Tamlyn Cairns Partnership

Male Prison HNA PART B

Methodology & Supporting Notes for Health & Social Care Needs Assessment

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Introduction

Aims and Objectives

This Health and Social Care Needs Assessment (HSCNA) was commissioned to better understand the health needs of the prisoner population and to assess the extent to which the current need and demand for health and social care in the prison establishment(s) were being met.

The methodology used for this is the PHE 'Toolkit'[1] and NICE:

> *A health needs assessment is a systematic method for reviewing the health issues facing a population leading to agreed priorities and resource allocation that will improve health and reduce inequalities.*[2]

It should be noted that health needs may be *met* or *unmet* and that there is a difference between a *need* and a *demand* for a service. These concepts are addressed later in this report.

Purpose

NHS England commissioned this Health and Social Care Needs Assessment primarily in order to inform their commissioning of healthcare services in the prison.

There is also a clear legislative expectation that regular and thorough health needs assessments are carried out for all prisons to ensure that the provision of services within a given establishment meets the needs of the inmate population, and that services are adapted to meet any changes in the population.

Her Majesty's Inspectorate of Prisons (HMIP) stipulates that the following governance arrangement must be in place:

> *Prisoners are cared for by a health service that accurately assesses and meets their health needs while in prison and which promotes continuity of health and social care on release.*[3]

An important indicator of this expectation is that:

> *Health services are informed by the assessed needs of the prison population and are planned, provided and quality assured through integrated working between the prison and its local health economy.* [4]

This Health and Social Care Needs Assessment ensures compliance with this indicator for this establishment.

The document is also intended to assist commissioners of prison healthcare services (NHS England) and the providers of these services.

Scope

As is always the case, there is a fine line between undertaking a health needs assessment and a service audit/review. This report focuses on describing the likely and actual health needs of

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[1] PHE (2014) Health and Justice health needs assessment toolkit for prescribed places of detention (parts 1 and 2). [Accessed 2/12/20].

[2] Cavanagh, S. & Chadwick, K. (2005) Health needs assessment: a practical guide. [Accessed 2/12/20].

[3] HMIP (2012) Expectations: criteria for assessing the treatment of residents and conditions in prisons. [Accessed 2/12/20].

[4] *Ibid.*

prisoners and the extent to which they appear to be being met, rather than assessing service efficacy.

Policy Context

Policy documents acknowledge the strong evidence base that prisoners have complex health and social care needs.[5]

> *Children, young people and adults in contact with the criminal justice system, or in detained settings, are more likely to smoke, misuse drugs or alcohol, have mental and physical health problems, report having a disability, self-harm or attempt suicide. Their lives are often further complicated by complex social and personal issues such as unemployment, low educational attainment or even homelessness. They are marginalised by society. As a consequence of all these influences, their lives are often cut short in a brutal manifestation of social and health inequality.*[6]

> *[H]omeless populations, individuals with substance use disorders, sex workers, and imprisoned individuals experience extreme health inequities across a wide range of health conditions, with the relative effect of exclusion being greater in female individuals than male individuals. The high heterogeneity between studies should be explored further using improved data collection in population subgroups.*[7]

The picture with mental health follows a similar pattern:

> There are more than 10 million prisoners worldwide, and the prevalence of all investigated mental disorders is higher than general population comparisons. Although the extent to which prison increases the incidence of mental disorders is uncertain, there is considerable evidence of low rates of identification and treatment of psychiatric disorders.[8]

Around 80% of prisoners in the UK are estimated to be suffering with some form of mental health problem, including substance misuse.[9] Following publication of The Bradley Report, there has been a significant focus on vulnerable adults caught up in the criminal justice system.[10] A national operating model has been developed for the roll-out of Liaison and Diversion (L&D) services, which now have a remit reaching beyond just mental health and covering a whole spectrum of vulnerabilities.[11] [12]

A consistent key aim of current government focus and policy is to reduce health inequalities.[13]

The NHS Long Term Plan[14] and NHS England Strategic Direction[15] are crucial policy documents which set a useful framework for a healthcare needs assessment, with a focus on areas including patient engagement, timely access to services and better access to secondary care.

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[5] Public Health England (2019) Health and justice annual review 2018/19 [Accessed 10/12/20].

[6] NHS England (2016) Strategic direction for health services in the justice system: 2016-2020. [Accessed 2/12/20].

[7] Aldridge, W. *et al.* (2018) Morbidity and mortality in homeless individuals, prisoners, sex workers, and individuals with substance use disorders in high-income countries: a systematic review and meta-analysis [Accessed 18/11/20].

[8] Fazel, S. *et al.* (2016) The mental health of residents: a review of prevalence, adverse outcomes and interventions. [Accessed 2/12/20].

[9] HM Government (2009) The Bradley Report: Lord Bradley's review of people with mental health problems or learning disabilities in the criminal justice system. [Accessed 2/12/20].

[10] *Ibid*.

[11] NHS England (2013) Liaison and diversion operating model 2013/2014. [Accessed 10/12/20].

[12] Prison Reform Trust (2016) WI members welcome additional £12 million government commitment to keep its care not custody promise. [Accessed 10/12/20].

[13] Marmot, M. *et al.* (2010) Fair society, healthy lives [Accessed 2/12/20]. NHS England (2015) Guidance for NHS commissioners on equality and health inequalities legal duties. [Accessed 2/12/20].

[14] NHS (2019) The NHS long term plan. [Accessed 10/12/20].

[15] NHS England (2016) Strategic direction for health services in the justice system: 2016-2020. [Accessed 10/12/20].

In 2016, NHS England set out three aims:

- *narrow the gap between those in criminal justice and detained settings and the rest of the population in terms of health and care outcomes, through improved support from all health and social care;*
- *reduce the number of people who are detained as a result of untreated health problems, and so support reductions in offending;*
- *and ensure continuity of care post release, and so support reductions in re-offending.*[16]

This sits within a wider duty to address health inequalities that is detailed in NHS England guidance.[17] The delivery of effective healthcare interventions in prison settings is an important component of this work that should not only improve the health of the prison population, but also the wider community.

The aim of 'equivalence' between community and prison healthcare was established in 2001.

> *[P]risoners should have access to the same range and quality of services appropriate to their needs as are available to the general population through the NHS.*[18]

In 2008, prison health performance indicators were developed to measure the quality of prison health services and to help meet the objective of giving prisoners *'the same range and quality of healthcare as the public receives from the NHS'*.[19]

From April 2013, the responsibility for commissioning health services in prisons came within the remit of NHS England. NHS England's responsibility also involves the commissioning of prison substance misuse services, which was previously the responsibility of local Drug Action teams.

NICE have produced a report titled 'Physical health of people in prison'[20] and a complementary report: 'Further mental health assessment and care planning for people in prisons and young offender institutions'.[21]

NHS England set out seven 'priority areas' for 2016-2020:

- *A drive to improve the health of the most vulnerable and reduce health inequalities*
- *A radical upgrade on early intervention*
- *A decisive shift towards person-centred care that provides the right treatment and support*
- *Strengthening the voice and involvement of those with lived experience*
- *Supporting rehabilitation and the move to a pathway of recovery*
- *Ensuring continuity of care, on perception and post release, by bridging the divide between healthcare services provided in justice, detained and community settings*
- *Greater integration of services driven by better partnerships, collaboration and delivery.*[22]

Furthermore, the NHS England National Commissioning Intentions for Health & Justice (2017-2018) set out priorities for people detained in secure settings as outlined below:

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[16] NHS England (2016) Strategic direction for health services in the justice system: 2016-2020. [Accessed 10/12/20].

[17] NHS England (2015) Guidance for NHS commissioners on equality and health inequalities legal duties. [Accessed 10/12/20].

[18] DH and HMPS (2001) Changing the outlook: a strategy for developing and modernising mental health services in prisons. [Accessed 10/12/20].

[19] NOMS, DH & HMPS (2007) Prison health performance indicators. [Accessed 10/12/20].

[20] NICE (2016) Physical health of people in prison. [Accessed 10/12/20].

[21] NICE (2017) Further mental health assessment and care planning for people in prisons and young offender institutions. [Accessed 10/12/20].

[22] NHS England (2016) Strategic direction for health services in the justice system: 2016-2020. [Accessed 10/12/20].

- *Commission services in all programme areas which meet the national **patient and quality safety standards**.*
- *Commission services to meet the **Intercollegiate Healthcare Standards for Children and Young People in Secure Settings** (CYPSS) across the Children and Young People's Secure Estate (CYPSE) and support the work of the **children and young people mental health transformation programme**.*
- *Continue to support NHS England's ambition to **reduce the incidence of suicide** as set out in the Mental Health Five Year Forward View, through the ongoing implementation of the agreed recommendations for healthcare from the Harris Review and Prison and Probation Ombudsmen investigations into **deaths in custody**.*
- *To improve the **quality assurance** of healthcare services commissioned across the secure and detained estate.*
- ***Engage and involve patients,** families and the public in the planning, commissioning and delivery of healthcare services within the secure and detained estate.*
- *Delivering specific pathways within prisons and detained settings to **support stepped care approaches in meeting mental health needs.** We will develop mental health treatment pathways between establishments and into the community and ensure mental health hospital transfers are timely and appropriately managed.*
- *We will seek to implement **specialist dementia care services** across appropriate prison settings.*
- *Reduce health inequalities by improving delivery and uptake of **national screening and immunisation** programmes.*
- *Further develop NHS England's public health section 7a commissioning responsibilities by ensuring the delivery of the phased roll-out of **smoke-free** prisons in England by improving and enhancing the delivery, uptake and effectiveness of smoking cessation programmes.*
- *Implementation of our new service specification for **adult substance misuse services** to support and drive improvement and continue to make effective links and care pathways with community provision with a focus on recovery (including new psychoactive substances, alcohol and dual-diagnosis and incorporating stop smoking services).*
- *Further establish **pathways for those moving through the custodial or detained estate** to better support and manage integrated care, the national "through the gate" programme and CYP transitions agenda. Continue to establish these pathways during the ongoing reconfiguration of the male and female estate.*
- *Embed phase 1 of the **Health and Justice Information System** and complete the phased roll-out during 2017/18.*
- *Continue to improve the quality of data and reporting of the **Health and Justice Indicators of Performance,** further extend the dataset to support key strategic programmes. Embed the new performance dashboard for individual establishments to improve transparency and commissioning.*
- *Support for the **justice reform agenda** which constitutes reforms to the adult prison estate, children and young people's secure settings, the courts and sentencing guidelines. We will support the development of **local co-production and commissioning arrangements** with prison governors and ensure a focus on reducing health inequalities, strengthening rehabilitation and supporting the contribution healthcare services can make to the reduction of reoffending.*

Prisoners present with a range of needs. The Care Act (2014) clarified the responsibilities of each local authority in respect of the social care needs of those resident in prisons within the authority area.

The Offender Rehabilitation Act (2014) supports the Transforming Rehabilitation programme and makes changes to both the sentencing and releasing framework, including the offer of more support for those on short-term sentences.

There are concerns which, to date, appear to be very real, that the impact of the Offender Rehabilitation Act and, in particular, the management of breaches, will increase the very short-term prison population. This is articulated in a consultation response to the document:

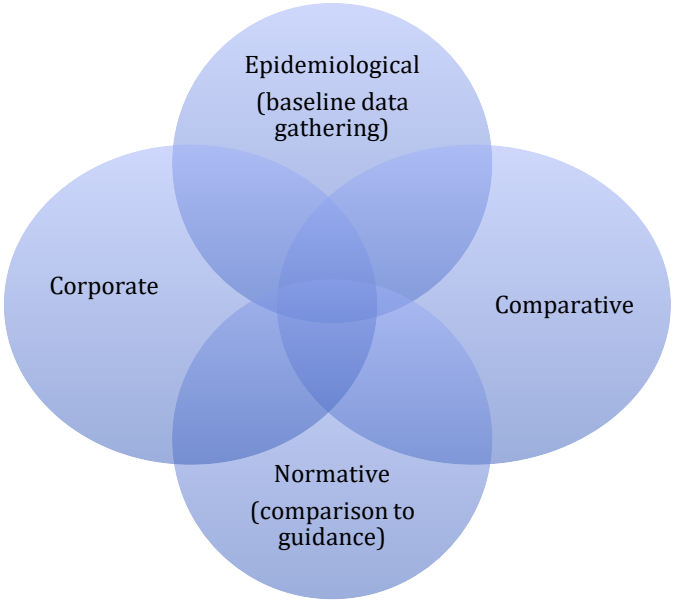
> *The Prison Reform Trust is particularly concerned that the proposals will result in an increase in breach and recall to custody, which will drive up the short sentenced prison population. As the Transforming*

Rehabilitation consultation acknowledges, many people serving short prison sentences have complex and multiple needs including homelessness, unemployment, drug and alcohol addictions, mental health needs and learning disabilities. This in turn increases the likelihood of breach and recall to custody if sanctions imposed for non-compliance are too onerous. The risk of breach and recall to custody is acknowledged but not quantified in the impact assessment.[23]

Methodology

The methodology acknowledges the guidance described in *Health Needs Assessment Toolkit for Prescribed Places of Detention*[24] and *Health and Social Care Needs Assessments of the Older Prison Population.*[25] The former is referred to in this document as the *HNA Toolkit.* In addition, we refer to the previous *Birmingham Toolkit*. Whilst it is a little dated, this document still provides a useful summary of the literature and highlights the likely major health needs of the prison population.[26]

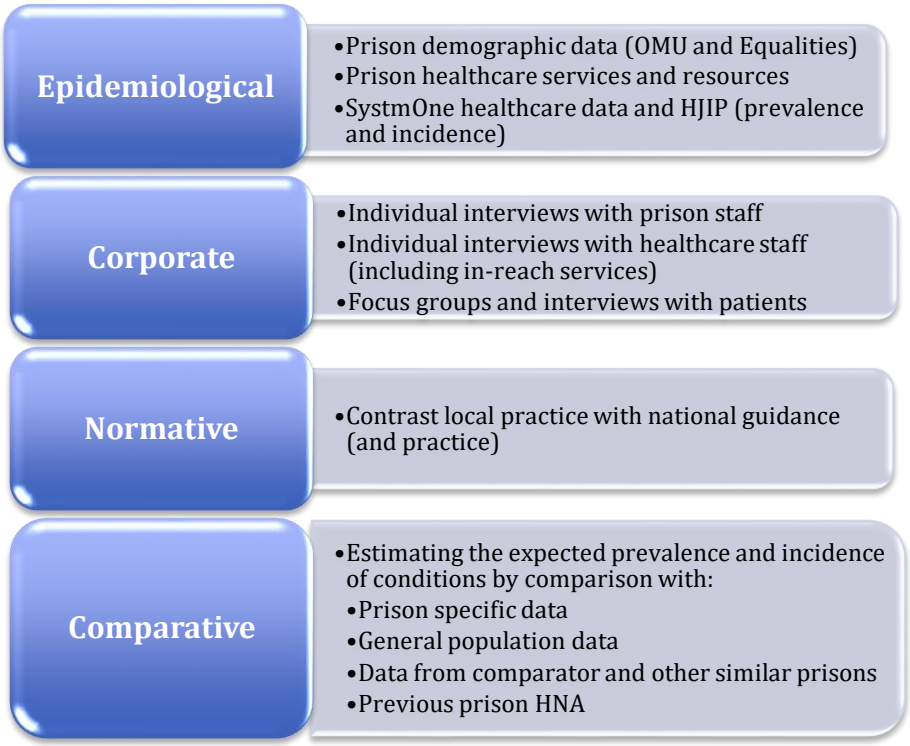
Figure 1 – Methodological Overview



For the purpose of this needs assessment, four distinct exploratory areas were interrogated to develop a full picture of need.

[23] Prison Reform Trust (2013) Offender rehabilitation bill. [Accessed 10/12/20].
[24] PHE (2014) Health and Justice health needs assessment toolkit for prescribed places of detention. Parts 1 and 2. [Accessed 2/12/20].
[25] PHE (2017) Health and social care needs assessments of the older prison population. [Accessed 2/12/20].
[26] Marshall, T. *et al.* (2000) Toolkit for health care needs assessment in prisons. [Accessed 2/12/20].

Figure 2 – Methodology



Epidemiological

Basic demographic data on prisoners was obtained from the Offender Management Unit (OMU) in the prison/s.

The prison healthcare database (SystmOne) was interrogated to look at prevalence of health conditions across the prisoner population. Often, the numbers (i.e. OMU and SystmOne) did not exactly match: the report cites the source at all relevant places and, occasionally, offers both sets of data.

The equalities team within the prison was asked to provide data about men with protected characteristics.

Corporate

A series of semi-structured, 1:1 interviews was undertaken with key stakeholders in the prison. These involved a cross-slice of both strategic and operational staff.

Patient (prisoner) views were gathered in the prison by means of a questionnaire, distributed and collected by healthcare.

There is a range of measures providing independent scrutiny to prisons. These are summarised below and the report draws on them all.

HM Inspectorate of Prisons (HMIP) reports directly to the government on the treatment of, and conditions for, people in prison in England and Wales and other matters. Prison establishments holding adults and young adults are inspected once every five years. Establishments holding juveniles are inspected every three years.

The Prisons and Probation Ombudsman (PPO) investigates all deaths that occur in prisons, young offender institutions, probation approved premises, and immigration removal centres, whatever the cause of death. After each investigation, the PPO produces a fatal incident report, which may provide information on current health services in prisons.

Independent Monitoring Boards (IMBs) are statutory bodies established by the Prison Act 1952 to monitor the welfare of prisoners in the UK to ensure that they are properly cared for within prison and immigration centre rules whilst in custody and detention. Each IMB produces an annual report, which often makes comments about the state of health services in the prison.

Care Quality Commission (CQC) now conducts joint inspections with HMIP and is working its way around the estate. In addition, when they inspect a community provider who reaches into prison, there may be relevant commentary. CQC inspects against a number of standards; the standards and the number will vary between inspections.

Health and Justice Indicators of Performance (HJIPs). These performance measures have been developed by NHS England, Public Health England (PHE) and HM Prison and Probation Service (HMPPS).

Normative

This is not a service review; the report does not set out to evaluate practice. In a few instances where there is clear guidance or good practice, resources which are likely to impact on the identification of, or capacity to respond to need, these are noted. Examples include reference to Prison Service Instructions or NICE guidelines.

Comparative

Accompanying the *Toolkit* referred to above, Marshall *et al.* conducted a health needs assessment for the entire prison estate.[27] This took the form of a meta-analysis of published work to give both prevalence and incidence estimates for a wide range of conditions that present to healthcare. This document is subsequently referred to as the *Birmingham HNA.* As noted above, whilst rather dated, because it is so comprehensive, this still forms the baseline comparator data for many conditions across the prison estate. Where there is more recent, or more appropriate published data, we have replaced the *Birmingham HNA* data and made this clear in the referencing.

The demographics of the prison are outlined. Sources may vary depending upon the kinds of comparisons being made, but all are acknowledged in the referencing.

Any previous HNA is reviewed and comparisons have been made with the data from this time to illustrate change.

The report contains details of the Ministry of Justice (MOJ) list of 'comparator prisons' (i.e. those which are considered to be similar in size, population type, etc.). Where HNA data is available, it is referenced through the report.

[27] Marshall, T. *et al.* (2000) Toolkit for health care needs assessment in prisons. [Accessed 2/12/20].

The MOJ selection of comparators is largely informed by size and security status. From a health perspective, security status is less relevant than turnover and demographic factors. In addition, our team has collated data from over 175 HNAs which we have delivered. We have extracted relevant data from these and include it where applicable.

