, likely to already have experience of prison, be mentally ill, with substance misuse problems and limited educational attainment is living in poor housing, or is homeless. | <p>Little assertive outreach. The future prisoner is not seen as 'vulnerable' and they do not engage easily with normal community services and primary care, and vice versa.</p> <p>Probably not engaged with social care except through the benefits system.</p> <p>The potential exists to assess individuals as likely to become involved with the criminal justice system, provide proactive educational, health and social care support.</p> <p>Need to ensure engagement with health services to address wide range of health needs.</p> |
| The person is arrested and held in police cells awaiting charging. | <p>Health and social care needs are met in relation to substance misuse withdrawal and in relation to any overt mental health needs, or medication supply.</p> <p>Potential for an assessment in relation to the health and social factors which may have contributed to criminal activity and support mitigation and if appropriate, alternatives to imprisonment planning. Whose role? Perhaps linked to legal advocacy.</p> <p>There is an urgent need at this point to get early consent from the person to enable agencies to transfer otherwise confidential information, for it to be collated and then used to generate a supportive regimen and to sustain a culture aimed at avoiding imprisonment whenever possible.</p> |
| Person is charged and remanded in custody | <p>Undergoes first night reception screen, and receives necessary medications and support for detoxification from drugs and alcohol.</p> <p>But, no or limited access to community health and social care records. Limited planning for longer term health and social care needs despite this critical opportunity. Potential for electronic communications and records to support integrated health, social and criminal justice assessment and planning of support and alternatives to prison sentence.</p> |

| | |
|--|--|
| | <p>The role of PCTs and their health records services are key. With awareness and encouragement these bureaucracies can help significantly in providing and coordinating support services and access to primary care, before imprisonment and after release.</p> <p>Potential for mental health and substance misuse interventions linked to work, housing and educational opportunistic support.</p> |
| Person charged and awaits trial in the community | <p>Tends to revert to normal poor health and social functioning. Significant opportunity exists to proactively assess as above and plan longer term support and life planning. An acceptable alternative to imprisonment might be scoped and planned with criminal justice and prisoner advocacy.</p> |
| Prisoner sentenced | <p>At this point it is essential that, for the majority of prisoners with mental health, personality disorders, learning difficulties, drug and alcohol dependence, a pause is taken before passing a custodial sentence. Alternatives aimed at addressing the causes of criminal behaviour are effective and will prevent the negative physical and mental health and social impact of imprisonment, and perhaps avoid a career of cycling through prison.</p> |
| Prisoner begins sentence | <p>Reception screening again, rarely informed by prior information. Risks of self harm and mental health problems. Also opportunity to intervene with long standing health and social problems. Prison regimens interfere with self care and professional provided care. Issue of lack of information and continuity of care if prisoner moves between prisons. Uncertainty about level of health care to begin and invest in, dependent on length of sentence.</p> <p>Significant potential to work with the prisoner to address life planning and help mitigate against health driven criminal behaviours, from mental health and drug problems.</p> |
| Prisoner during sentence | <p>Health care and prison regimen issues (focussing on work, education, meals, security and association periods), tend to conflict and require constant balancing of priorities.</p> <p>Health problems of a physical or addictive nature tend to improve but prolonged incarceration adds to mental health problems.</p> |
| Prisoner released | <p>Resettlement does include consideration of health and social care issues however this is rarely well informed and continuity of care in to</p> |

| | |
|-------------------------------------|---|
| | <p>the community is notoriously poor. Referral and assertive engagement with the person in to a well integrated health and social care support service will help address the needs. Retention in the programme will be essential and the potential exists to encourage this as part of early release planning.</p> <p>Key is the level of integration of the service and the presence of good quality health and social care information.</p> <p>Performance management of these services would monitor their ability to reduce recidivism and give confidence to and encourage sentencers to avoid imprisonment in the event of criminality.</p> |
| Person is included again in society | <p>Long term support is likely to be helpful in maintaining social inclusion, with the opportunity of ex prisoners to access easily, services for social and life advice and health maintenance. Health trainers, and social buddying relationships are envisaged, perhaps linked to prison originated therapeutic relationships and perhaps involving ex-prisoners.</p> |

7. What gaps are there in.....?

Research

That there is a dearth of research focussing on prison health is oft reported, this paper demonstrates the particular shortage and therefore need for research in the area related to the post release period.

Following on from the launch of the national Prison Health Research Network, (PHRN) in York in May 2005, a synthesis of delegates reported views of research priorities is being produced.

The following is a brief outline of the areas and issues which are being further considered. The national budgets for prison health research have an initial categorisation around primary care, mental health, dental care and substance misuse, and are lead respectively by, Bonnie Sibbald, Jenny Shaw, Martin Tickle and Mike Farrell, and are administered by the PHRN Programme Board.