Defining Prevalence, Incidence and Demand

Throughout, the report attempts to distinguish between *prevalence*, *incidence* and *demand*.

Prevalence gives a figure at a single point in time. Prevalence is normally expressed as a percentage. For example, based on published studies, noting the link between prevalence and deprivation, we predict that the prevalence of diabetes in a prison population will be in excess of 9.6% for adult males.[28] Thus, for example, given an operational capacity (op cap) of 500, this predicts 48 men will have the condition. It is a *static* prediction and does not take into account possible changes. This is one approach to demand. An additional approach is to think about the turnover, i.e. how many cases healthcare will have to manage in a year. Here, taking the same prevalence estimate of 9.6%, but this time multiplying it by the predicted number of people seen in a one-year period (population on day one plus new receptions), for example: (1,500 new receptions per annum + op cap 500) x 9.6% = 192 cases per annum. The latter relates to *incidence*.

Incidence is defined by the Royal College of Nursing as:

> *the number of instances of illnesses commencing, or of persons becoming ill during a given period in a specific population.*[29]

For the purpose of this HSCNA, we define incidence as new cases coming to the prison in a given period (e.g. per year). In a prison setting, this primarily relates to the number of new receptions. Those prisons with higher turnover rates will have higher incidence, so any changes in turnover will significantly impact on healthcare demand.

The prevalence (i.e. the needs of the static population) for many conditions (such as asthma) may have only a small impact on healthcare resources – for example, just performing annual reviews. However, the incidence potentially places a huge demand on healthcare as the result of reception screening identifying new (whether a *new condition* or more likely *new to the prison*), often previously unmanaged conditions.

It is unrealistic, and indeed unsound, to attempt to design a healthcare system to meet every possible need (or manifestation of that need) based on what evidence tells us about prevalence and incidence. The issue of *demand* differs widely depending on the actual health condition. Demand is also, in part, influenced by the service model that commissioners want to commission. For example, a service modelled on wellbeing may well increase demand for certain physical healthcare conditions, such as hypertension, as more prisoners prioritise taking blood pressure checks, or as Health Trainers are increasingly used to undertake such activities. This approach typically uncovers previously unidentified and unmet needs.

In many cases, not all those with a condition will present for treatment. We would expect a high proportion of those with type 1 diabetes to engage with healthcare because they will be insulin dependent. Therefore, the levels of incidence are likely to be similar to demand.

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[28] PHE (2016) Diabetes prevalence model. [Accessed 2/12/20].

[29] Shields, L. (2003) The difference between incidence and prevalence. [Accessed 2/12/20].

However, there will be men with type 2 diabetes who are undiagnosed and, indeed, some who are aware of their condition and choose to self-manage. The same applies to mental health conditions where we would expect to see a large difference between the prevalence/incidence and subsequent demand for services.

National studies estimate that between 30 and 85% of people with mental health problems go undiagnosed.[30] Additionally, a further 11-12% of individuals decline medication/psychosocial interventions and 6.2% of individuals meeting diagnostic criteria for mental health services do not require a service.[31]

The Department of Health (DH) states that less than 33% of people with diagnosable depression, and less than 25% of people with anxiety disorders, are in treatment.[32] For the purpose of this HSCNA, in modelling demand for services, we took a combined identification and entry to treatment figure of 50% of incidence as the demand for mental health services.

Looking to substance misuse services, establishments receiving individuals from the community will be managing acute detoxifications; they will see a greater proportion of untreated conditions. However, establishments that receive prisoners only from other prisons will, in general, be seeing a more stable population who have previously been screened by prison healthcare and should have ongoing conditions that are managed. For example, they would not be treating acute alcohol detoxification. In terms of the broader definition of incidence, there will be new cases where prisoners develop, or are diagnosed with, conditions at all points throughout the prison system. Thus, any reports and calculations we offer in respect of incidence only present part of the picture and cannot describe the full picture.

Efficiency/DNA rates

If a booked patient does not arrive at an appointment, most healthcare providers will separately report 'no access visits'. This is where the reason for non-attendance is outside of the patient's direct control, for example, he was not unlocked or was in court. Did Not Attend (DNA) is where the patient was able to attend but chose not to. Both of the above combine to significantly impact the efficiency of many prison healthcare providers.

Prisoners miss an average of 15% of medical appointments, largely because of a lack of staff to escort them.[33]

The NHS does not centrally collate non-attendance rates in the community, though there are various reports, usually based on surveys. An example is a quoted 5.34% DNA for appointments with GPs or other practice staff.[34] Local studies describe higher DNA rates, for example 7% of follow up appointments in Cambridgeshire hospitals.[35]

[30] Unity Behavioural Health (2018) Why mental illness often goes undiagnosed and untreated. [Accessed 8/12/20].
[31] Boardman, J. *et al.* (2004) Needs for mental health treatment among general practice attenders. [Accessed 2/12/20].
[32] DH (2011) A practice-based commissioning business case for IAPT. [Accessed 10/12/20].
[33] House of Commons (2017) Committee of public accounts mental health in prisons eighth report of session 2017–19. [Accessed 8/12/20].
[34] GPonline (2018) Next-day GP appointments three times as likely to be missed as same-day bookings. [Accessed 2/12/20].
[35] Cambridge News (2017) Numbers of patients missing appointments at Cambridgeshire hospitals on the rise. [Accessed 2/12/20].

Prisoner Demographics – Determinants of Health

Age

The age of prisoners is particularly relevant to a health needs assessment, as some health conditions are highly correlated with age, with the risk/prevalence increasing commensurate with age. This applies to both physical health (e.g. diabetes, coronary heart disease), and mental health (e.g. ADHD, depression and dementia). In addition, patterns of substance misuse change with age.

In considering healthcare needs, there is a great deal of discussion about older prisoners, including recent PHE guidance 'Health and Social Care Needs Assessments of the Older Prison Population'[36] and a thematic review by HMIP and CQC: 'Social care in prisons in England and Wales'.[37]

For the general population, the National Service Framework (NSF) for Older People[38] distinguishes three groups of older people:

- **Entering old age** These are people who have completed their career in paid employment and/or child rearing. This is a socially-constructed definition of old age, which, according to different interpretations, includes people as young as 50, or from the official retirement ages [which was] 60 for women and 65 for men. These people are active and independent and many remain so into late old age.
- **Transitional phase** These are people in transition between a healthy, active life and frailty. This transition often occurs in the seventh or eighth decades but can occur at any stage of older age.
- **Frail older people** These people are vulnerable as a result of health problems such as stroke or dementia, social care needs or a combination of both. Frailty is often experienced only in late old age so services for older people should be designed with their needs in mind.

Noting the premature ageing effect of prison, HMIP and CQC observe:

> *In the general population, it estimates that around 10% of those aged over 65 years have frailty, rising to 25–50% of those over 85.*[39]

There have been different definitions of 'older' prisoners; for the purposes of this report the definition is 50+. When describing the prison population, this definition has been adopted by HMPPS[40] and HMIP[41], it is consistent with those of: AGE UK, the Prison Reform Trust and the charity RECOOP (Resettlement and Care for Older Ex-Offenders and Prisoners).[42]

The general population is ageing and the numbers of older prisoners in the UK have risen sharply in recent years, and this trend is continuing.

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[36] PHE (2017) Health and social care needs assessments of the older prison population. [Accessed 2/12/20].
[37] HMIP and CQC (2018) Social care in prisons in England and Wales. [Accessed 2/12/20].
[38] DH (2001) National service framework for older people. [Accessed 2/12/20].
[39] HMIP and CQC (2018) Social care in prisons in England and Wales. [Accessed 2/12/20].
[40] Noted in PHE (2017) Health and social care needs assessments of the older prison population. [Accessed 10/12/20].
[41] HMIP and CQC (2018) Social care in prisons in England and Wales. [Accessed 10/12/20].
[42] UK Parliament (2013) Written submission from RECOOP. [Accessed 10/12/20].

> *Older people are the fastest growing age demographic in prisons and the only group to nearly double in size over the last decade.*[43]

> *Older people now comprise more than 1/6 of the prison population in England and Wales.*[44]

> *By 2035 the number of people aged 85 and over is projected to be almost 2½ times larger than in 2010.*[45]

However, it also interesting to note that the number of male 15-17 year olds in prison in England and Wales increased by 19% between 30th June 2016 and 30th June 2020.[46]

Even prior to the recent prosecutions for historic sex offences, 'older prisoners' was the fastest growing subgroup in the UK prison population. When HMIP published their thematic report in 2004,[47] they described 1,700 'older prisoners.' At this time 'older was defined as over 60 years. Fourteen years later, the definition of 'older' is now 50 years plus and the number is 13,522.[48]

The current focus on historic sex offences has significantly exacerbated this trend. The MOJ predicts this trend to continue, and that the over 50s (and over 60s) population is projected to continue growing, both in real terms and as a proportion of the total prison population.

In spite of an overall fall in prisoner numbers, in the period 2002 to 2011, the proportion of male prisoners who are aged over 60 doubled from 2% to 4%.[49] By 2020, this proportion is projected to reach 6.4%.[50] This may not sound massive, but put another way:

> *As at the end of March 2016 the number of prisoners aged 50 or over was 161% higher than the number in 2002.*[51]

This trend is projected to continue; in March 2016, there were 12,577 residents aged 50 and over in England and Wales. By March 2020, this had risen to 13,765.[52]

The Department of Health recognises that older people have a *'wide range of health and social care needs'*.[53] The term *'frail'* is becoming more commonly used in prisons; RCGP offers guidance for care of this group.[54]

As prisons continue to receive older men who have never been in prison before, some are facing lengthy sentences which may means they will end their days in prison. This will have an impact on the demand for end of life care.[55] The Prison Reform Trust states that:

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[43] Public Health England (2018) Health and Justice annual review 2017/18. [Accessed 10/12/20].

[44] *Ibid.*

[45] Joint Commissioning for Mental Health Panel (2013) Guidance for commissioners of older people's mental health services. [Accessed 10/12/20].

[46] Ministry of Justice and HM Prison Service (2020) Offender management statistics quarterly. [Accessed 2/12/20].

[47] HMIP (2004) 'No problems old and quiet': older residents in England and Wales. [Accessed 2/12/20].

[48] HMIP and CQC (2018) Social care in prisons in England and Wales. [Accessed 2/12/20].

[49] Senior, J. *et al*. (2013) Health and social care services for older male adults in prison: the identification of current service provision and piloting of an assessment and care planning model. [Accessed 2/12/20].

[50] MOJ (2016) Prison population projections 2016-2021 England and Wales. [Accessed 10/12/20].

[51] House of Commons Library (2016) Prison population statistics. [Accessed 2/12/20].

[52] Ministry of Justice and HM Prison Service (2020) Offender management statistics March 2020. [Accessed 2/12/20].

[53] See for example DH (2001) National service framework for older people. [Accessed 2/12/20].

[54] RCGP (2016) Integrated care for older people with frailty. [Accessed 2/12/20].

[55] Risk assessment for early release on compassionate grounds includes both reference to the length of time served and the nature of the offence. See NOMS (2012) PSI 21/2012. Release on temporary licence (ROTL). [Accessed 2/12/20].

As the prison population ages, more residents will die of natural causes while in prison.[56]

PPO focusses on this issue in their report Older Prisoners[57] which was informed by their enquires arising from deaths in prison from natural causes.

For those returning to the community, the Department of Health notes specific needs of older prisoners on release.[58] In 2014, HMIP conducted a review of older prisoner care and raised concerns that older prisoners' needs were not planned or provided for after release.[59] Despite this issue being raised on many occasions over many years, the most recent reports continue to raise the same concerns.[60]

A number of studies describe the health of older prisoners as being equivalent to someone in the community who is some 10 years their senior,[61] the thinking behind this was that prisoners were stereotypically from the lower socio-economic groups. Health and wellbeing are closely correlated to socio-economic status. For example, someone born in the highest socio-economic group enjoys eight years' longer life expectancy than someone born to the lowest socio-economic group.[62] A broad-brush approach for understanding the health needs of prisoners is to take health indicators for the most deprived cohort in society and assume prisoners will be at the lower ends of this. Note that observations of older men imprisoned for the first time in later life, typically for historic sex offences, are now challenging this thinking.

Over half of all elderly prisoners suffer with some form of mental health issue, with depression being the most common, and over 80% of sentenced male prisoners aged 60 or over suffer from a chronic illness or disability.[63]

Lifestyle factors negatively impact long-term health. Prevalence rates for smoking amongst residents are perhaps four times greater than in the community, approximately 80% of all residents smoked before imprisonment[64] compared with 15% of the general population.[65] Estimates vary, a recent study reports that 24% of residents have an alcohol problem.[66] There are no directly comparable community equivalent studies. In the community, 22% of men report drinking more than 21 units per week.[67] Thirty per cent of residents have a drug problem at reception.[68] In the community, 9.0% of adults report taking any drug in the previous 12 months, just 3.5% had taken a Class A drug in the previous 12 months.[69]

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[56] Prison Reform Trust (2019) Bromley briefings prison factfile. [Accessed 3/12/20].

[57] PPO (2017) Older prisoners. [Accessed 2/12/20].

[58] Prison Reform Trust (2008) Doing time: the experiences and needs of older people in prison. [Accessed 2/12/20].

[59] HMIP (2004) 'No problems old and quiet': older residents in England and Wales. [Accessed 2/12/20].

[60] HMIP and CQC (2018) Social care in prisons in England and Wales. [Accessed 2/12/20].

[61] Prison Reform Trust (2008) Doing time: the experiences and needs of older people in prison. [Accessed 2/12/20].

[62] ONS (2016) Trend in life expectancy at birth and at age 65 by socio-economic position based on the national statistics socio-economic classification, England and Wales. [Accessed 2/12/20].

[63] Prison Reform Trust (2008) Doing time: the experiences and needs of older people in prison. [Accessed 2/12/20].

[64] Data from recent TamlynCairns HNAs.

[65] DH (2015) Statistics on smoking England 2018. [Accessed 2/12/20].

[66] Fazel, S. *et al.* (2017) Substance use disorders in residents: an updated systematic review and meta-regression analysis in recently incarcerated men and women. [Accessed 2/12/20].

[67] Health and Social Care Information Centre (2015) Health survey for England – 2014 trend tables. [Accessed 2/12/20].

[68] Fazel, S. *et al.* (2017) Substance use disorders in residents: an updated systematic review and meta-regression analysis in recently incarcerated men and women. [Accessed 2/12/20].

[69] CSEW (2018) Drug misuse: findings from the 2017/18 crime survey for England and Wales. [Accessed 2/12/20].

Fifteen per cent of prisoners in the sample reported being homeless before custody. Three and a half per cent of the general population reported having ever been homeless.[70]

> *Homeless men and women die young – by an average age of 47 for men and 43 for women. This compares to 79.5 for males and 83.1 for females in the general population.*
> *An estimated 41% of people classified as 'rough sleepers' have long-term physical health problems such as heart disease, diabetes and addiction problems, compared to 28% of the general population. Another 45% have been diagnosed with mental health issues, compared to 25%.*[71]

The assumptions behind the assertion that prisoners faced unique health challenges were valid, but especially for older male prisoners these are decreasing in relevance. In describing the demographic traits, one study describes older sex offenders as being '*of higher socioeconomic status, having stable backgrounds'*.[72]

A recent phenomenon is elderly men serving their first sentence, which negates any perceived health impact arising from spending large periods of adult life in prison.

Sex offenders represent a broad cross section of society and, for this section of the prison population, we should therefore assume average prevalence when looking at most conditions.

Gender

The vast majority of the prison population is male, with 92% or 76,259 male residents.[73]

Data is not regularly collected, but according to MOJ, there were 163 transgender residents in the population in 2019. 129 prisoners reported their legal gender as male, 32 as female and 2 did not state their legal gender.[74] The transgender pathway is discussed separately.

Ethnicity and Nationality

> *In March 2019, prisoners who declared themselves in the White ethnic group made up almost three quarters (59,911 or 73%) of the prison population in England and Wales. Prisoners who declared their ethnicity as Black, Asian or Minority Ethnic (BAME) represented 22,227 (or 27%) of all prisoners.*[75]

This indicates that prisoners from a 'non-white' ethnic group are over represented in prison, considering that 86% of the national population is white.[76] However, sexual offenders are more likely to be from UK white ethnic backgrounds, with 82% of those convicted and sentenced to prison being white. Whilst the numbers convicted have increased, the ethnic make-up has been consistent since 2005.[77]

The older population has been the least ethnically diverse age group; the projections are that, as over time the older population grows, it will also become more ethnically diverse.[78]

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[70] MOJ (2012) Accommodation, homelessness and reoffending of residents: Results from the Surveying Prisoner Crime Reduction (SPCR) survey. [Accessed 2/12/20].
[71] Seria-Walker, E. (2018) The inequalities of homelessness – how can we stop homeless people dying young? [Accessed 2/12/20].
[72] Clark, C. and Mezey, G. (1997) Elderly sex offenders against children: a descriptive study of child abusers over the age of 65. [Accessed 2/12/20].
[73] Ministry of Justice and HM Prison Service (2020) Offender management statistics. [Accessed 2/12/20].
[74] Ministry of Justice (2019) Her Majesty's prison and probation service offender equalities annual report 2018/19. [Accessed 2/12/20].
[75] Ministry of Justice (2019) Her Majesty's prison and probation service offender equalities annual report 2018/19. [Accessed 2/12/20].
[76] Gov.uk (2020) Population of England and Wales. [Accessed 2/12/20].
[77] MOJ, ONS and HO (2013) An overview of sexual offending in England and Wales. [Accessed 2/12/20].
[78] See for example: Lievesley, N. (2010) The future ageing of the ethnic minority population of England and Wales. [Accessed 2/12/20].

Whilst there is a direct correlation between ethnicity and some healthcare concerns, in most prisons the numbers are not really great enough to impact overall health needs. The type of issues typically noted include: coronary heart disease (CHD) being more prevalent in South Asian men and, whilst numbers are very low, sickle cell anaemia being far more prevalent in black Africans and black Afro-Caribbean men.

Across the English prison estate, 12% of the prison population consists of foreign nationals (this is a slight decrease on the 13% cited later in this report); however, in Welsh prisons this percentage was much lower, at just 5%.[79] We would expect to see higher rates of post-traumatic stress disorder (PTSD) amongst foreign nationals originating from conflict zones, potentially higher rates of HIV especially amongst those from sub-Saharan Africa, and lower rates of immunisation where programmes are less well developed. In some cases, language barriers add complexity to delivering healthcare. Foreign national residents were disbursed throughout the estate, MOJ proposals are to manage this differently in the future with more dedicated foreign national prisons.

Disability

The World Health Organisation (WHO) defines disability as the following:

> *Disability is an umbrella term, covering impairments, activity limitations and participation restrictions. An impairment is a problem in body function or structure; an activity limitation is a difficulty encountered by an individual in executing a task or action; while a participation restriction is a problem experienced by an individual in involvement in life situations. Thus disability is a complex phenomenon, reflecting an interaction between features of a person's body and the society in which he or she lives.*[80]

As a result of a move in 2004 to include prisons within the Disability Discrimination Act, prisons must now ensure that services are accessible for those with disabilities. This duty was further clarified in Prison Service Instruction 32-2011.[81] Disability is a protected factor, so an aspect of the work for the prison's equalities team.

It is estimated that 29% of male residents say they have a disability; this rises to 38% in residents over the age of 50, above the age of 70 years three times more residents describe a disability than do not.[82] As the older prisoner population continues to rise nationally, we can expect to see the number of residents with disabilities increase.