Generic issues

Continuity of care, IMT, cost effectiveness, telemedicine, outcomes upon release.
Organisation of prison health services to ensure equivalence.
How can community or population based approaches be best adapted for prisons?
How to prioritise research questions?
What is the impact of family relationships on prisoner health care and re-offending?
Service user involvement in delivering prison health services.
Prison healthcare workforce, education, skill mix, occupational health, recruitment.
Health care information to prisoners at reception.

Health technology assessments

What is the impact of prisons on health status?
New treatment approaches for reducing death from overdose on discharge.
Impact of psycho-social approaches to drug treatment in prison.
The costs and outcomes of prison dental services
How best to deliver fluoride in prisons?
The costs and benefits of healthcare screening at reception.
Methadone maintenance, re-offending and sugar free forms?

Dentistry

How to determine which patients really have pain?
Healthy foods in the canteen.
The role of dentistry in health promotion.

Mental health

Suicide and self harm, process and services
Personality disorder, what works, first stages, treatments, staff training, burnout and support.

Mental health transfers

Primary care

Models of service

Continuity of care

Patient choice and voice

Adapting community approaches for use in prisons.

Reducing reoffending

Workforce

Prison environment

(The above list is reproduced with kind permission of Neisha Betts at the Department of Health.)

Training

The key strategic direction of the education and training in prison health relates to the twin requirements to mainstream into the NHS and to extend in to a wider criminal justice focus. Prison health has recently published, "An education and training framework for staff providing healthcare in prisons"⁹², which provides a detailed description of the professional and vocational qualifications which are a pre-requisite for all people who work in or interact with healthcare services in prisons. There has, however, been no formal training needs analysis for this workforce. The mainstreaming issue is addressed by the links in the document to the Knowledge and Skills Framework which is the core of the Agenda for Change process currently being deployed in the NHS. It also addresses key induction needs for staff working in prisons for the first time. The only recent issue for which a national training programme was initiated was mental health awareness.

A review of training needs for doctors working in the prison environment was undertaken by the University of Durham in 2003. The output of the review has fed in to the new masters programme in Health Care in secure Environments, at the University of Lincoln, led by the Royal College of General Practitioners.

Service development policy

As referred to before the, Prison Health at the Department of Health is developing policy in relation to primary care services for prisons and post release as part of the health in criminal justice element of the care services improvement programme national and regional structures.

8. An evidenced and principle based proposal - Integrated Inclusive Care Programmes.

The author in conjunction with colleagues from NIMHE took part in the International Trailblazers initiative and developed an approach or vision which seeks to address the current policy gap. The scope of the project is the health and social care services for socially excluded people, including young people, with an emphasis on primary care mental health and continuity of care into, through, and on release from, the prison system. The approach can be summarised as promoting Integrated Inclusive Care Programmes for local health and prison communities. Starting with a list of principles the project promotes the IICP approach and is currently planning how to influence policy, assure the effectiveness legitimacy of the approach, and gain further support.

A brief summary of the concept follows:

Aim

To improve significantly the health of and the health and social care services available to, socially excluded people, in the community and in prisons, ensuring continuity of care and with a special emphasis on primary mental health.

Key deliverables

- Improve access for mentally ill offenders to the NHS
- Reduce suicides in and after prison
- Continuity of primary care for offenders
- Increasing offender employment
- Reducing health inequalities parameters
- Influence partners and DH policy in this area
- Raising the profile of offender issues in related health and social care programmes delivery