There are clear links between general health and broader disability; of the five types of chronic illness identified as contributing most significantly to disability in people aged over 65, four are physical conditions.[83]

These are:

- Foot problems
- Arthritis
- Heart problems
- Vision

[79] Ministry of Justice (2019) Prison population December 2018. [Accessed 2/12/20].
[80] WHO (2015) Disabilities. [Accessed 2/12/20].
[81] NOMS (2011) SSI 32/2011 ensuring equality. [Accessed 2/12/20].
[82] HMIP (2018) Annual report 2017-18. [Accessed 3/12/20].
[83] Christensen, K. *et al.* (2009) Ageing populations: the challenges ahead. [Accessed 3/12/20].

Other common problems include hearing impairment, chronic obstructive pulmonary disease (COPD) and falls and hip fractures.[84]

Armed Forces Veterans

Military personnel constitute an interesting group of individuals as they are frequently referred to as vulnerable from a healthcare perspective, yet from an equalities perspective, this is not a 'protected factor'. However, it is more likely that the roots of their vulnerabilities are aligned to their social care needs in the community.

The proportion of the prison population who are veterans is not always clear.

> *Within the prison system, although prison data systems do have a question about veteran status, this is not routinely completed. Some veterans are also known to be reluctant to identify themselves in the prison system either due to fears of reprisal or due to stigma.*[85]

HMIP estimates that 13% of Category B residents are veterans; this is a far higher proportion than in lower security categories, at 7%.[86] The estimate is informed by the HMIP self-report prisoner surveys. This estimate is far higher than the MOJ estimates for the whole estate of some 2,032 veterans (4% of residents) in England and Wales.[87]

Howard League for Penal Reform report states:

- *Armed Forces Veterans are less likely to go prison than their respective civilian populations, but when they do, veterans are more likely to be serving sentences for violent and sexual offences.*
- *32.9% of veterans are in prison for violence against the person, compared to 28.6% of the non-veteran prison population.*[88]

HMIP described veterans as more likely to be first-time prisoners (54% compared to 34% of the whole prison population), also serving longer sentences (39% serving over 10 years compared to 26% of the general prison population), and more likely to be imprisoned for sex offences (24.7% as opposed to 10.9% of the general prison population).[89]

HMIP describes additional health and social care related issues that are specific to veterans:

- *Ex-service personnel were more likely to report feeling depressed or suicidal on arrival into prison (18% compared with 14%).*
- *The incidence of physical health problems on arrival into prison was higher among ex-service personnel than the general prisoner population (24% compared with 13%).*

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[84] Griffith, L. *et al.* (2010) Population attributable risk for functional disability associated with chronic conditions in Canadian older adults. [Accessed 3/12/20].

[85] CIE (2016) From gate to gate: improving the mental health and criminal justice care pathways for veterans and family members. [Accessed 3/12/20].

[86] HMIP (2014) People in prison: ex-service personnel a findings paper by HM Inspectorate of Prisons. [Accessed 3/12/20]. Note this is a greater figure than the 8% for Cat B prisons in: HMIP (2014) Ex-service personnel supplementary paper: veteran data from HM Inspectorate of Prisons' inspection surveys. [Accessed 3/12/20].

[87] MOJ (2018) Ex-service personnel in the prison population, England and Wales. [Accessed 3/12/20].

[88] Howard League for Penal Reform (2010) Report of the inquiry into former armed service personnel in prison. [Accessed 3/12/20].

[89] HMIP (2014) People in prison: ex-service personnel a findings paper by HM Inspectorate of Prisons. [Accessed 3/12/20]. Note this is a greater figure than the 8% for Cat B prisons in: HMIP (2014) Ex-service personnel supplementary paper: veteran data from HM Inspectorate of Prisons' inspection surveys. [Accessed 3/12/20].

- *A higher proportion of prisoners identifying as ex-service personnel stated they had a disability (34% compared with 19% of the general prisoner population).*[90]

A study at King's College London has been investigating the health and wellbeing of UK armed forces personnel since 2003.[91] It reported in 2011 that they have found no major differences in the psychological health of armed forces personnel who have been deployed to Iraq and Afghanistan compared to those who haven't. PTSD is widely publicised by the media as affecting many serving personnel but the study found that, while most who had been deployed did not return with a mental health issue, those who do tend to display symptoms of anxiety, depression or alcohol misuse.

Homelessness

There is little published data on the housing status of prisoners prior to imprisonment. MOJ says 15% of prisoners were homeless prior to imprisonment.[92] Homelessness is strongly correlated with poor outcomes on release.

> *Securing stable and appropriate accommodation is essential for enabling people to progress on their journey to desistance.*[93]

[90] Griffith, L. *et al.* (2010) Population attributable risk for functional disability associated with chronic conditions in Canadian older adults. [Accessed 3/12/20].

[91] Kings College London (2011) Health and wellbeing survey of UK armed forces personnel. [Accessed 3/12/20].

[92] MOJ (2012) Accommodation, homelessness and reoffending of residents: results from the surveying prisoner crime reduction (SPCR) survey. [Accessed 3/12/20].

[93] Clinks (2017) Clinks Briefing Are the accommodation needs being met for people in contact with the criminal justice system? [Accessed 3/12/20].

Physical Health

Thirteen per cent of male residents across England and Wales aged under 50 years said they had a physical health problem. This rose to 24% in over 50s.[94] Thirty-six per cent of people in prison are estimated to have a physical or mental disability compared with 19% of the general population:[95]

> *11% have a physical disability, 18% have a mental disability and 7% have both.*[96]

Long-Term and Chronic Conditions

> *A long-term condition is any medical condition that cannot currently be cured but can be managed with the use of medication and/or other therapies… Currently approximately 70% of the health spend in England is on 30% of the population who have LTCs.*[97]

Studies of the wider community show how the prevalence of a wide range of long-term conditions (LTCs) is greater in older people (58% of people over 60 compared to 14% under 40).[98] There is a strong link between LTCs and social inequalities – compared to the highest social class, those in the lowest social class in England have a 60% higher prevalence of LTCs and 30% higher severity of conditions.[99]

> *[A]ll the NICE guidelines, all the pathways, are designed for people allegedly with only one condition, but most people have multiple conditions.*[100]

Residents with one or more long-term and chronic diseases are typically repeat users of prison healthcare services.

Following the conventional approach in the *Toolkit*, this report largely focuses on individual conditions; however, a patient may have a complex presentation of two or more comorbid conditions. The prevalence of comorbidity is age-related; 44% of those over 75 years old live with more than one LTC,[101] so this will be an increasing feature in an ageing prison population. This underlines the increasing importance of having clinicians who specialise in long-term conditions and a coordinated approach to the management of these conditions.

The following outlines the strong correlation of LTCs by age:

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[94] HMIP (2019) Annual report 2018-19. [Accessed 3/12/20].

[95] Prison Reform Trust (2019) Bromley briefings prison factfile. [Accessed 3/12/20].

[96] *Ibid.*

[97] BMA Briefing Paper (2016) Living with long term conditions. [Accessed 3/12/20].

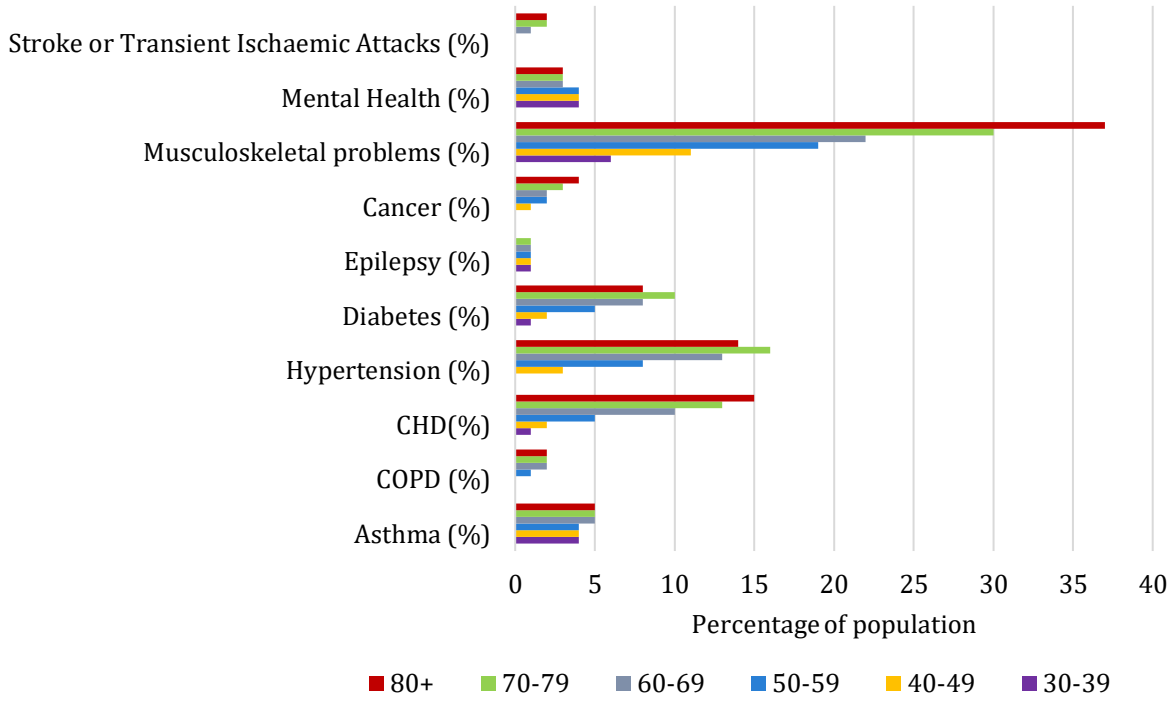
[98] Department of Health (2012). Long term conditions compendium of information: third edition. [Accessed 3/12/20].

[99] *Ibid.*

[100] House of Commons Health Committee (2014) Managing the care of people with long–term conditions. [Accessed 3/12/20].

[101] Royal College of General Practitioners (2016) Responding to the needs of patients with multimorbidity: A vision for general practice. [Accessed 3/12/20].

Figure 3 – Proportion of People in the General Population with LTC by Age (2009)[102]



Asthma

Unlike other chronic conditions, asthma is more prevalent in younger age groups; it is the most common chronic condition in children. In many cases described in the prison population, a prisoner self-reports the condition, which may have been suggested or given in childhood and is no longer relevant. Therefore, the healthcare screened numbers are typically lower than the self-report numbers.

Research indicates that prevalence may be decreasing over time.[103] The prevalence data in the current *Toolkit* is derived from the *Birmingham HNA*.[104] The sources cited date from 1996, which is 20 years old, and is based on presentations to general practice in the community, and thus should be noted with caution.

The table below is based on the Birmingham prevalence data and shows the estimated prevalence of asthma among the prison population, broken down by age category; unfortunately, the oldest grouping is 45+.

Figure 4 – Estimated Prevalence of Asthma by Age (male prisoners)

Age Band	Wheezing in the last year	Diagnosed Asthma	Treated Asthma
15-24	20%	19%	7%
25-34	19%	12%	5%
35-44	18%	11%	4%
45+	19%	8%	4%
Total	19%	14%	5%

[102] Department of Health and Social Care (2012). Long term conditions compendium of information: third edition. [Accessed 3/12/20].

[103] Simpson, C.R. & Sheikh, A. (2010) Trends in the epidemiology of asthma in England: a national study of 333,294 patients. [Accessed 3/12/20]. Sears, M. (2014) Trends in the prevalence of asthma. [Accessed 3/12/20].

[104] Marshall, T. *et al.* (2000) Health care in prisons: a health care needs assessment. [Accessed 2/12/20]. Prison population derived from Home Office statistics 31 December 1998. Citing Prescott-Clarke, P. *et al.* (1998) Health Survey for England 1996. [Accessed 3/12/20].

The British Lung Foundation state 'over 12% of the population' has a diagnosis for asthma.[105]

COPD

COPD is a term that includes a number of conditions, including chronic bronchitis and emphysema.

Smoking tobacco is seen as the major risk factor,[106] as noted elsewhere in this report smoking rates are high amongst residents. Also, there are anecdotal concerns of an increasing prevalence amongst drug users who heeded the message not to inject and instead have been smoking drugs, sometimes for many years.

The *Toolkit* does include COPD, but the *Birmingham HNA* did not include the condition; prison-specific reference data is difficult to obtain. The most recent national data is from Association of Public Health Observatories (APHO) in 2011 and indicates a prevalence of 4.5% in males over the age of 16 years in England.[107] The community data also shows that COPD is highly age-correlated. A more recent BMJ article states the 2011 figures are an under estimate.[108]

Figure 5 – Estimated Prevalence of COPD in Males by Age (2011 community data)[109]

Age	Prevalence of COPD (%) (England)
16-44	1.3%
45-64	4.2%
65-74	8.3%
75+	9%
Total	-

Coronary Heart Disease (CHD)

CHD is also referred to as Ischaemic Heart Disease.

A variety of factors, including high rates of smoking, combine to mean that in contrast to the general population, residents are at heightened risk of cardiovascular disease.[110]

The prevalence of CHD is highly age-correlated. In addition, the British Heart Foundation reports that CHD is 2.9 times more prevalent in men from the lowest socioeconomic group compared to the highest.

Figure 6 shows a pronounced increase in prevalence of CHD in older age groups. The most recent British Heart Foundation data on CHD prevalence broken down by age dates from 2006, but Public Health England estimates from 2011 are categorised similarly.[111] Allowing for

[105] British Lung Foundation (2020) Asthma statistics. [Accessed 10/12/20].

[106] WHO Factsheet (2017) Chronic obstructive pulmonary disease (COPD). [Accessed 3/12/20].

[107] APHO COPD prevalence estimates Dec 2011. [Accessed 9/12/20]

[108] Snell, N. *et al.* (2016) Epidemiology of chronic obstructive pulmonary disease (COPD) in the UK: findings from the British lung foundation's 'respiratory health of the nation' project. [Accessed 3/12/20].

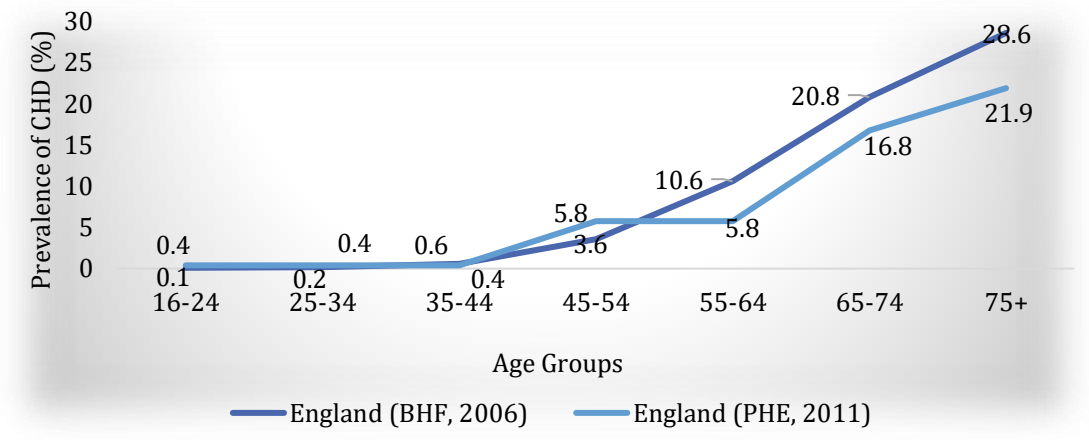
[109] *Ibid.*

[110] Aries, E. (2013) Cardiovascular risk factors among residents: an integrative review. [Accessed 3/12/20].

[111] PHE (2013) CHD prevalence estimates 2011. More recent British Heart Foundation publications do not present age breakdowns for CHD as a whole, but rather for specific conditions, e.g. angina, stroke and myocardial infarction. [Accessed 3/12/20].

methodological differences in the data collection between the two organisations, we notice a marked decrease in the CHD prevalence rates between 2006 and 2011.

Figure 6 – Prevalence of CHD in Men by Age[112]



For registered GP patients, the all-age prevalence of CHD in England in 2011 was 5.7% for males and 3.5% for females (4.6% for all adults).[113] The England prevalence for diagnosed hypertension is 13.8%.[114] These figures are lower than the overall prevalence, because not all those with the conditions have this registered with a GP (PHE estimates that a further 12% of the population have undiagnosed hypertension, for example). Many patients with these conditions can manage their care themselves and good outcomes can depend on the patient attending to this. Lifestyle choices significantly impact on risk and the following are examples of steps that can be taken to reduce risk: discontinuing smoking, making healthier food choices, increasing aerobic exercise, and moderating alcohol consumption.

The tables below are taken from a 2012 British Heart Foundation publication, thus are dated, but more recent publications do not include the same detailed age breakdown.

Figure 7 – Hypertension (prevalence - males)[115]

	Treated	Untreated	Total
16-24	0	5%	5%
25-34	0	6%	6%
35-44	1%	20%	21%
45-54	2%	22%	24%
55-64	12%	20%	32%
65-74	21%	18%	39%
75+	25%	12%	37%
All ages	7%	15%	22%

[112] British Heart Foundation (2012) Coronary heart disease statistics 2012 edition. Table 2.13, Data for England 2006. [Accessed 3/12/20]. PHE (2013) CHD prevalence estimates 2011. [Accessed 3/12/20]. The age groups are larger than those specified by BHF. Therefore, while the PHE data may look static in some places, this is a result of an average calculated across a wider age band than the corresponding BHF data.

[113] British Heart Foundation (2017) Cardiovascular disease statistics 2017 edition. [Accessed 3/12/20]. Table 2.9, Data for England 2011.

[114] PHE (2016) Hypertension prevalence estimates for local populations. [Accessed 10/12/20].

[115] British Heart Foundation (2012) Coronary heart disease statistics 2012 edition Table 5.3. [Accessed 3/12/20].

Figure 8 – CHD (prevalence - males)[116]

	Treated
16-24	0.1%
25-34	0.2%
35-44	0.6%
45-54	3.6%
55-64	10.6%
65-74	20.8%
75+	28.6%
All ages	6.5%

Stroke

A stroke is a medical emergency and requires urgent care. Long-term conditions management can reduce the risk of a stroke and the management of the impact of a stroke could be regarded as long-term condition management.

Around 1:6 men will have a stroke sometime in their life.[117] The risk of having a stroke increases with age and the average age at which men have strokes in England is 72 years.[118]

The older residents' toolkit describes a prevalence rate of 6%.[119]

Conditions which increase the risk of a stroke include:

- Hypertension
- High cholesterol
- Atrial fibrillation
- Diabetes

Diabetes

The prevalence of diabetes is increasing year on year, PHE project that this trend will continue.[120] Diabetes prevalence strongly correlates with increasing age. The *Birmingham HNA* states that diabetes could be between two and eight times as prevalent in prisons compared to the community.[121] The rates of diabetes are reported to be 1.5 times as great in the most deprived quintile compared to the least.[122] The rate of diabetes in the community in England is now described as 9.6% of males and 7.6% of females and continues to rise. There has been no recent study in UK prisons, but the *Toolkit* states 15% prevalence in older residents.[123] Noting the above changes, the report draws on recent PHE data below:

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[116] *Idem,* Table 2.13.

[117] Stroke Association (2018) State of the nation: stroke statistics. [Accessed 3/12/20].

[118] Royal College of Physicians (2018) Sentinel stroke national audit programme (SSNAP). National clinical audit annual results portfolio April 2017-March 2018. [Accessed 3/12/20].

[119] PHE (2017) Health and social care needs assessments of the older prison population. [Accessed 3/12/20]. Quoting from Munday *et al.* (2019). The prevalence of non-communicable disease in older people in prison globally: a systematic review and meta-analysis. [Accessed 3/12/20].

[120] PHE (2016) Diabetes prevalence model. [Accessed 3/12/20].

[121] Marshall, T. *et al.* (2000) Health care in prisons: a health care needs assessment. [Accessed 2/12/20].

[122] Diabetes UK (2016) Facts and stats. [Accessed 3/12/20].

[123] PHE (2017) Health and social care needs assessments of the older prison population. [Accessed 3/12/20].

Figure 9 – Diabetes Expected Prevalence

Age Band	Prevalence (%)
16-24	0.8%
25-34	1.2%
35-44	3.5%
45-54	9.0%
55-64	12.7%
65-74	16.9%
75+	23.8%

We would not expect demand to equal prevalence or incidence. The prevalence figure includes both non-insulin dependent, and insulin dependent diabetes. The diabetes service is used more by insulin dependent patients than other patients with diabetes; though non-insulin dependent patients should also receive planned care.

National data indicates that 10% of those with diabetes have insulin dependent diabetes (Type 1) and that 90% have non-insulin dependent diabetes (Type 2).[124] The link between diabetes and deprivation is only associated with Type 2, which is influenced by lifestyle issues.

Diabetes is almost twice as prevalent in Asian and black ethnic groups, compared to white (for both genders 15.2% compared to 8.0%).

Epilepsy

The *Birmingham HNA* discusses epilepsy and draws upon community estimates. This is what we would expect to find in prisoners:

Figure 10 – Epilepsy Prevalence by Age (males)[125]

Age Band	Prevalence (%)
16-24	0.45%
25-44	0.36%
45-64	0.40%
65-74	0.38%
75-84	0.46%
85+	0.30%
Total	0.36%

These figures illustrate that there is little difference in prevalence across age groups.

A meta-analysis published in the *British Medical Journal* described a rate of 0.7% in a sample group of 3000 residents.[126] More recent data reports an increased prevalence in the community of 0.95%, and the Joint Epilepsy Council also notes that rates are 25% higher in the most deprived populations.[127] Given the above, this report takes the more recent estimate of 0.95% and adds 25% to give a revised figure of 1.19%. Identified rates of epilepsy are usually well above the predicted prevalence; this is down to misdiagnosis in childhood that never leaves the systems.

[124] Diabetes UK (2016) Facts and stats. [Accessed 3/12/20].
[125] Marshall, T. *et al.* (2000) Health care in prisons: a health care needs assessment. [Accessed 2/12/20].
[126] Fazel, S. *et al.* (2002) Prevalence of epilepsy in residents: systematic review. [Accessed 3/12/20].
[127] Joint Epilepsy Council (2011) Epilepsy prevalence, incidence and other statistics. [Accessed 3/12/20].

There is a potential for residents to be misdiagnosed with epilepsy, as evidenced in an audit of healthcare in residents of one UK prison. The diagnoses of epilepsy were reviewed in 19 of the 26 cases identified and, of those, only 11 were believed to have epilepsy after the review. It is interesting to note that in this study, 38.4% of residents reported that their seizures developed within 12 months of beginning significant substance misuse, and a number of the residents also identified substance abuse as a cause for further seizures.[128]

A French study postulates to a link between traumatic brain injury and the high rate of epilepsy amongst residents.[129]

Sickle Cell Disease

Sickle cell disease is an inherited condition, most commonly affecting people of African and Afro-Caribbean heritage. The most severe form is sickle cell anaemia. Sickle cell disease is generally detected during pregnancy or shortly after birth.

Patients with sickle cell will experience a range of symptoms[130] and may require regular monitoring. In some cases, they will require care from secondary healthcare services. See NICE quality standard.[131]

It is estimated that 14,000 people in the UK are living with the disease (1 in 4600 people).[132]

The table below describes rates identified via screening of newborn babies and illustrates how the conditions are concentrated in ethnic groups.

Figure 11 – Rates of Significant Haemoglobin Conditions by Ethnic Category, 2016 to 2017[133]

Ethnicity Category	Significant Conditions	
	Rate/1000	1 in x
White	0.01	118,676
Mixed	0.41	2,439
Asian	0.23	4,381
Black Caribbean	4.35	230
Black African	7.69	130
Any other black background	4.23	236
Other	0.20	5,108

Cancer

The following paragraphs are based on an all-age population.

[128] Tittensor *et al.* (2008) Audit of healthcare provision for UK residents with suspected epilepsy. [Accessed 3/12/20].
[129] Waiter, L. *et al.* (2016) Prevalence of traumatic brain injury and epilepsy among residents in France: results of the Fleury TBI study. [Accessed 3/12/20].
[130] NHS (2019) Sickle cell disease. [Accessed 10/12/20].
[131] NICE (2014) Sickle cell disease. [Accessed 10/12/20].
[132] Dormandy, E. *et al.* (2017) How many people have sickle cell disease in the UK? [Accessed 10/12/20].
[133] PHE (2017) NHS sickle cell and thalassaemia screening programme. [Accessed 10/12/20].

> *In 2018, there was a continued increase in the number of malignant cancer diagnoses in England, from 309,453 new cases in 2017 (as at April 2020) to 320,395 new cancer diagnoses in 2018.*[134]
>
> *As in previous years, more cancers were diagnosed in males (167,281) than females (153,114).*[135]
>
> *Incidence rates for all cancers combined in the UK are highest in people aged 85 to 89 (2015-2017).*[136]

Lifestyle choices impact on the risk of contracting cancer. Cancer Research UK attributes smoking as the cause of 15% of cancer deaths.[137]

> *The socioeconomic profile of [the prison] population means that it is at a higher risk of cancers associated with smoking, alcohol and socioeconomic deprivation.*[138]

Incidence of prostate cancer is increasing and is predicted to continue to rise. Cancer Research UK states that lifetime risk will increase from 5% for men born in 1990 to 14% for men born in 2015.

Specifically in the prisoner population, a study found that while the number of men diagnosed with cancer in London prisons was low, it increased over time, from just five in 1986-1990 to 24 in 2001-2005.[139]

When a prisoner is diagnosed with cancer, the impact is far more likely to be felt in terms of prisoner escorts and bedwatches as opposed to within healthcare, as treatment is largely delivered from hospitals. This is particularly the case for stage-three cancers.

Tissue Viability

With an ageing population and men with a history of drug injecting, there is a demand for tissue viability nursing. Some prisons continue to refer out for this service, which is a major call on escorts as dressings require regular changing.

Pain and Pain Management

Pain management is a large demand upon healthcare resources. As noted elsewhere in this report, prisoners may have a low threshold for pain or have previously suppressed pain via drug use.

PHE state that there is no data identifying the prevalence of pain amongst the population in secure environments, though they note that:

> *Among the prison population, 16% have musculoskeletal disorders, 5% have cardiovascular disease and 5% have neurological conditions.*[140]

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[134] Public Health England. Cancer registration statistics, England: final release 2018. [Accessed 7/12/20].
[135] *Ibid.*
[136] Cancer Research UK (N.D.) Cancer incidence statistics. [Accessed 3/12/20].
[137] Cancer Research UK (2015) Tobacco statistics. [Accessed 3/12/20].
[138] Davies, E.A. (2010) Cancer in the London prison population, 1986-2005. [Accessed 3/12/20].
[139] *Ibid.*
[140] PHE (2013) Managing persistent pain in secure settings. [Accessed 3/12/20].

An article reported how 20% of a sample of residents described, and were receiving treatment for, chronic non-cancer pain, further that the prevalence rate was age-correlated.[141]

Recent NHS England guidelines have further restricted the prescribing of a range of analgesics in prison settings.[142]

[141] Croft, M. & Mayhew, R. (2015) Prevalence of chronic non-cancer pain in a UK prison environment. [Accessed 3/12/20].

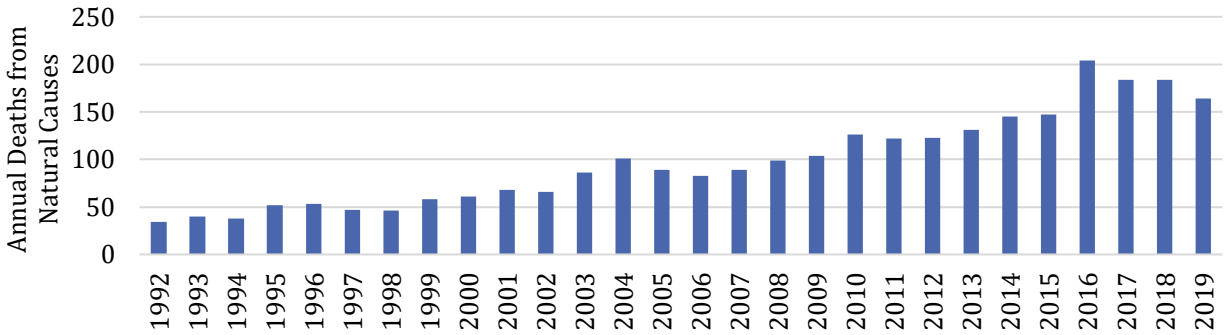
[142] NHS England (2017) Pain management formulary for prisons: the formulary for acute, persistent and neuropathic pain. [Accessed 3/12/20].

Palliative and End of Life Care

> *For those older residents who reach the end of life while still serving a prison sentence, who have spent a long time in prison and may have lost contact with friends and family, dying in prison may be the most appropriate and humane course of action.*[143]

The number of prisoner deaths from natural causes has risen sharply, notably as the age of prisoners has risen, which raises important issues in terms of the management of terminally ill prisoners.

Figure 12 – Prison Deaths from Natural Causes (male and female)[144]



The Prisons and Probation Ombudsman (PPO) Annual Report 2018/19 describes 180 deaths from natural causes, of which 53% were of men aged over 60.[145]

The DH states that healthcare should treat dying as a:

> *core activity with the same rigorous measures and outcomes as applied to other areas of health and social care.*[146]

End of life care is defined by the NHS as *'support for people who are in the last months or years of their life.'*[147] End of life care includes palliative care, which is designed to make patients as comfortable as possible by managing pain and other distressing symptoms. Palliative care also involves psychological and spiritual support.[148] Figure 13 demonstrates the relationship between end of life and palliative care.

[143] The Centre for Policy on Aging (2016) Diversity in older age – older offenders. [Accessed 3/12/20].
[144] MOJ (2019) Safety in custody statistics. [Accessed 11/12/20].
[145] PPO (2019) Prison and Probation Ombudsman annual report 2018-19. [Accessed 7/12/20].
[146] DH (2008) End of life care strategy: promoting high quality care for all adults at the end of life. [Accessed 3/12/20].
[147] NHS (2015) End of life care. [Accessed 3/12/20].
[148] *Ibid.*

Figure 13 – End of Life and Palliative Care

NICE describes quality standards for end of life care.[149] PSI 64-2011 includes a section on palliative care and states:

> *<u>Family involvement for terminally ill residents</u>*
> *For those residents who may not be released before they die, it is important that residents are able to maintain close contact with their family or a nominated person. With the prisoner's agreement, the family should be kept informed and updated on the prisoner's condition, particularly if there is deterioration in their condition.*
>
> *<u>Consideration of early compassionate release</u>*
> *It is important to discuss this with the prisoner, as an application may take some time, or the prisoner may not wish to apply.*[150]

Older residents may have lost contact with their families, especially if their crimes were against family members. The PPO underlines how, wherever possible, family involvement with the latter stages of a prisoner's life has huge positive impact.[151]

HMPPS and NHS England are working together to ensure that, as far as possible, residents are able to exercise informed choice about where they die. PSI 21-2012 outlines the policy regarding compassionate release on temporary licence (ROTL). Some residents will be entitled to compassionate release and others will not. The PPO notes how just over a third of residents in their study were considered for compassionate release and a further quarter for ROTL.[152]

Even for those who may be entitled to early release, some choose to end their days in the familiar surroundings of prison. In these cases, it is important they receive comparable care to that on offer in the community. Applying this principle of equity and choice raises a number of issues.

All people who remain in prison for their last days are entitled to nursing care comparable to that which is available to those in the community. This can be provided by healthcare from the prison or by visiting palliative care specialists.

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[149] NICE (2011 updated 2017) Quality standard for end of life care for adults (QS13). [Accessed 3/12/20].

[150] NOMS (2013) PSI 64/2011: management of residents at risk of harm to self, to others and from others (safer custody). [Accessed 3/12/20].

[151] PPO (2013) Learning from PPO investigations: end of life care. [Accessed 3/12/20].

[152] *Ibid.*

There will be real challenges: the patient may need nursing and other medical or social care at various hours of the day and night. Whilst the services from the community could deliver this, it can pose security and cost issues. These challenges have been acknowledged by the PPO, who states that:

> *The tension between traditional prison policies and the new geriatric penal reality is…reflected in my frequent criticism of prisons for failing to balance security with humanity when using restraints on the terminally ill. Protecting the public is fundamental, but this is not achieved by inappropriately chaining the infirm and dying. With an ageing prison population, visits to [and from] hospitals and hospices will only increase, and with them daily tests of the humanity of our prison system.*[153]

NHS Physical Check

The PHE population screening programme includes the NHS health check programme for vascular risk (for those aged 35-74 who haven't had an NHS health check in the previous five years and who are incarcerated for two years or more).[154] In prisons this is known as a physical check.

Emergency Codes

A 'code' is an emergency call to healthcare. A code blue is where someone is unconscious or having respiratory problems etc; a code red is where there is blood. The relevant PSI 03/13 requires that each 'code' generates an automatic call from the control room to the ambulance service.

Deaths in Custody

More than half of all deaths in prisons occur in older residents.[155] The rate of deaths amongst both male and female residents per 1,000 prison population has fallen over the past year. The rate of deaths amongst both male and female prisoners per 1,000 prison population has fallen over the past year. In 2019/20, there were 280 male deaths in prison and six female deaths.[156]

Those who identified themselves as white constituted 1% of deaths in custody in the 12 months ending December 2017; the remaining 9% were BAME residents.[157]

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[153] PPO (2015) Annual report 2014-15. [Accessed 10/12/20]

[154] PHE (N.D.) Population screening programmes. [Accessed 10/12/20]

[155] Public Health England (2018) Health and justice annual review 2017/18. [Accessed 3/12/20].

[156] MOJ (2018) Her Majesty's prison and probation service offender equalities annual report 2017/18. Equivalent data has not been included in more recent Equalities reports. [Accessed 10/12/20]

[157] *Ibid.*

Oral Health

Oral Health Amongst Prisoners

> *Poor oral health is well documented for this patient group [prisoners] with the prevalence of oral disease being four times higher, on average, than that of the general population. A number of behavioural predisposing factors have been identified such as alcohol, tobacco, substance misuse, high sugar diets, chaotic lifestyles, and poor oral hygiene. These issues are further compounded by the high incidence of learning difficulties and mental health problems. These patients often have had little oral health education, resulting in a low perception of oral health. The oral health of the general population has improved markedly in the last 30 years whilst there has been little or no improvement for this vulnerable, socially excluded group.*[158]

> *Successful ageing is synonymous with maintenance of quality of life. From a dental perspective this involves controlling oral disease and restoring damaged tissue, with an underlying premise that treatments effective in achieving those goals will consequently produce improved oral function, comfort and social wellbeing.*[159]

There is a solid evidence base demonstrating that residents have poorer dental health than the general population. Residents exhibit more decay and fewer filled teeth,[160] in addition to experiencing a higher prevalence of oral disease and unmet dental needs than the general population.[161]

> *Residents have poorer general and oral health than the non-prison population. Remand residents reported a higher level of dental anxiety and were more likely to value their teeth, visit the dentist and opt for restoration of an anterior tooth than convicted residents. Convicted residents expressed more perceived need than their fellow remand residents, even though convicted residents' normative need tended to be lower.*[162]

A needs assessment of the oral health of residents in Wales found high levels of need.[163] Eighty per cent of those screened required dental treatment and 35% had at least one tooth that required extraction, compared with just 10% in the community. Similarly, a study in a Scottish prison revealed that 29% of the prison population had severe dental decay in comparison to 10% of the general public.[164]

Residents note poor access to dental health services in comparison to other healthcare services, with appointments and treatments required to fit around the strict prison timetable.[165] Another reason that could explain the poor oral health among residents includes the items that are permitted within the prison. Residents claim that the toothbrushes and toothpaste they have access to are of inferior quality to those available in shops.[166] Furthermore, floss, mouthwash and regular toothbrushes are not allowed in some prisons due to the risk that they may be used as weapons.

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[158] National Association of Prison Dentistry (2015) Service specification prison dentistry. [Accessed 9/12/20].

[159] Galgiardi, D.I. *et al.* (2008) Impact of dental care on oral health-related quality of life and treatment goals among elderly adults. [Accessed 3/12/20].

[160] SOHIPP (N.D.) The oral health and psychosocial needs of Scottish residents and young offenders. [Accessed 3/12/20].

[161] Marshman *et al.* (2014) Does dental indifference influence the oral heath related quality of life of residents? [Accessed 3/12/20].

[162] Heidari, E. *et al.* (2008) An investigation into the oral health status of male residents in the UK. [Accessed 3/12/20].

[163] NHS Public Health Wales (2014) Oral health needs assessment of the prison population in Wales: executive summary and recommendations. [Accessed 3/12/20].

[164] Neville, P. (2015). Oral health among UK residents. [Accessed 3/12/20].

[165] *Ibid.*

[166] *Ibid.*

A number of reports also make reference to the prison diet negatively impacting on oral health. Prisoners turn to snacking as a cure for boredom, but the snacks available tend to have a high sugar content.[167] This may increase as an unintended consequence of the smoking ban.

The transient nature of prison populations also prevents effective dental treatment. A prisoner may be released or moved to another prison with limited notice, meaning that dental procedures may not be carried out and courses of treatment may not be completed. Failure to adequately transfer healthcare records when a prisoner is transferred can also negatively impact on a prisoner's treatment, with them having to start from the beginning with a new healthcare professional.

Demographic Factors

> *Oral health is affected by deprivation and, in the more deprived areas of the country, oral health is poorer and edentulousness is higher than in the more affluent areas.*[168]

The Adult Dental Hygiene Survey (ADHS) indicated that adults in households from routine and manual occupations were 11% more likely to have tooth decay than those from managerial and professional occupation households.[169] This emphasises the likelihood that prisoners are more likely to have higher oral health requirements than those in higher socio-economic groups before their prison term even begins.

Oral Health and BAME Populations

Note that older residents are the fastest growing cohort, and that the projections for the general population are that the old will become more ethnically diverse.[170]

Whether this change will impact on oral health needs is unclear:

> *There is evidence that members of ethnic minority communities have generally worse health (Acheson 1998) and are less likely to regularly visit a dentist (DoH 1999). This poor oral health means that older people from ethnic minority communities will require targeted services that are culturally appropriate and accessible and tackle their particular needs.*[171]

However other publications contract this:

> *Contrary to most health inequalities, oral health was better among non-White groups, in spite of lower use of dental services.*[172]

With the growing proportion of ethnic minority older people, it needs to be borne in mind that risk behaviours associated with oral cancer are more prevalent among certain ethnic groups.[173]

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[167] SOHIPP (N.D.) The oral health and psychosocial needs of Scottish residents and young offenders. [Accessed 7/12/20]. See also Heidari *et al.* (2008) An investigation into the oral health status of make residents in the UK. [Accessed 7/12/20].