Principles

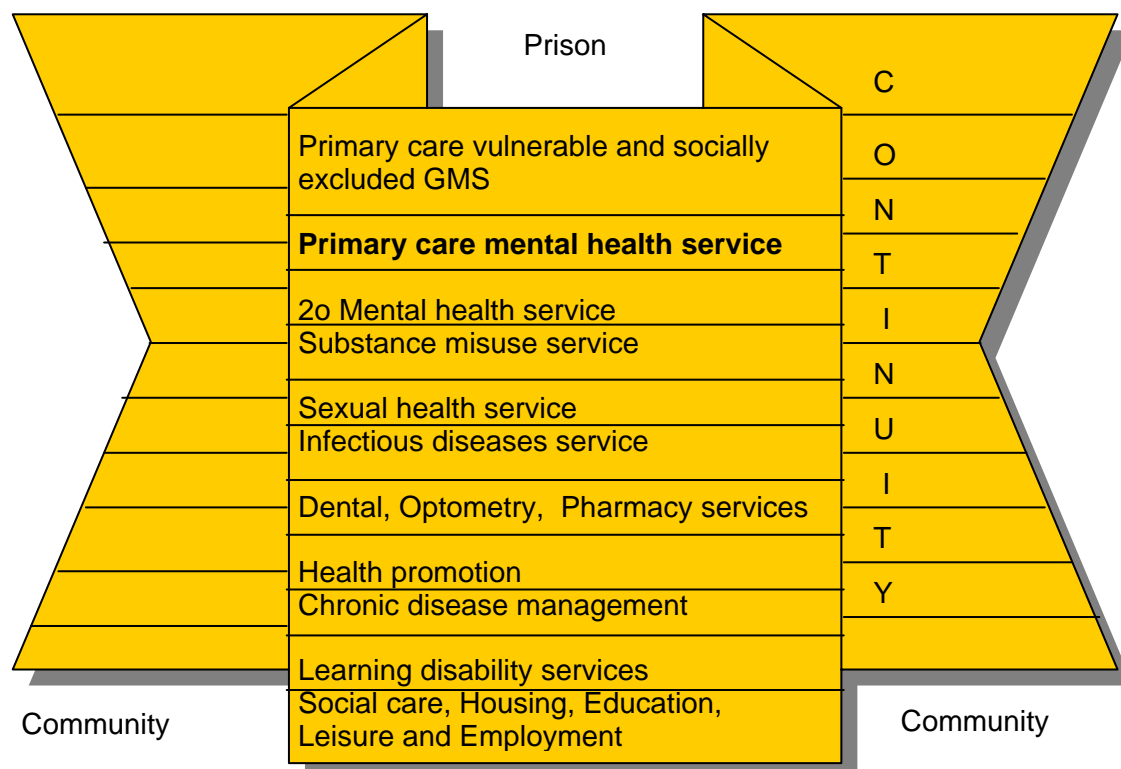
We believe that;

- there should be health care services designed to be more effective to support the socially excluded.
- continuity of care as people pass through, in and out, of the prison system is a critical issue, morally and in respect of delivering effective care.
- these services should be designed by local stakeholders to be responsive to the needs of the individuals and their families , responding ,over time, to a changing population. Access to the services is on the basis of choice.
- to be effective services will need to be proactive and incorporate such resources as assertive outreach, patient tracking, identified support personnel and advocates.
- These services should deliver the same or better quality of care to the socially excluded as is delivered to the population as a whole. This should be measured in relation to patient outcomes thereby reducing health inequalities.

- In designing these services it will be important to identify which specific health care interventions/ service functions are required for a particular local socially excluded population and prison population.
- The range of services provided will need to be appropriate, supported by best available evidence and ensure an equivalence of standards of care across the country.
- That the workforce to deliver these services can be configured in a range of different ways and with a range of different skill mix. Additionally the workforce will need to be well trained, resourced and supported, working within and between, the prison and community.
- That primary care will be the foundation of these services, delivered by a range of providers, including alternative or PCT MS and incorporating enhanced service and specialist clinician models.
- That adherence to these principles will prove to be effective and efficient but that the implementation should be as far as possible evidenced based.

The **strategic vision** therefore becomes:

To make these principles manifest, to improve the health and wellbeing, the healthcare, and the social capital of the socially excluded and of prisoners.



The diagram demonstrates a *horizontal integration over time* and between prison and community services, and a *vertical integration between the range of services* required to tailor health and social care to meet the needs of prisoners before, during incarceration and after release.

Hence the service model is called an Integrated Inclusive Care Programme, locally designed for local needs.

The challenges to taking this forward are seen as:

- Need for champions from service users
- Overcoming concerns of the workforce
- Lack of workforce
- Clinicians concerns regarding these potential service users.
- Managing change in the current structures and workforce
- Training.
- IT systems, records and communication.
- Making this a priority for local health communities.
- To deliver creative solutions for the realisation of the principles.

Improving the health, social care and prospects of the socially excluded including prisoners is seen as a significant goal. Are the principles right, in particular is the approach of tailoring services v. providing an equity of services right, morally and in terms of effectiveness and efficiency? And how and over what timeframe should the pursuit of this vision proceed?

It has been reassuring that this approach has received general support from the trailblazer international group, at a regional CSIP launch conference, a local health community, at executive, public health and health promotion level, and colleagues at the DH and in the prison health community. The approach resonates with the need for continuity of care, community based services, and breadth of services, all discussed at the recent WHO conference on prison health, and is further evidenced by this paper.

Finally the research review which has supported this paper has revealed the effectiveness of locally designed, multi-agency and multi-disciplinary, primary care based programmes which follow closely the prisoner as they move from the prison in to the community. The vision presented is therefore seen as a key area for policy development.

9. Key learning points

Some of this list may also be considered as a set of recommendations based on the evidence from this report:

- More research is required particularly looking at what works, in reducing mortality, morbidity and health related re-offending behaviour in the post release period.
- Prisoners are marginalised in society and fall between care systems and structures as they attempt to have their multiplicity of needs met. Care should be taken to overcome this tendency.
- Health care in prisons and upon release faces many uniquely difficult challenges e.g.;
 - High consulting rates
 - Prisoner reliability as historians
 - Poor prisoner concordance with treatment planning
 - Prisoner personal health neglect and health damaging behaviours
 - Poor clinical information and support systems
 - Staff shortages
 - Poor planning of service integration

This must therefore be considered when designing services.