[168] PHE (2015) What is known about the oral health of older people in England and Wales: a review of oral health surveys of older people. [Accessed 7/12/20].

[169] Steele *et al.* (2011) Adult dental health survey. [Accessed 7/12/20].

[170] See for example: Lievesley, N. (2010) The future ageing of the ethnic minority population of England and Wales. [Accessed 7/12/20].

[171] BDA (2003) Oral healthcare for older people: 2020 vision. [Accessed 7/12/20].

[172] Arora, G. *et al.* (2017) Ethnic differences in oral health and use of dental services: cross-sectional study using the 2009 adult dental health survey. [Accessed 7/12/20].

[173] BDA (1996) Improving oral health amongst ethnic minority elderly people. London.

> *The prevalence of oral cancer is particularly high among the South Asian community, correlating with use of smokeless tobacco, though survival rates of these patients reportedly compare favourably with those of oral cancer sufferers in other sections of British society.*[174]

The 1998 Adult Dental Health Survey suggested that Bangladeshi, Irish and Black Caribbean men were more likely to smoke cigarettes than the general population. In addition, the survey found that individuals from minority ethnic groups were less likely to visit the dentist for a regular check-up and to go only when in pain. This means that oral cancer in these groups is unlikely to be seen until the late stages when the morbidity and mortality associated with its treatment are greater.[175]

Smoking, Alcohol and Drug Use

Prevalence rates for smoking amongst residents are four times greater than in the community.[176] Approximately 80% of all residents smoke[177] compared with 15.5% of the general population.[178]

A key study into the impact of smoking on older people's oral health found that:

> *Among those retaining one or more natural teeth, current smokers had fewer teeth, fewer functional units, more crown surfaces with decay and more decayed root surfaces. Periodontal indicators showed that the extent and severity of periodontal disease were more marked among current smokers when compared with those who had never smoked. Current smokers also showed a higher prevalence of mucosal disorders and needed more dental treatment.*[179]

Nineteen per cent of all residents (predominantly male) and 29% of female residents report having alcohol problems.[180] There are no community equivalent studies but, in the community, 22% of men report drinking more than 21 units per week and 16% of women said they drink more than 14 units per week.[181]

Drinking hazardously is indicated as a cause of oral disease, including cancers of the mouth, larynx, pharynx and oesophagus.[182] Alcohol, and lifestyles closely associated with alcohol misuse, can also have detrimental effects on dentition: dental erosion, dental caries and periodontal disease.[183]

Thirty per cent of prisoners have a drug problem at reception.[184] In the community, 9.0% of adults report taking any drug in the previous 12 months, and just 3.5% had taken a Class A drug in the previous 12 months.[185]

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[174] BDA (N.D.) The British dental association oral health inequalities policy. [Accessed 7/12/20].

[175] BDA (2003) Oral healthcare for older people: 2020 vision. [Accessed 7/12/20].

[176] Prison Reform Trust (2019) Bromley briefings prison factfile. [Accessed 3/12/20].

[177] Data from recent TamlynCairns HNAs.

[178] DH (2017) Statistics on smoking England 2017. [Accessed 7/12/20].

[179] Locker, D. (1992) Smoking and oral health in older adults. [Accessed 7/12/20].

[180] Community Justice portal (2010) Prison service failing to address growing problem of alcohol misuse in prisons. [Accessed 7/12/20].

[181] Health and Social Care Information Centre (2015) Health survey for England – 2014 trend tables. [Accessed 7/12/20].

[182] Rehm, J. *et al.* (2003). The relationship of average volume of alcohol consumption and patterns of drinking to burden of disease: an overview. [Accessed 7/12/20].

[183] Amaral, C.S. *et al.* (2009). The relationship of alcohol dependence and alcohol consumption with periodontitis: a systematic review. [Accessed 7/12/20].

[184] Fazel, S. *et al.* (2017) Substance use disorders in prisoners: an updated systematic review and meta-regression analysis in recently incarcerated men and women. [Accessed 7/12/20].

[185] CSEW (2018) Drug misuse: findings from the 2017/18 crime survey for England and Wales. [Accessed 7/12/20].

> *Drug abuse is associated with serious oral health problems including generalised dental caries, periodontal diseases, mucosal dysplasia, xerostomia, bruxism, tooth wear, and tooth loss. Oral health care has positive effects in recovery from drug abuse: patients' need for pain control, de-stigmatisation, and HIV transmission.*[186]

Residents with any history of previous drug use show greater numbers of decayed teeth when compared to those with no history of drug use.[187]

However, it is also interesting to note that residents with substance misuse issues are likely to report toothache soon after entering the prison, because the drugs they took (especially opiates) may have suppressed any pain.[188]

Homelessness and Medications

A study into the oral health of the homeless population states:

> *Dental problems are widespread among people experiencing homelessness – and in many cases they may be preventing people from escaping lives of poverty and addiction.*
>
> - *Sixty per cent of participants had experienced dental pain since they had been homeless*
> - *Thirty per cent were currently experiencing dental pain. Many participants had had to go to A&E to sort out this issue as they were not able to get treatment through a dental practice*
> - *Fifteen per cent of participants had pulled out their own teeth since they had been homeless*[189]

Differences in Oral Health of Prisoners by Age

Although the literature comparing oral health needs among residents of differing ages is sparse, there is one study of particular interest which evidenced oral health differences between new and repeat offenders, as well as older and younger residents. The study showed that young offenders had greater numbers of decayed teeth, alongside fewer numbers of filled teeth, in comparison to women and older male residents.[190] It also showed that residents with a greater experience of remand had greater numbers of teeth missing due to caries, and higher rates of obvious decay. Those with longer current imprisonment had greater obvious decay, fewer decayed teeth, fewer filled teeth and a greater number of missing teeth. This evidence implies that older residents who have served multiple, or longer prison sentences, are likely to have poorer oral health than those who have served shorter, or single sentences. This study also indicated that residents with a greater experience of prison, or longer current prison sentences, were more likely to have fewer than 20 standing teeth.

For older residents, 'active ageing' policy framework proposed by the World Health Organisation (WHO) states that *'good oral health is an essential component of active ageing.'*[191]

Poor oral health leads to: pain, a loss of self-confidence, problems with eating and communication. Functioning dentition is described as having 21 or more teeth.[192]

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[186] Shekarchizadeh, H. *et al.* (2013) Oral health of drug abusers: a review of health effects and care. [Accessed 7/12/20].

[187] SOHIPP (N.D.) The oral health and psychosocial needs of Scottish residents and young offenders. [Accessed 7/12/20].

[188] BDA (2012) Oral health in prisons and secure settings in England. [Accessed 7/12/20].

[189] Edgar (2017) Homelessness and oral health: a neglected issue. [Accessed 7/12/20].

[190] Williams, S. (2007) Oral health needs of the homeless. [Accessed 7/12/20].

[191] PHE (2015) What is known about the oral health of older people in England and Wales: a review of oral health surveys of older people. [Accessed 7/12/20].

[192] ONS (2011) Adult dental health survey 2009 - summary report and thematic series. [Accessed 7/12/20].

Public Health England (PHE) sums up the differential oral health needs of the older population:

- *Older adults living in residential and nursing care homes are more likely to be edentulous, and less likely to have a functional dentition*
- *Untreated caries is higher in the household resident elderly population than in the general adult population and older adults living in care homes have higher caries prevalence still, where the majority of dentate residents have active caries*
- *Signs of severe untreated caries appear to be more common in the oldest age groups across all settings and current pain also appears to be slightly higher than in the general adult population*
- *Periodontal disease is most common in the age groups of 65 to 84*[193]

Over the years, several major initiatives have had a positive impact on oral health. Firstly, access to dental care was dramatically widened by the creation of the NHS in 1948 – especially for those on lower income. Secondly, the widespread introduction of fluoride into toothpaste in the 1970s led to a dramatic improvement in oral health. In part because of these step changes, the oral health profile of elderly people is improving. In 2003 the British Dental Association (BDA) described three distinct cohorts within the general population:

- People who are old and very old, of whom a large proportion are edentulous (without any natural teeth)
- Those now entering old age, who have retained much or most of their natural dentition, but in a state that requires a lot of maintenance if dentures are to be avoided
- Those now in middle age and younger, who are retaining their dentition in a good state[194]

Also, in 2003 the BDA predicted that:

> *the proportion of adults of pensionable age with some natural teeth will rise dramatically over the next two decades.*

Recent surveys bear this out.

A study published by the American Dental Association identifies the most common oral problems in older patients as:

- *An increase of difficult-to-restore dental caries;*
- *Xerostomia due to decreased salivary flow and medications;*
- *Loss of natural teeth;*
- *Ongoing, unrecognized periodontal disease;*
- *Excessive tooth wear;*
- *A desire to look better and younger;*
- *Impaired oral hygiene due to concomitant medical problems;*
- *Loss of alveolar bone and resultant impaired use of removable prosthesis.*[195]

There is also a greater need for interventions such as dentures, partial dentures and bridges in those aged over 50. If not properly maintained (professionally and personally), these can also become the cause of other oral health problems, such as dental stomatitis (thrush).[196]

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[193] PHE (2015) What is known about the oral health of older people in England and Wales: a review of oral health surveys of older people. [Accessed 7/12/20].

[194] BDA (2003) Oral healthcare for older people: 2020 vision. [Accessed 7/12/20].

[195] Christensen, G.J. (2007) Providing oral care for the aging patient. [Accessed 7/12/20].

[196] British Dental Health Foundation (2015) Dental care for older people. [Accessed 7/12/20].

Communicable Diseases

Routine Immunisations

The Health Protection Agency[197] states:

> *Introduced in prisons in England and Wales in 2003 the Hepatitis B vaccination programme has been responsible for a significant reduction in the transmission of the infection in injecting drug users (IDUs) overall.*[198]
>
> *Hepatitis A and B vaccinations are recommended for all residents.*
>
> *Individuals who have not completed the five doses of diphtheria, tetanus and polio vaccines should have their remaining doses at the appropriate interval. In addition to the diphtheria, tetanus and polio vaccines and in line with the UK routine childhood immunisation schedule, young adults who are not protected against measles, mumps, and rubella (MMR) and meningococcal C disease, should complete immunisation against these infections. Where there is an unclear history of vaccination, adults should be assumed to be unimmunised and the recommendations for individual vaccines should be followed.*
>
> *All residents aged 65 years and over should also be offered seasonal flu vaccination annually and pneumococcal polysaccharide vaccine once only.*

In prisons with high proportions of young offenders (whether male or female), there will be significant work, therefore, in terms of catching up on missed childhood immunisations, particularly those relevant in later childhood that may have been missed e.g. HPV vaccine (girls), meningitis, and boosters for tetanus, diphtheria and polio (14 years). As noted above, if there is no clear evidence that vaccinations have been received, individuals should be vaccinated in accordance with the National Immunisation Schedule.[199]

Blood Borne Viruses

PHE state that BBV infection rates are four times higher amongst prisoners compared to the general population.[200] Figures from Public Health England show that hepatitis B and C cases accounted for 1,174 of 1,268 infectious diseases reported in English prisons during 2014.[201] PHE are promoting opt out testing for prisoners using dry blood spot testing; this approach is increasing rates of testing.[202]

The comparator data provided in the *Toolkit* is largely outdated, so the report draws on more recent work. The prevalence of HIV, hepatitis B and hepatitis C viruses, sexually transmitted infections (STIs) and tuberculosis among people in prisons is estimated to be two to ten times higher than in the general population.[203] The rate of infection for blood-borne viruses, like hepatitis B and C and HIV, is four times higher in prisons than in the general population while the prevalence rate of TB amongst people in prison in England is nearly five times higher than in the general population.[204] This is likely due to risky behaviour, for example, associated with

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[197] Health Protection Agency (2009) Schedule for vaccination of residents and young offenders in North West region. [Accessed 7/12/20].
[198] Public Health England (2011) PHE press release. [Accessed 7/12/20].
[199] PHE (2018) The complete routine immunisation schedule from autumn 2018. [Accessed 7/12/20].
[200] PHE & WHO (2018) Public Health England health and justice annual review 2017/18. [Accessed 10/12/20].
[201] Public Health England (2015) Hepatitis cases responsible for 93% of prison disease reports. [Accessed 10/12/20].
[202] PHE (2018) Hepatitis C in the UK. [Accessed 10/12/20].
[203] Public Health England (2017) Infection inside international. [Accessed 7/12/20].
[204] Prison Reform Trust (2019) Bromley briefings prison factfile. [Accessed 3/12/20].

substance misuse. Over 90% of new hepatitis C cases are believed to be acquired through injecting drug use.[205]

Figure 14 – BBV Prevalence[206]

Blood Borne Viruses	Estimated Prevalence (%) Prisons	General Community
Hep B	1.3%	0.3%
Hep C	6.7%	1.6%
HIV	0.6%	0.16%

In 2019, PHE reported that while HIV testing rates are increasing, prevalence has decreased in the decade 2009-19 with the greatest decrease from 2016-19.[207] The National AIDS Trust reports that, in 2013, over one in four (27%) adults living with diagnosed HIV were over 50 years of age. Both improvements to life expectancy and people acquiring HIV later in life are factors in the large increase of older people living with HIV in recent years.[208]

More recently, NICE published guidelines on testing for BBVs in prisons.[209] The introduction of dry spot blood testing across the estate is expected to assist implementation of a true opt-out approach and substantially increase testing rates.[210]

NICE recommend routine HBV vaccinations for staff and inmates of custodial institutions.[211]

At the same time as the push to increase testing, there have been major advances in the treatment of HCV and initiatives to increase uptake.[212]

Sexual Health

The national chlamydia screening programme (for under 25s) is relevant to the prison population.

NHS England states that:

> *anyone under 25 who is sexually active should be screened for chlamydia annually, and on change of sexual partner.*[213]

Chlamydia is the most common sexually transmitted infection and, whilst not detectable without a test, can lead to long-term health issues including infertility. Chlamydia was the most commonly diagnosed STI, with 218,095 diagnoses in 2018.[214] From 2017 to 2018 there

[205] PHE (2015) Blood-borne virus opt-out testing in prisons: preliminary evaluation of Pathfinder Programme. phase 1, April to September 2014. [Accessed 7/12/20].

[206] PHE & WHO (2018) Public Health England Health and Justice annual review 2017/18. [Accessed 7/12/20].

[207] PHE (2019) Health matters: preventing STIs. [Accessed 10/12/20].

[208] National AIDS Trust (2015) Royal College of Nursing's statement on aging and HIV - National AIDS Trust comment. [Accessed 7/12/20].

[209] NICE (2017) Physical health of people in prisons. Quality standard 3: blood borne viruses and sexually transmitted infections. [Accessed 7/12/20].

[210] Morey, S. *et al.* (2018) Increased diagnosis and treatment of hepatitis C in prison by universal offer of testing and use of telemedicine. [Accessed 7/12/20]. PHE (2017) National engagement event for blood- borne virus (BBV) opt-out testing in prisons in England, 2017. [Accessed 7/12/20].

[211] NICE (2020) Hepatitis B vaccine. [Accessed 10/12/20].

[212] PHE (2018) Hepatitis C in England 2018 report. [Accessed 7/12/20].

[213] PHE (2018) Sexually transmitted infections and screening for chlamydia in England, 2017. [Accessed 7/12/20].

[214] PHE (2019) Health matters: preventing STIs. [Accessed 10/12/20].

was a 6% increase in the number of chlamydia cases. This was, at least in part, attributed to better testing.[215]

> *Gonorrhoea and syphilis have re-emerged as major public health concerns, especially among gay, bisexual and MSM. In 2018, 47% of gonorrhoea and 75% of syphilis diagnoses were in MSM.*[216]

The PHE published rate of diagnosed sexually transmitted infections (STI) amongst residents is reported to be low.[217]|

Chlamydia is most relevant and pertinent in establishments (both male and female) with YO populations.[218]

Tuberculosis (TB)

In England, people in prison are four times more likely to contract TB than people in the general population, but in 2019, tuberculosis cases in England hit the lowest ever rate.[219]

Prisoners include a disproportionate number of those with social and clinical risk factors for tuberculosis and pose a challenge for control.[220] The most deprived 10% of the population have a rate of TB over seven times higher than the least deprived 10%. Those born outside the UK have a rate 13 times higher than people born in the UK.[221]

In 2018, 4,655 people were diagnosed with TB in England, and people born outside the UK accounted for 72% of cases.[222]

[215] PHE (2019) Health matters: preventing STIs. [Accessed 10/12/20].
[216] PHE (2019) Health matters: preventing STIs. [Accessed 10/12/20].
[217] PHE (2016) Public Health England Health and Justice annual review 2015/16. [Accessed 7/12/20].
[218] PHE (2016) Public Health England Health and Justice annual review 2015/16. [Accessed 7/12/20].
[219] PHE (2019) Tuberculosis cases in England hit lowest ever levels. [Accessed 7/12/20].
[220] Anderson, C. (2010) Tuberculosis in UK prisoners: a challenge for control. [Accessed 7/12/20].
[221] PHE (2019) Tuberculosis cases in England hit lowest ever levels. [Accessed 7/12/20].
[222] Public Health England (2019) Tuberculosis in England 2019 report. [Accessed 7/12/20].

Immunisation

The National Immunisation Programme focuses on children and then on adult specific interventions. For residents who have incomplete immunisation status, PHE provides guidance.[223]

Routine vaccinations which should be completed:

Figure 15 – PHE Routine Immunisation Schedule[224]

Age	Vaccination
All Age groups	Hepatitis B
Up to 24 years	Measles, mumps, rubella (MMR) Meningococcal ACWY vaccine Tetanus (T), diphtheria (d), and polio (IPV)- Td/IPV
25 years and older	Measles, mumps, rubella (MMR) Tetanus (T), diphtheria (d), and polio (IPV)- Td/IPV
65 years and over	Influenza Pneumococcal
70-79 years	Shingles

In addition, some vaccines should be offered to patients with certain increased risks:

- Hepatitis A vaccine should be offered to individuals in groups such as injecting drug users (IDUs), men who have sex with men (MSM), or in the event of a hepatitis A outbreak
- Flu vaccination should be offered (annually) to those under 65 years of age who are at increased risk due to an underlying health condition
- Pneumococcal vaccine (PPV) should be offered to those under 65 years of age who are at increased risk due to an underlying health condition
- Human papillomavirus vaccine (HPV) is recommended for men up to the age of 45 who have sex with men and for those at similar risk

Influenza

The 2019 to 2020 flu season saw fewer confirmed outbreaks of seasonal flu reported in prisons across England and Wales than in 2018 to 2019. In total, prisons reported 7 confirmed outbreaks of flu A or B compared with 13 in the year before. Most of the reported outbreaks occurred in adult prisons in England, but 1 outbreak occurred in a prison in Wales and 2 outbreaks were reported in immigration removal centres in England.[225]

A PHE audit discusses influenza vaccination programmes in prison settings.[226] Guidance requires that all those aged 65 or older, and those who fall into clinical risks groups, should be offered the vaccine.[227]

[223] PHE (2020) Vaccination of individuals with uncertain or incomplete immunisation status. [Accessed 7/12/20].

[224] PHE (2020) The routine immunisation schedule. [Accessed 10/12/20].

[225] Public Health England (2020) Flu in prisons and secure settings. [Accessed 7/12/20].

[226] PHE (2015) Audit of influenza (flu) vaccination programme in prisons in London 2014/15. [Accessed 7/12/20].

[227] PHE (2018) Seasonal flu guidance for 2018 to 2019 for healthcare and custodial staff in prisons, immigration removal centres and other prescribed places of detention for adults in England. [Accessed 7/12/20].

Health Checks

PHE have a specific health check programme for prisons to address health inequalities:

> *All prisoners aged between 35 and 74, AND with a period of incarceration of two years or more should be reviewed and offered a physical health check, delivered in accordance to the best practice guidance, to assess their risk of heart disease, stroke, type 2 diabetes and kidney disease, and raise awareness of dementia.*[228]

Each patient should be subject to a rolling five-year recall for review. The health check programme covers:

- CVD risk assessment
- Hypertension assessment
- Atrial fibrillation assessment
- Diabetes risk assessment
- Chronic Kidney Disease risk assessment
- Full alcohol risk assessment
- Assessment for familial hypercholesterolemia

The National Screening Programme

NICE (2016) recommend that prison healthcare should:

> *offer people equivalent health checks to those offered in the community*.[229]

All new receptions are eligible for both a first and secondary health screen; in some prisons this may include NHS health checks.[230]

The PHE population screening programme makes reference to 12 recognised screening programmes in the UK.[231] Seven of these relate to antenatal and newborn babies. The following three screening programmes are relevant for the young offender and adult male prison population:

- NHS abdominal aortic aneurysm (AAA) programme (men in their 65th year, men aged over 65 years can self-refer)
- NHS diabetic eye screening (DES) programme (everyone aged over 12 years with type 1 and type 2 diabetes)
- NHS bowel cancer screening programme (BCSP) (men and women aged 60-74 years)

It is expected that there will be increased uptake following recent changes to the Bowel Cancer Screening Programme (BSCP) in England with a new test – the Faecal Immunochemical Test (FIT) which is easier to use.[232]

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[228] PHE (2017) Physical health checks in prisons programme guidance

[229] NICE (2016) Physical health of people in prison. [Accessed 10/12/20].

[230] NICE (2016) Physical health of people in prison. [Accessed 10/12/20].

[231] PHE (N.D.) Population screening programmes. [Accessed 10/12/20].

[232] Bowel Cancer UK (N.D.) Crucial changes to the bowel cancer screening programme in England. [Accessed 10/12/20].

Substance Misuse

Overview

The government drug strategy of 2010 championed recovery from both drug and alcohol addiction.[233] In respect of illicit drug use only, HMIP in *'Changing patterns of substance misuse in adult prisons and service responses'* continued to carry the recovery agenda forward, including a focus on psychoactive substances (PS) (previously referred to as NPS).[234]

The Drug Strategy 2017[235] continues to develop the concept of recovery and now includes a focus on PS. The MOJ[236] places a strong emphasis on *'getting offenders off drugs'* and restricting supply within prisons. In 2019. HMPPS issued a new Prison Drug Strategy,[237] with the stated aim of supporting the national strategy. The three aims are: restrict supply, reduce demand and build recovery.

In 2018, NHS England issued a new service specification, which includes a focus on NPS drug users, dual diagnosis and continuity of care on release.[238]

A recent prison health report noted that 42% of female residents and 28% of male residents report having a drug problem on arrival, while 8% of women and 13% of men reported they had developed a problem with illicit drugs while in prison.[239] The most recent national opiate and cocaine prevalence estimates refer to 2014/15 and describe a slight increase in prevalence since the previous estimates (2.3% since 2011/12). This is in contrast to an estimated 2.4% reduction in prevalence nationally in 2010/11, and a 1.6% reduction in 2011/12; however, as noted, the increase is small.[240] Significantly, 47% of men and 31% of women reported that it was easy to access drugs in their prison and an estimated 225kg of drugs were confiscated from within prisons in 2016.[241]

Drug use in prisons is changing. HMIP notes that:

> *A declining number of residents needing treatment for opiate misuse reflects trends in the community, although many of those requiring opiate treatment in prison have complex dependence, social, physical, and mental health issues.*[242]

Psychoactive substance use in the secure estate has increased in recent years.

> *The number of drug seizures in prisons has risen from 2,500 in 2015 to just over 10,500 in 2016. There has been a huge switch in drug use in prison towards psychoactive substances, which existing detection and treatment programmes were not designed to deal with. Spice is now a substantial problem in prison, with the number of seizures going up from 408 in 2015 to nearly 3,500 in 2016.*[243]

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[233] HM Government (2010) Drug strategy 2010. Reducing demand restricting supply, building recovery: supporting people to live a drug free life. [Accessed 10/12/20].

[234] HMIP (2015) Changing patterns of substance misuse in adult prisons and service responses. [Accessed 10/12/20].

[235] HM Government (2017) 2017 drug strategy. [Accessed 10/12/20].

[236] MOJ (2016) Prison safety and reform. [Accessed 10/12/20].

[237] HMPPS (2019) Prison drug strategy. [Accessed 10/12/20].

[238] NHS England (2018) Service specification: integrated substance misuse treatment service provision in prisons in England. [Accessed 10/12/20].

[239] House of Commons Health and Social Care Committee (2018) Prison health twelfth report of session 2017–19. [Accessed 8/12/20].

[240] Hay, G. *et al.* (2017) Estimates of the prevalence of opiate use and/or crack cocaine use (2014/15). [Accessed 7/12/20]. Hay, G. *et al.* (2013) Estimates of the prevalence of opiate use and/or crack cocaine use, 2011/12. [Accessed 7/12/20].

[241] Prison Reform Trust (2019) Bromley briefings prison factfile. [Accessed 3/12/20].

[242] HMIP (2015) Changing patterns of substance misuse in adult prisons and service response. [Accessed 7/12/20].

[243] House of Commons (2017) Committee of public accounts mental health in prisons eighth report of session 2017–19. [Accessed 8/12/20].

HMIP notes that:

> *A declining number of prisoners needing treatment for opiate misuse reflects trends in the community, although many of those requiring opiate treatment in prison have complex dependence, social, physical, and mental health issues.*[244]

Previously, drug treatment was largely informed by a harm reduction philosophy, the view being that it was better to have people in treatment than using street drugs. The emphasis was on engaging people in treatment. Whilst the recovery agenda has shifted the focus to the numbers of individuals who complete treatment and become drug free, recent research identifies that engagement in prison-based opioid substitution programmes results in '*an 85% reduction in fatal drug-related poisoning in the first month after release*'.[245]

> *The number of drug seizures in prisons has risen from 2,500 in 2015 to just over 10,500 in 2016. There has been a huge switch in drug use in prison towards psychoactive substances, which existing detection and treatment programmes were not designed to deal with. Spice is now a substantial problem in prison, with the number of seizures going up from 408 in 2015 to nearly 3,500 in 2016.*[246]

Prevalence of Substance Misuse Among Residents

The numbers in treatment (in England and Wales) and a detailed breakdown of their characteristics, informed by NDTMS data, are published annually by PHE.[247]

- 70% of offenders report drug misuse prior to prison
- 51% report drug dependency
- 35% admit injecting behaviour
- 36% report heavy drinking
- 16% are alcohol dependent

A national survey of both male and female prisoners, however, found stark differences between the genders in terms of substance misuse. Female prisoners have higher usage and are more likely to inject. [248]

[244] HMIP (2015) Changing patterns of substance misuse in adult prisons and service response. [Accessed 10/12/20].

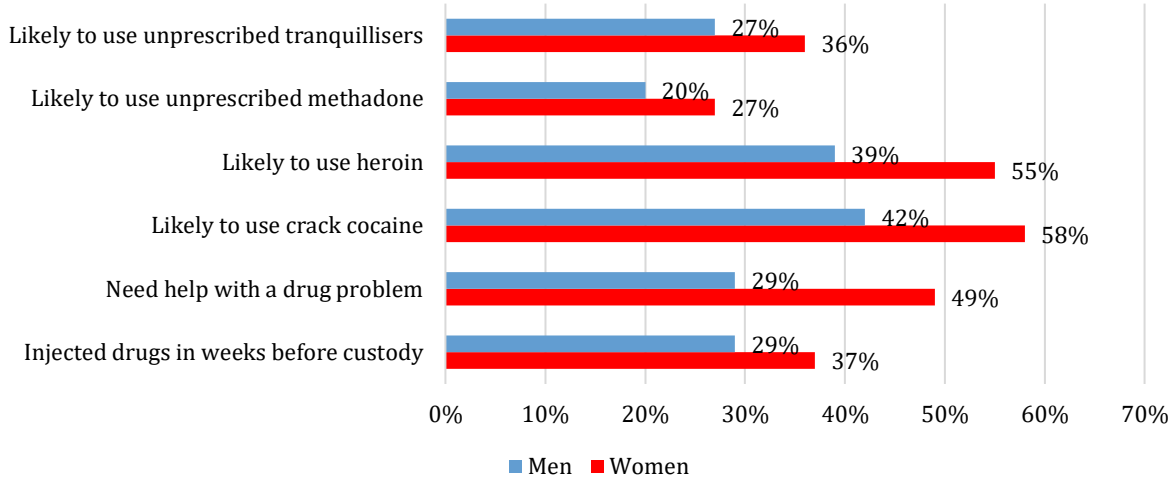
[245] Marsden, J. *et al.* (2017) Does exposure to opioid substitution treatment in prison reduce the risk of death after release? A national prospective observational study in England. [Accessed 7/12/20].

[246] House of Commons (2017) Committee of public accounts mental health in prisons eighth report of session 2017–19. [Accessed 8/12/20].

[247] PHE (2018) Secure setting statistics from the National Drug Treatment Monitoring System. [Accessed 10/12/20].

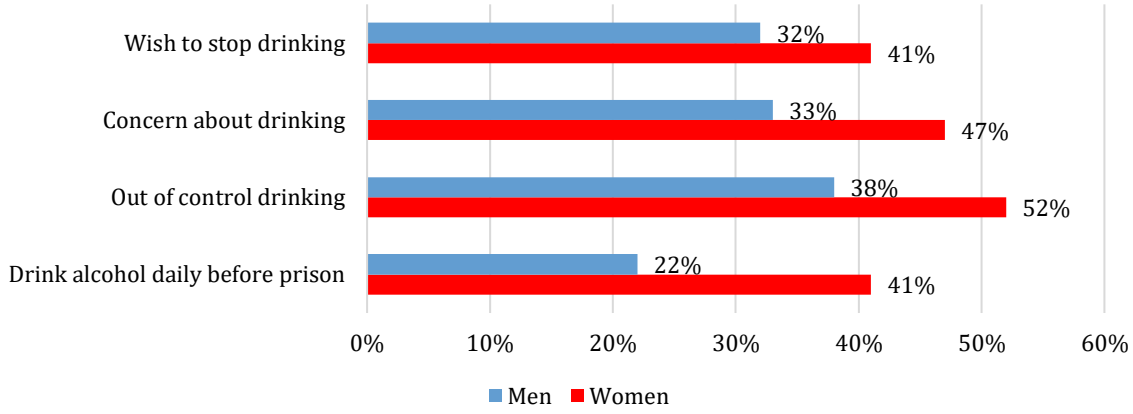
[248] MoJ (2013) Gender differences in mental health & substance misuse issues (SPCR). [Accessed 11/12/20].

Figure 16 – Findings from National Prisoner Survey (SPCR)



Likewise, gender differences in the same survey were evident in terms of alcohol misuse, with a higher level of need amongst female prisoners:

Figure 17 – Findings from National Prisoner Survey (SPCR)



Drug use was seen as a preserve of the young, but this is no longer the case.[249]

The 2015 HMIP thematic report[250] stated that drug use varies a lot from one prison to another. In a survey, 52% of respondents said they had used illicit drugs or medication in the two months prior to imprisonment. HMIP described how this varied by age from 64% of under 30s to 19% of over 50s. Fifteen per cent of respondents said they had used opiates and 29% cocaine. HMIP reports that treatment data describes 25% of all prisoners starting substance misuse treatment within three weeks of arrival at prison. Separately, the NDTMS updates regularly and quotes a far higher proportion; this data has informed the recent PHE report which outlines trends in substance misuse in secure settings.[251]

> *Drug use in prisons will, to some extent, reflect use in the community, but there are some important differences. There is a preference for depressants, rather than stimulants, in prisons. Security measures affect the choice and quality of what is available. The misuse of opiates in prisons appears to be declining but remains an important issue. There has been an increase in the use of diverted medication. Large numbers of prisoners present with chronic pain, and some come into prison taking, or are started in*

[249] Wadd, S. *et al.* (2014) The forgotten people: drug problems in later life. [Accessed 7/12/20].
[250] HMIP (2015) Thematic Report. Changing patterns of substance misuse in adult prisons and service responses. [Accessed 10/12/20].
[251] PHE (2018) Secure setting statistics from the National Drug Treatment Monitoring System. [Accessed 10/12/20].

prison on, inappropriately prescribed drugs. In recent years, the use of NPS – in particular, synthetic cannabis, known as 'Spice' or 'Mamba' – has grown significantly.[252]

A rapid systematic review[253] found that between 34% and 43% of males in custody scored for alcohol dependency, compared to 6% of the general population.

In terms of service planning, the range of predictions generated from estimates is unhelpful. We have, therefore, taken a mid-point for predictions based on the available evidence.

It is important to note that the predicted demand simply gives likely numbers of individuals, not the specific interventions. For example, some individuals may require clinical detoxification, individual psychosocial interventions, and group work. The resources needed for a clinical detoxification are vastly different to those needed to undertake psychosocial interventions.

Given all of the above, the estimates used to predict rates of drug and alcohol misuse in Part A are:

Figure 18 – Rates of Drug and/or Alcohol Problems Used in Prevalence Estimates

	Male Residents	Female Residents
Alcohol abuse or dependence	16[254]-43%[255] (midpoint 29.5%)	20[256] - 54%[257] (midpoint 37%)
Drug abuse or dependence	28[258] to 51%[259] (midpoint 39.5%)	52%[260] 58%[261] (midpoint 55%)

In a remand setting, the majority of presentations will be people arriving in the prison system who are seeking clinical support for dependency or who are seeking psychosocial support for a substance misuse problem developed in the community. In a long-term prison, presentations for clinical interventions will be from transfers in who are currently prescribed Opioid Substitution Therapy (OST) or people with 'a prison habit'. A recent shift of focus in DH guidelines moves away from detoxification, so more prisoners will be in receipt of long-term prescriptions.[262] Psychosocial referrals will be largely for support regarding a previous substance misuse problem or assistance in how to remain substance free after release.

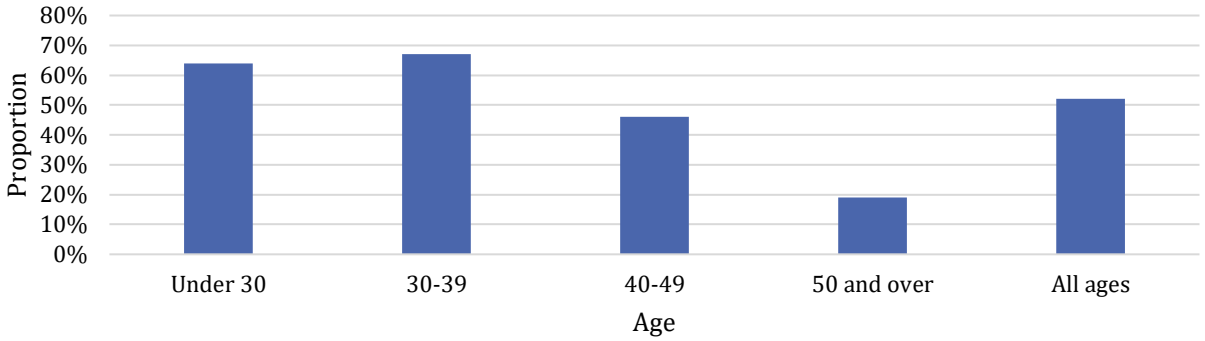
Therefore, for this section of the report we are taking incidence to be the static population plus the number of new arrivals (new receptions and/or transfers in) to the prison during the year. This is consistent with the approach to incidence taken throughout the report, but may generate different figures to those seen in some NDTMS reports.

252 HMIP (2015) Thematic Report. Changing patterns of substance misuse in adult prisons and service responses. [Accessed 7/12/20].
253 Newbury-Birch, D. *et al.* (2016) A rapid systematic review of what we know about alcohol use disorders and brief interventions in the criminal justice system. [Accessed 7/12/20].
254 Singleton *et al.* (1999) Substance misuse among residents in England and Wales. [Accessed 7/12/20].
255 Newbury-Birch, D. *et al.* (N.D.) Alcohol screening and brief intervention in the prison system. [Accessed 7/12/20].
256 Singleton *et al.* (1999) Substance misuse among residents in England and Wales. [Accessed 7/12/20].
257 Parkes *et al.* (2011) Prison health needs assessment for alcohol problems. [Accessed 7/12/20].
258 HMIP (2015) HM Inspectorate of Prisons annual report 2014-2015. [Accessed 7/12/20].
259 Home Affairs Committee (2012) Drugs in prisons: drug use in prisons. [Accessed 7/12/20].
260 Women in Prison website Key facts. [Accessed 7/12/20].
261 Light, M. *et al.* (2013) Gender differences in substance misuse and mental health amongst residents. [Accessed 7/12/20].
262 DH (2017) Drug misuse and dependence. UK guidelines on clinical management (Often referred to as 'The Orange Book'). [Accessed 7/12/20].

Substance Misuse and Young Offenders

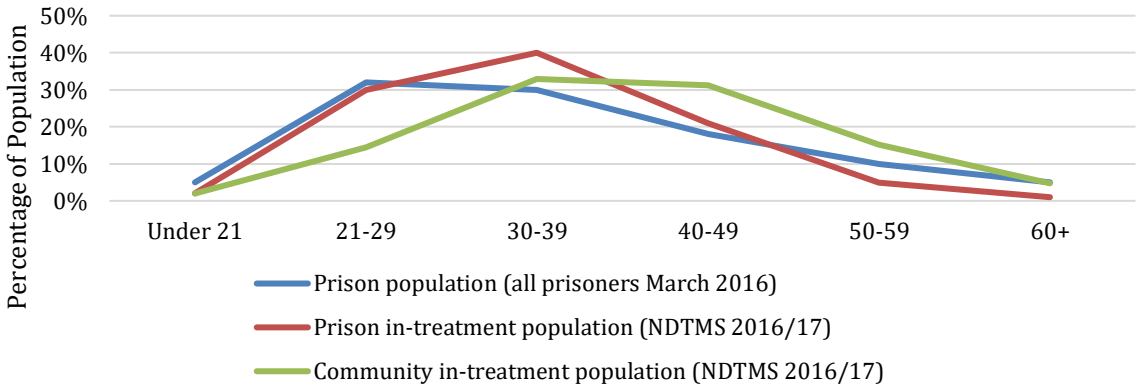
Drug misuse is more prevalent among younger residents than older residents, as is illustrated in the latest HMIP thematic report.[263]

Figure 19 – Prevalence of Drug Misuse by Age[264]



Younger prisoners are also more likely to be in treatment than older prisoners; the in-treatment population in prisons is also notably younger than that in the community.