- Despite the relative lack of evidence much good work, appropriately designed and planned, can be effective in each unique prison and community setting.
- Imprisonment can be good for physical health and improving health intervention opportunities but is usually not good for mental health.
- The post release period is extremely dangerous in physical and mental health terms and for recidivism.
- Prisons can be seen as another, 'community based healthcare station'.
- Imprisonment rates are increasing especially amongst women and the elderly and alternatives, whenever possible, should be used to avoid the deleterious health effects of incarceration.
- Health and social care services need to be designed to be acceptable to and accepting of young people.
- Women and young prisoners have special needs. Other sections of the population, e.g. older men, should be considered and their special needs identified.
- It is imperative that screenings for infectious diseases be conducted in prisons and/or treatment administered before detainees are released back into the general population.
- There is a move to multi-disciplinary and multi-agency models of care and such new modes of delivery require further evaluation.
- For the clinical management of prisoner health problems, unless proven otherwise, the assumption should be that a normal approach will achieve normal outcomes.
- There is no evidence that prison per se prevents the successful application of any particular healthcare interventions however technological.
- The quality of post release planning is variable and to be effective must be strengthened, particularly for prisoners with mental health problems who will require assertive outreach, and should become a key quality indicator to be performance managed.
- There are negative implications from the cumulative effects of engagement with the criminal justice system and the process through which persons with mental illness and a criminal history cycle through institutions.
- The multiple and diverse aetiologies driving behavioural disturbance in mentally ill

offenders need to be better understood for individuals at sentencing and for populations in respect of service planning.

- There is an important role to be developed for therapeutic communities and group support methodologies as aids to personal future planning for prisoners.
- Investment in, monitoring, reporting and evaluation of, prison-based and community interventions is needed to help reduce substantially drugs-related, suicides and all cause deaths in recently released offenders.
- Services which aim to meet the needs of substance misusing prisoners will, because of the high prevalence of dual diagnosis, have to be effectively delivered in partnership with mental health providers.
- Integrated Inclusive Care Programme approaches work, but must be focussed, provide continuity from within the prison into the community, be multi-disciplinary and multi agency, well resourced and well integrated with mainstream services.
- Reduction in structured support and reduced autonomy both contribute to the risk of poor management of chronic conditions, or adherence to recovery programmes for more acute conditions, following release from prison.
- Using the prisoner journey from pre-arrest to post release as a template it will be possible for local health and social care communities to better plan continuity of health and social care, alternatives to imprisonment and long term support services,
- The key challenge for prison healthcare is to enable continuity of care, within, between, on admission and upon release.
- Maintaining therapeutic relationships initiated with in the prison, into the post- release period are likely to reduce recidivism and improve health outcomes
- Because it can be shown that prisons can be a place of relative safety and health promotion for some prisoners, we should endeavour to make them more so for all.

10. Conclusion

This paper has been written by an individual and therefore, despite the literature review and policy context, offers a single perspective, of the subject. It is now necessary to take this agenda forward at a strategic national policy level, with the statutory regional local health, criminal justice and social services, and via the national and local representatives of the non-statutory sector.

The focus of the paper has been on prisoners and their needs, particularly in the post release period. It has been necessary throughout, due to lack of research, and literature, to rely on extrapolation, of prisoner characteristics, and informed conjecture, of reasons for the poor outcomes, in the examination of the post release phase. It is imperative that we build the evidence base in this country and work with international colleagues to improve our wider understanding. The term prisoner has tended to be used throughout, with occasional use of the term offender. Many offenders do not become prisoners and yet share many of the same characteristics and will use the same health, criminal justice and social services. The development over time of a more coherent and seamless understanding of the needs of offenders, prisoners and the marginalised and vulnerable of society needs to be built with a broader approach to evidence building and policy development.

That there is a great deal which could be done, which is currently not being done, to support released prisoners, is apparent. That there is, as yet, an unfulfilled potential to benefit prisoners, their families and society is also clear. The moral imperative to try to prevent the continuation of the shameful and unacceptable level of mortality, morbidity and wasted human potential, suffered by offenders as they leave prisons, must now be vigorously grasped, and acted upon.

Dr. Mark Williamson

Acknowledgements

Alan Cohen
Sean Duggan
Cliff Howells
Dave Marteau
Kieran Murphy
Jackie Prosser
Bonnie Sibbald
Colleagues at DH

This paper has been supported by funding from, and written to inform, the Sainsbury Centre for Mental health.

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