Figure 20 – Age of In-Treatment Populations



Alcohol

Data from the Adult Psychiatric Morbidity Survey suggests that 20% of British people consume alcohol at 'hazardous' levels – this is more common in men (26%).[265] Alcohol Concern describes a strong correlation between drinking and offending.[266]

New Psychoactive Substances (NPS/PS)

Psychoactive substances (PS) drugs are defined as:

> *Psychoactive drugs, newly available in the UK, which are not prohibited by the United Nations Drug Conventions but which may pose a public health threat comparable to that posed by substances listed in these conventions.*[267]

[263] HMIP (2015) Changing patterns of substance misuse in adult prisons and service responses. [Accessed 7/12/20].
[264] *Ibid.*
[265] ONS (2016) Adult psychiatric morbidity survey: survey of mental health and wellbeing, England, 2014. [Accessed 7/12/20].
[266] Alcohol Concern (2016) Statistics on alcohol. [Accessed 7/12/20].
[267] Home Office (2014) New psychoactive substances review. [Accessed 3/12/20].

There have been changes in the law regarding possession in the community,[268] though all PS-type drugs have been prohibited in prison for some considerable time.[269] Prison mandatory drug testing (MDT) has evolved to include testing for some forms of PS drugs.

The HMIP Annual Report for 2017-18 repeats its previous view[270] that:

> *Much of the violence seemed to be linked to drugs and debt.*[271]

The thematic report expanded on this to observe that:

> *The extent and the nature of illicit drug misuse vary between individual establishments and can even be different in different parts of the same establishment. Synthetic cannabis is not the only drug issue facing prisons in England and Wales, and its use varies in different prisons. Patterns of use change rapidly at both a national and individual level.*[272]

Concerns about PS use are not restricted to the UK, it is an EU-wide problem.[273]

In 2016, 17 9.3% of random mandatory drug tests within prison were positive. At this time, it was not possible to test for PS.[274] Following the inclusion of NPS drugs in mandatory drug tests from September 2017, HMIP reports on the positive rates in prisons they have inspected:

HMP Liverpool 37.5%
HMP Wandsworth *'nearly 30%'*
HMP Hull 24% (noting it had peaked at 45%)
HMP Oakwood 17.9% (peaked at 25%)
HMP Woodhill 15.5%

It is somewhat misleading to describe PS and particularly 'Spice' as synthetic cannabinoids; the effects and side effects bear little resemblance to those of even the most potent forms of cannabis. Project Neptune[275] has suggested PS and club drugs can be divided into four categories:

Figure 21 – PS and Club Drug Types

Synthetic Cannabinoids	Depressants	Stimulants	Hallucinogens
Include a large number of drugs, the most widely used being Spice and Black Mamba.	Include such drugs as GHB, GBL, and ketamine - which has dissociative effects in addition to its depressant effects.	Include drugs like MDMA, better known as ecstasy, and ecstasy variants such as PMA and PMMA.	Include drugs such as LSD and assorted tryptamines and phenethylamines.

Of these, the so-called synthetic cannabinoids are most common in prison. Different data sources describe very different numbers of finds. In response to a parliamentary question, data was made available on finds of prohibited substances in prison. Spice was, by far, the most common and finds have increased significantly over the five years:

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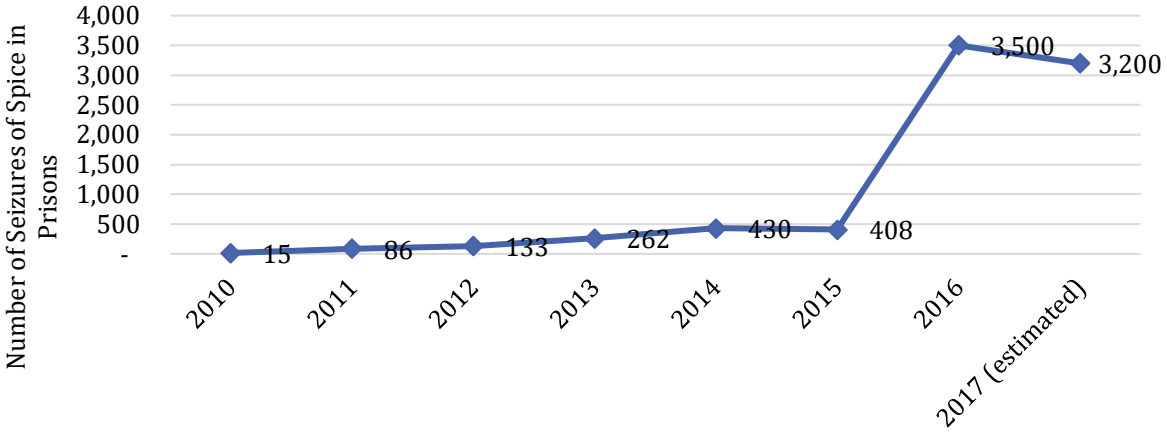
[268] Home Office (2016) Psychoactive Substances Act 2016. [Accessed 3/12/20].
[269] Including specific powers under the Criminal Justice and Courts Act (2015). [Accessed 3/12/20].
[270] HMIP (2017) Annual report 2016-17. [Accessed 3/12/20].
[271] HMIP (2018) Annual report 2017-18. [Accessed 3/12/20].
[272] HMIP (2015) Changing patterns of drug use in adult prisons and service responses. [Accessed 3/12/20].
[273] EMCDDA (2018) New psychoactive substances in prison. [Accessed 3/12/20].
[274] MOJ (2017) Supplementary tables and MDT data tool. [Accessed 3/12/20].
[275] Project Neptune (N.D.) Neptune clinical guidance. [Accessed 7/12/20].

Figure 22 – HMPS Seizures of Spice (2010-2014)

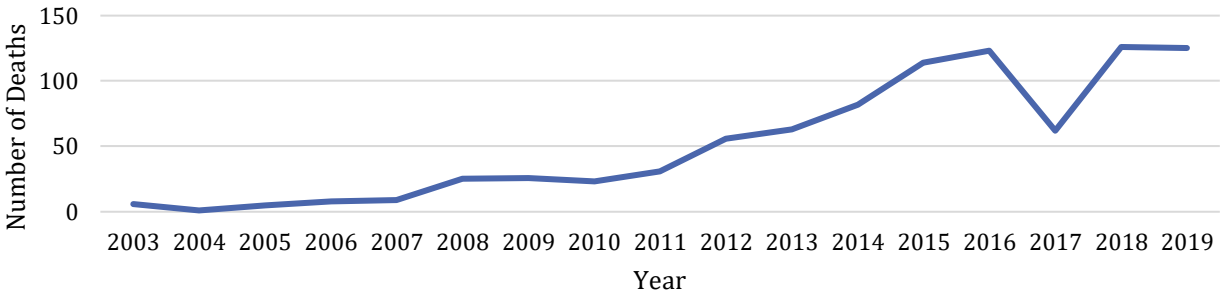


Spice is now a substantial problem in prison, with the number of seizures having gone up from 408 in 2015[276] to 4,261 in 2016.[277]

Of all substances including psychoactive substances, HMPPS reports that 17.7% of drug tests were positive in the 12 months to March 2019.[278] PS are the most prevalent types of drug in prison and were present in 51% of all positive samples, overtaking cannabis, opiates and buprenorphine by a large margin.[279]

There were 117 deaths in prison between June 2013 and September 2018 where the person was known, or strongly suspected, to have used or possessed new psychoactive substances (NPS) before their death.[280] In the community, ONS reports that deaths attributed to PS use across the whole community remain infrequent but are increasing over time.[281]

Figure 23 – PS Deaths in England and Wales (2005-2016)



Predicting future demand, common across all establishments, we believe that healthcare will continue to see impacts from the use of PS. SMMGP has produced good practice guidelines for GPs working in prisons.[282] Looking wider afield, PS use in prisons is becoming a problem across Europe, indicating that this is not a passing fad.[283] Changes in MDT may have a positive impact, but the very nature of PS-type drugs is such that chemical formulas can be changed easily, thus evading tests. Keeping up becomes a game of cat and mouse. In some prisons, men have learned and either use less, or less dangerously, because the frequency of incidence has peaked.

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[276] House of Commons (2017) Mental health in prisons. [Accessed 7/12/20].

[277] Forward Trust (2016) Prison seizures of 'legal highs' increased by 30 times in five years. [Accessed 7/12/20].

[278] HMPPS (2020) HMPPS annual digest. [Accessed 7/12/20].

[279] *Ibid.*

[280] Prison Reform Trust (2019) Prison: the facts. [Accessed 7/12/20].

[281] ONS (2020) Deaths related to drug poisoning in England and Wales: 2019 registrations. [Accessed 10/12/20].

[282] Ryan, G. (2017) Novel psychoactive substances: synthetic cannabinoids – best practice treatment approaches. [Accessed 7/12/20].

[283] EMCDDA (2018) New psychoactive substances in prison. [Accessed 7/12/20].

Figure 24 – PS Drug Challenges

Challenges for Healthcare Staff	Challenges for Prison Staff/Regime
Unpredictable effects, coupled with covert nature of drug use often means a delay in seeking medical help.	Rapidly increasing prevalence is placing additional demands on prison and security staff resources in terms of supply reduction, searching and detection activities.
Some of the extreme effects of synthetic cannabinoids require immediate response and may require urgent transfer to hospital.	
The adverse effects of synthetic cannabinoids can be long-lasting and healthcare staff may have to manage the consequences for months following the initial presentation.	Prison staff managing long-term challenging or aggressive behaviour has resource implications.
Some prisoners using PS may not see themselves as having 'substance misuse problems' and therefore unlikely to access treatment in prisons.	The need to restrain and control prisoners behaving abnormally or dangerously.
It may be necessary to withhold prescribed medication where PS use is suspected due to interactions with drugs.	PS use in prison is linked to rising problems with debt, bullying and violence, with organized crime groups believed to be supplying PS drugs into prisons.

PHE produced a toolkit[284] and a useful discussion document about PS use in prisons, informed by a series of training events.[285]

An MA dissertation, partly informed by research in a North West prison, provides a synopsis of the published research, and explores reasons for NPS use and approaches to combatting it.[286]

Alcohol Consumption and Age

A social care study at the University of Bedfordshire examined issues relating to problem drinking among older people (aged 50 and over). It found that:

> *As individuals become older, they often experience multiple losses, for example, loss of family, friends and health, and changes in role such as retirement or becoming a caregiver for an elderly partner or relative. Additional stressors (e.g. chronic pain or insomnia) and multiple crises (e.g. economic and health problems) may result in an overwhelming situation in which alcohol misuse may begin to increase.*[287]

Figure 25 – Prevalence of Drinking by Age

Age Group	Proportion likely to drink every day (%)
16-25	1%
25-44	4%
45-64	9%
>65	13%

The Mental Health Foundation states that alcohol abuse is more likely to go unrecognised in older people.[288]

In terms of wider substance misuse, one of the key findings from the *Surveying Prisoner Crime Reduction* survey was that:

[284] PHE (2015) NPS toolkit. [Accessed 7/12/20].
[285] PHE (2017) Thematic analysis of training for prison staff on new psychoactive substances. [Accessed 7/12/20].
[286] Norton, A. (N.D.) Spicing up the subject. [Accessed 7/12/20].
[287] Wadd, S. *et al.* Working with older drinkers. [Accessed 7/12/20].
[288] Mental Health Foundation (2015) Mental health in later life. [Accessed 7/12/20].

> *Older residents reported lower levels of drug use compared to younger residents, with fewer than three in ten older residents reporting using any drug before custody compared to the majority of younger residents.*[289]

Referring to those over 60 years in the general population, the World Health Organisation notes:

> *Substance use problems affect almost 1% …. Substance abuse problems among the elderly are often overlooked or misdiagnosed.*[290]

Prevalence of Substance Misuse Among Sex Offenders

Any assumption that drug and alcohol misuse will be less among sex offenders than the wider prison population appears misplaced.

A large-scale longitudinal study exploring the correlation between sexual offending behaviour and severe mental illness in men, examined data from the Swedish national registers for crime and national hospital discharge diagnoses between the years of 1988 and 2000. The results showed that sex offenders in this study were four times more at risk than the general population of alcohol or drug dependency.[291]

A more recent Dutch meta-analysis of international published articles reported that approximately half of sex offenders had a history of drug misuse and between a quarter and a half had a history of alcohol misuse. These figures are far higher than the general population and closer to those quoted for all residents.[292]

[289] MOJ (2014) The needs and characteristics of older residents: results from the Surveying Prisoner Crime Reduction (SPCR) survey: analytical summary. [Accessed 7/12/20].

[290] World Health Organisation (2013) Mental health of older adults. [Accessed 7/12/20].

[291] Fazel, S. *et al.* (2007) Severe mental illness and risk of sexual offending in men: a case-control study based on Swedish national registers. [Accessed 7/12/20].

[292] Kraaen, F. & Emmelkap, P. (2011) Substance misuse and substance use disorders in sex offenders: a review. [Accessed 7/12/20].

Mental Health

Context

The NHS Five Year Forward View for Mental Health (2016) states:[293]

> *The NHS needs a far more proactive and preventative approach to reduce the long term impact for people experiencing mental health problems and for their families, and to reduce costs for the NHS and emergency services…Mental health has not had the priority awarded to physical health, has been short of qualified staff and has been deprived of funds. We must provide equal status to mental and physical health, equal status to mental health staff and equal funding for mental health services as part of a triple approach to improve mental health care – a fresh mindset for mental health within the NHS and beyond.*

As part of this systemic overhaul, a new national service specification has been developed for prison mental health services.[294]

In 2016–17, NHS England spent an estimated £400 million on the provision of healthcare to adult prisons in England, of which it estimates £150 million was spent on mental health and substance misuse services (although it could not provide an exact figure).[295]

While all prison officers receive basic training on mental health awareness when they are recruited, 40% of prisons do not offer any mental health awareness refresher training to existing staff.[296]

New NICE guidelines were issued in March 2017 covering the assessment and management of people (over 18) with mental health problems in prison.[297]

In June 2017, the head of the National Audit Office stated:

> *Improving the mental health of those in prison will require a step change in effort and resources. The quality of clinical care is generally good for those who can access it, but the rise in prisoner suicide and self-harm suggests a decline in mental health and well-being overall. The data on how many people in prison have mental health problems and how much government is spending to address this is poor.*[298]

In March 2018, NHS England issued a new Service Specification.[299]

The Independent Advisory Panel on Deaths in Custody undertook interviews with residents who stated that mental health treatment and wellbeing could be improved by focusing on prevention work, tailoring drug treatment to the individual, and ensuring timely responses from trained mental health teams.[300] The same report indicates that residents suggested that their basic mental health needs could be met through the maintenance of a safe and clean environment, and ensuring access to sanitation, showers, exercise, fresh air, daylight, nourishing food at sensible times and a decent night's sleep.[301]

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[293] Mental Health Taskforce (2016) The five year forward view for mental health. [Accessed 10/12/20].

[294] NHS England (2018) Service specification. Integrated mental health service for prisons in England. [Accessed 8/12/20].

[295] House of Commons Committee of Public Accounts (2017) Mental health in prisons eighth report of session 2017–19. [Accessed 8/12/20].

[296] *Ibid.*

[297] NICE (2017) Mental health of adults in contact with the criminal justice system. [Accessed 8/12/20].

[298] Morse, A. (2017) Mental health in prisons. [Accessed 8/12/20].

[299] NHS England (2018) Service specification. Integrated mental health service for prisons in England. [Accessed 8/12/20].

[300] Independent Advisory Panel on Deaths in Custody (IAP) (2017) Keeping safe - preventing suicide and self-harm in custody. Residents' views collated by the IAP December 2017. [Accessed 8/12/20].

[301] *Ibid.*

> *Twenty-five per cent of the prison population, according to the Revolving Doors Agency, a charity specialising in the criminal justice system, have problems communicating or handling complex information, although they might not strictly meet diagnostic criteria for a learning disability and, consequently, are unlikely to be eligible for support.*[302]

An investigation by the PPO found that nearly one in five of those diagnosed with a mental health problem received no care from a mental health professional in prison.[303]

National Evidence Base on Prevalence

There is a solid evidence base demonstrating that prisoners, in general, are more likely to suffer from mental illness than the general population. For example, UK papers describe the level of psychosis to be four times as high among male prisoners (15%) as in the general adult population.[304] Male prisoners are described as being more than ten times as likely to have a personality disorder than a member of the general community[305] and, as discussed in the previous section, the level of drug dependency is nine times as high.

A previous systematic review on the mental health of residents in the UK found a wide range of prevalence rates for mental health disorders.[306] The updated 2009 descriptive review identified 18 studies reporting on the prevalence of mental health disorders in prison populations and concluded that:

> *… overall, the prevalence of mental health disorders and substance misuse is shown to be substantially higher in prison populations than in community populations around the world.*[307]

The most robust prevalence study, covering both England and Wales, was conducted in 1998.[308] Although almost two decades old, it remains the most relevant prevalence study, conducted in all the then 131 prisons, and involving in-depth clinical interviews with a large sample of residents (men and women, remanded and sentenced).

- Nine out of every ten residents in the UK display evidence of one or more mental disorders (including substance misuse)
- 78% of remanded and 64% of sentenced men have some form of personality disorder
- 10% of remanded and 7% of sentenced men have suffered from functional psychosis in the year before being sentenced
- 12-15% of residents have four to five co-existing mental disorders
- 7% of the prison population have a serious and enduring mental health problem
- Over 50% of remand and 30% of sentenced young offenders have a diagnosable mental health disorder[309]

A more recent meta-analysis by NICE found that prescribing rates of psychotropic

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[302] House of Commons Health and Social Care Committee (2018) Prison health twelfth report of session 2017–19. [Accessed 8/12/20].

[303] Prison Reform Trust (2019) Bromley briefings prison factfile. [Accessed 3/12/20].

[304] Prison Reform Trust (2019) Bromley briefings prison factfile. [Accessed 3/12/20].

[305] The Centre for Mental Health (2011) Briefing 39: mental health and the criminal justice system. [Accessed 8/12/20].

[306] Brooker, C. *et al.* (2002) Mental health services and residents: a review. [Accessed 8/12/20].

[307] Sirdeifield, C. *et al.* (2009) A systematic review of research on the epidemiology of mental health disorders in prison populations: a summary of findings. [Accessed 8/12/20].

[308] Singleton, N. *et al.* (1998) Psychiatric morbidity among residents in England and Wales. [Accessed 8/12/20].

[309] HMIP and Home Office (1997) Young residents: a thematic review by HM Chief Inspector of Prisons for England and Wales. [Accessed 8/12/20].

medications to men in prisons are four times greater than for an equivalent age-adjusted community sample:

> *[P]sychotropic medicines were prescribed for a wider range of clinical indications than currently recommended, with discernible differences in drug choice.*
>
> *There were significant preferences for certain antidepressant and antipsychotic drugs in prison, compared with in the community. In 65.3% of cases, indications for psychotropic drugs were recorded and upheld in the British National Formulary. Antipsychotic prescriptions were less likely than other psychotropics to be supported by a valid indication in the patient note.*[310]

In 2016, this pattern was confirmed to still be the case.[311]

Learning Difficulties and Disabilities

Learning difficulty is a broad term and the majority of people with learning difficulties should receive any assistance they require from education. Nearly three in 10 people (29%) were identified as having a learning disability or difficulty following assessment on entry to prison in 2015–16.[312] HMIP states:

> *Although believed to be a sizeable minority, possibly as high as 30%, we have no way of knowing the number of people with such conditions within the criminal justice system.*[313]

Learning disability is a more restricted definition, and responsibility for care falls to both healthcare and the prison's equalities team:

> *[A] learning disability is defined by three criteria: an IQ score of less than 70; significant difficulties with everyday tasks; and onset prior to adulthood.*[314]

It is estimated that between two and 10% of offenders have a learning disability.[315] Supporting this order of prevalence, a study of nearly 3,000 residents using the Learning Disability Screening Questionnaire (LDSQ) tool found 7% were screened positive.[316] In addition, *'a significant percentage of the prison population'*[317] have borderline learning disability, defined as an IQ between 70 and 80.

The *No One Knows* report suggests that offenders with learning disabilities are particularly vulnerable as:

> *[t]hey are at risk of re-offending because of unidentified needs and consequent lack of support and services. They are unlikely to benefit from conventional programmes designed to address offending behaviour. They are targeted by other people when in custody and they present numerous difficulties for the staff who work with them, especially when these staff often lack specialist training or are unfamiliar with the challenges of working with this group of people.*[318]

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[310] Hassan, L. *et al.* (2014) A cross-sectional prevalence survey of psychotropic medication prescribing patterns in prisons in England. [Accessed 8/12/20].

[311] Hassan, L. *et al.* (2016) Prevalence and appropriateness of psychotropic medication prescribing in a nationally representative cross-sectional survey of male and female residents in England. [Accessed 8/12/20].

[312] Prison Reform Trust (2019) Bromley briefings prison factfile. [Accessed 3/12/20]. [Accessed 8/12/20].

[313] HM Inspectorates of Prisons and Probation (2015) A joint inspection of the treatment of offenders with learning disabilities within the criminal justice system. [Accessed 8/12/20].

[314] Hughes, N. *et al.* (2012) Nobody made the connection: the prevalence of neurodisability in young people who offend. [Accessed 8/12/20].

[315] DH (2015) Equal access, equal care; guidance for prison healthcare staff treating patients with learning disabilities. [Accessed 8/12/20].

[316] Murphy *et al.* (2015) Screening residents for intellectual disabilities in three English prisons. [Accessed 8/12/20].

[317] DH (2015) Equal access, equal care; guidance for prison healthcare staff treating patients with learning disabilities. [Accessed 8/12/20].

[318] Prison Reform Trust (2007). No one knows. [Accessed 8/12/20].

ADHD

ADHD is a relatively common disorder amongst children, with estimates suggesting a prevalence of 3.62% in boys and 0.85% in girls between 5-15 years. The worldwide prevalence of ADHD in children is between 3 and 7%.[319]

Of children diagnosed with ADHD, it is estimated that only 15% retain their full diagnosis by the age of 25. Therefore, ADHD in partial remission is far more common from the age of 25 years. Population surveys estimate that 3-4% of the adult population have ADHD.[320]

There is strong evidence to suggest higher rates of ADHD in prison than in the general community:

> *Research suggests there is a disproportionately high concentration of ADHD individuals involved with the CJS, and for these individuals criminal justice procedures often interface with a complex web of behaviour, substance use and mental health issues. International studies…report that up to two-thirds of young offenders and half of the adult prison population screen positively for childhood ADHD, and many continue to be symptomatic with rates reported at 14% in adult male offenders and 10% in adult female offenders. In young offenders rates are around 45%. A UK study of personality disorder wards in Forensic Mental Health Services found similar screening rates (33%), with a sizeable number of individuals in partial remission of symptoms.*
>
> *UK prison studies have indicated a rate of 43% in 14-year-old youths and 24% in male adults screening positive for a childhood history, 14% of whom had persisting symptoms. Those with persisting symptoms accounted for eight times more aggressive incidents than other residents and six times more than residents with Antisocial Personality Disorder. They had a significantly younger onset of offending by around 3.5 years (16 vs. 19.5 years); and they had a significantly higher rate of recidivism. ADHD was the most important predictor of violent offending, even above substance misuse.*[321]

RCPsych Standards say that all those prescribed for ADHD should be reviewed annually.[322]

Autistic Spectrum Disorders

Whilst often bundled alongside learning disabilities,[323] autistic spectrum disorder is quite distinct.

> *Autism is a lifelong, developmental disability that affects how a person communicates with, and relates to, other people, and how they experience the world around them.*[324]
>
> *Although it is important to consider that there is no evidence to suggest that individuals with autism are more likely to offend than the 'neurotypical' population, specific vulnerability factors may increase an individual's risk within the context of social exclusion.*[325]
>
> *It is estimated that a disproportionately high number of residents have an autistic spectrum condition, i.e. autism or Asperger's syndrome, however, there is currently no national data to present exact figures. Whilst autistic spectrum conditions are not classed as a learning disability in themselves, recent research from the learning disabilities observatory indicates that around 20-30 per cent of people with a learning*

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[319] Austen *et al.* (2019) Onset and prevalence of ADHD. [Accessed 8/12/20].

[320] NICE (2008) Attention deficit hyperactivity disorder: diagnosis and management. [Accessed 8/12/20].

[321] Young *et al.* (2011) The identification and management of ADHD offenders within the criminal justice system: a consensus statement from the UK Adult ADHD Network and criminal justice agencies. [Accessed 8/12/20].

[322] RC Psych (2015) Standards for prison mental health services. [Accessed 8/12/20].

[323] HM Inspectorates of Prisons and Probation (2015) A joint inspection of the treatment of offenders with learning disabilities within the criminal justice system. [Accessed 8/12/20].

[324] National Autism Society (2020) What is autism? [Accessed 8/12/20].

[325] Murphy D (2010) Understanding offenders with autism-spectrum disorders: what can forensic services do? [Accessed 8/12/20].

disability also have an autistic spectrum condition.[326]

DH guidance to support the adult autism strategy[327] includes a chapter specifically on working in the criminal justice system.[328] This states that:

> *NHS England is responsible for arranging the provision of health services for such residents and detainees. For people with autism this will include offering access to the local diagnosis pathway and access to assessment of care and support needs in advance of release from prison.*
>
> *Local authorities have responsibilities, under the Care Act from April 2015, to assess the care and support needs of adults (including those with autism) who may have such needs in prison.*

There is further detailed guidance available from the National Autistic Society.[329]
The evidence about prevalence of autistic conditions shows an increase, which is likely as much to do with better knowledge of the condition as it is to do with increased numbers of people having the condition.

The 2014 Adult Psychiatric Morbidity Survey estimated a UK prevalence rate of 0.8% for all adults, predominantly men; a rate of 1.5% for men nationally.

The study noted:

> *Rates may be different in specific adult populations, such as among people who are homeless or living in prison. Rates were higher in men and in those without educational qualifications.*[330]

People with vulnerabilities including autism, ADHD or acquired brain injury may suffer linked health problems but may find it harder to communicate their situation.[331]

Speech, Language and Communication Needs

The Royal College of Speech and Language Therapists produced a dossier of evidence in 2012 that suggests high prevalence of speech, language and communication disorders amongst offenders, particularly young offenders

> *Over 60% of people in the youth justice estate have difficulties with speech, language or communication. A survey at Polmont Young Offender's Institution found that 70% of young men had significant communication problems.*
>
> *Studies have shown varying levels of need. In one study, a high proportion (74%) of young people with the youth offending team had below average communication skills, which is significantly more than the average population (approximately 10%). There is a high level of severe communication difficulty (42%) which is significantly higher than the average population.*
>
> *In another study, all new entrants to the Intensive Supervision and Surveillance Programme (ISSP) were screened and 65% (49) required speech and language therapy intervention. A significant number (20%) scored at the 'severely delayed' level on standardised assessment and six per cent as 'very severely delayed'.*

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[326] DH (2015) Equal access, equal care: guidance for prison healthcare staff treating patients with learning disabilities. [Accessed 8/12/20].
[327] DH (2015) Adult autism strategy. [Accessed 8/12/20].
[328] DH (2015) Statutory guidance for local authorities and NHS organisations to support implementation of the adult autism strategy. [Accessed 8/12/20].
[329] National Autistic Society (2011) A guide for criminal justice professionals. [Accessed 8/12/20].
[330] McManus, S. *et al.* (2016) Mental health and wellbeing in England: adult psychiatric morbidity survey 2014. [Accessed 8/12/20].
[331] NHS England (2018) Service specification: integrated mental health service for prisons in England. [Accessed 8/12/20].

Another study showed that over 60% of service users have speech, language and communication needs (SLCN). This proportion mirrors what previous studies, above, have identified. In comparison, a separate study showed that there is a high level (91%) of communication disability in young people known to the youth offending team. This is significantly greater than in the general population (10%).[332]

Trauma

There has been growing recognition of the long-term impact of childhood trauma, the concept of:

Adverse childhood experiences (ACEs), such as being a victim of violence or neglect, or living with a household member who abuses substances or is involved in criminal activity.

A positive relationship was found between ACEs and certain lifestyle factors (smoking and unhealthy weight) and ACEs and long-term health conditions.

Patients with ≥2 ACEs were over two and a half times more likely to suffer from asthma and almost three times more likely to have complex health needs and be living with multiple long-term conditions, compared with those with 0-1 ACE(s).

Mental health had the strongest association with childhood adversity, with patients with ≥2 ACEs over three and a half times more likely to be experiencing current mental health problems, compared with those with 0-1 ACE(s). ACE count was also found to correlate with severity of depression and anxiety among those being treated for mental health problems.[333]

Other studies explicitly link ACEs to youth offending:

certain vulnerable groups, such as people involved in offending, are known to have experienced higher levels of adversity than others. .... [T]he impact of childhood bereavement which, although known to be a common feature in the lives of young people involved in offending, is rarely documented in Adverse Childhood Experience studies.[334]

A study in Wales concluded that adults with four or more ACE events were 15 times more likely to have committed violence against another person than those who had no ACEs.[335]

Studies describe how children who experience chronic stress from adverse events can become 'locked' into a state of hyper-arousal, wary of further trauma.[336]

A study[337] examining the backgrounds and psychiatric morbidity of young offenders in custody found:

- 29% of the male sentenced group and 42% of the male remand group had been taken into local authority care as a child
- Approximately a quarter of the young men who were interviewed reported having suffered from violence at home
- Approximately 5% of the young men reported having suffered sexual abuse

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[332] Royal College of Speech and Language Therapists (2012) Speech, language and communication needs in the criminal justice system and best practice responses to these. [Accessed 8/12/20].

[333] Hardcastle, K. & Bellis, M. (2018) Routine enquiry for history of adverse childhood experiences (ACEs) in the adult patient population in a general practice setting: A pathfinder study. [Accessed 10/12/20].

[334] Vaswani (2018) Adverse childhood experiences in children at high risk of harm to others. A gendered perspective. [Accessed 10/12/20].

[335] Bellis, M. *et al.* (2015). Adverse childhood experiences and their impact on health-harming behaviours in the Welsh adult population. [Accessed 10/12/20].

[336] Anda, R.F. *et al.* (2006) The enduring effects of abuse and related adverse experiences in childhood. A convergence of evidence from neurobiology and epidemiology. [Accessed 10/12/20].

[337] Singleton, N. *et al.* (2000) Psychiatric morbidity among young offenders in England and Wales. [Accessed 10/12/20].

- 13% of male remand and 11% of male sentenced respondents reported having received help for mental or emotional problems in the year before coming to prison
- Around one in 10 male young offender respondents had been offered help for mental, nervous or emotional problems which they had turned down in the year before coming to prison

Another large scale, slightly more recent study[338] also of young people in custody reported that for boys:

- 40–49% had a history of local authority care
- 25% suffered violence at home
- 5% reported sexual abuse
- 66% reported hazardous drinking
- 85% showed signs of personality disorder
- 40% reported anxiety/depression

PTSD

Singleton *et al*. identified a 3% prevalence amongst prisoners.[339] A recent international meta-analysis described a higher rate of 6.2% prevalence in male prisoners.[340]

In addition to medication, NICE guidance for the treatment of PTSD recommends CBT interventions including: cognitive processing therapy, cognitive therapy for PTSD, narrative exposure therapy and prolonged exposure therapy. EMDR is also a recognised treatment.[341]

Traumatic Brain Injury

There are around 900,000 hospital admissions for head injuries each year, 10% of which are categorised as severe. Head injuries are proportionately higher among young adults and those over 75 years. Estimates state that from 31%[342] to 60%[343] of offenders have a history of traumatic brain injury. A recent study found Hospitalised Head Injury (HHI) has been found in 24.7% (1,080/4,374) of prisoners; this rate is significantly more than that found in the matched general population.[344]

Traumatic brain injury is especially associated with offending patterns in young offenders.[345]

Head injury doubles a person's risk of going on to experience mental health problems.[346] A French study postulates to a link between traumatic brain injury and the high rate of epilepsy

[338] Stuart, M. and Baines, C. (2004) Safeguards for vulnerable children: three studies on abusers, disabled children and children in prison. [Accessed 10/12/20].

[339] Singleton, N. *et al.* (1998) Psychiatric morbidity among residents in England and Wales. [Accessed 8/12/20].

[340] Baranyi G *et al.* (2018) Prevalence of posttraumatic stress disorder in prisoners. [Accessed 10/12/20].

[341] NICE (2018) Post traumatic stress disorder. [Accessed 10/12/20].

[342] Waiter, L. *et al.* (2016) Prevalence of traumatic brain injury and epilepsy among residents in France: results of the Fleury TBI Study. [Accessed 8/12/20].

[343] Parsonage, M. (2016) Traumatic brain injury and offending. [Accessed 8/12/20].

[344] Mc Millan T *et al.* (2019) The lifetime prevalence of hospitalised head injury in Scottish prisons: a population study. [Accessed 10/12/20].

[345] Williams, H. *et al.* (2010) Self-reported traumatic brain injury in male young offenders: A risk factor for re-offending, poor mental health and violence? [Accessed 8/12/20].

[346] Parsonage, M. (2016) Traumatic brain injury and offending. [Accessed 8/12/20].

amongst residents.[347]

Mental Health and the Elderly

> *Older people's mental health services should not be subsumed into a broader 'adult mental health' or 'ageless service'. The needs of older people with functional mental illness (for example depression) and/or organic disease such as dementia and their associated physical and social issues are often distinct from younger people.*[348]

In considering emerging needs, there is a new population of older prisoners serving their first sentence in later life who do not fit wide demographic profiles for prisoners; it is important to also reference wider community data which indicates that one in five older people suffer with depression, and this increases to two in five in other institutional settings (care home populations).[349]

Older people tend to have a complex combination of long-term physical as well as mental health issues. The guidance promotes integrated care:

> *Commissioners and service providers need to seek and exploit opportunities for joint working and service delivery that can address both physical and mental health needs. Older people with long-term health conditions make up the greater proportion of this care group. Having more than one long-term condition greatly increases the risk of depression. Planning and delivering an integrated service to manage service delivery to this group through joint working protocols will be the best and most cost-effective way to manage care.*[350]

Because of these factors, the current national HNA datasets and toolkits are somewhat unrepresentative of this part of the prison population and may therefore not be a reliable indicator regarding the prevalence of mental health issues in the prison. Published articles describe how:

> *As the elderly population continues to grow worldwide, depression is also likely to become an increasing health problem.*[351]

The World Health Organisation summarises the mental health of older people as follows:

> *Over 20% of adults aged 60 and over suffer from a mental or neurological disorder (excluding headache disorders) and 6.6% of all disability [...] among over 60s is attributed to neurological and mental disorders. The most common neuropsychiatric disorders in this age group are dementia and depression. Anxiety disorders affect 3.8% of the elderly population.*[352]

The Department of Health estimates an even greater prevalence of mental health problems among older people, suggesting that as many as 40% seeing their GP, 50% in general hospitals and 60% of care home residents, have a mental health problem.[353] It is also estimated that between 10% and 25% of those over the age of 65 will experience

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[347] Waiter, L. *et al.* (2016) Prevalence of traumatic brain injury and epilepsy among residents in France: results of the Fleury TBI Study. [Accessed 8/12/20].

[348] Joint Commissioning for Mental Health Panel (2013) Guidance for commissioners of older people's mental health services. [Accessed 8/12/20].

[349] Jacoby, R. & Oppenheimer, C. (eds.) (2002) *Psychiatry in the Elderly.* 3rd ed. Oxford University Press.

[350] Joint Commissioning for Mental Health Panel (2013) Guidance for commissioners of older people's mental health services. [Accessed 8/12/20].

[351] Solhaug, H.I. *et al.* (2012) Increased prevalence of depression in cohorts of the elderly: an 11-year follow-up in the general population – The HUNT Study. [Accessed 8/12/20].

[352] World Health Organisation (2013) Mental health of older adults. [Accessed 8/12/20].

[353] Social Care Institute for Excellence (2006) Assessing the mental health needs of older people. [Accessed 8/12/20].

depression.[354] The Surveying Prisoner Crime Reduction (SPCR) report indicates that 15% of prisoners over the age of 50 will experience both anxiety and depression and that a further 11% will also experience a physical disability in addition to these mental health conditions.[355] WHO indicates that individuals with depressive symptoms may have:

> *… poorer functioning compared to those with chronic conditions such as lung disease, hypertension or diabetes.*[356]

The literature notes the comorbidity of depression alongside a range of age-related issues:

- 50% of people with Parkinson's disease suffer depression[357]
- 25% following stroke[358]
- 20% with coronary heart disease[359]
- 24% with neurological disease[360] and
- 42% with chronic lung disease.[361]

Dementia

Dementia is the decline in a person's mental ability and the most common form of dementia is Alzheimer's disease. Recognising both the profound impact of the condition and the rapidly increasing prevalence, the government created 'The Prime Minister's Challenge on Dementia 2020'.[362] This includes programmes of: research, early diagnosis, training for health and social care professionals and a 'Dementia Friends' awareness programme for the wider public.

Dementia is most common in the elderly and it has not, historically, been common in the secure estate. However, the number of older prisoners has increased sharply in recent years, and dementia, described as a *'hidden problem'* in prisons,[363] will become an increasingly common healthcare concern in the future. Recognising the need in the secure estate, in 2016, the PPO published a learning lessons bulletin.[364] This was followed up with PPO guidance identifying how dementia can make delivering all aspects of healthcare more complex and demanding.[365]

With a rapidly ageing population, it is very relevant to note that between 2% and 10% of all cases of dementia start before the age of 65 years. After 65 years of age, the prevalence doubles every five years.[366] Put another way: the 2014 Dementia UK Update report indicates that one in 14 people over the age of 65 will develop some form of dementia, and this rises to one in four over the age of 85.[367]

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[354] Mental Health Information (2009) Mental health problems with the elderly. [Accessed 8/12/20].

[355] Omolade, S. (2014) The needs and characteristics of older residents: results from the Surveying Prisoner Crime Reduction (SPCR) Survey. Analytical summary. [Accessed 8/12/20].

[356] World Health Organisation (2013) Mental health of older adults. [Accessed 8/12/20].

[357] NICE (2006). Parkinson's Disease: diagnosis and management in primary and secondary care. [Accessed 8/12/20].

[358] Chemerinski, E., & Robinson, R.G. (2000). The neuropsychiatry of stroke. [Accessed 8/12/20].

[359] Davidson (2012) Depression and coronary heart disease. [Accessed 8/12/20].

[360] Sirey, J. *et al.* (2007). An intervention to improve depression care in older adults with COPD. [Accessed 8/12/20].

[361] *Ibid.*

[362] DH (2015) The Prime Minister's challenge on dementia 2020. [Accessed 8/12/20].

[363] Moll, A. (2013) Losing track of time. Dementia and the ageing prison population. [Accessed 8/12/20].

[364] PPO (2016) Learning lessons bulletin fatal incidents investigations Issue 11. Dementia. [Accessed 8/12/20].

[365] PPO (2017) Older residents. [Accessed 8/12/20].

[366] Prince, M. *et al.* (2014). World Alzheimer's report, dementia and risk reduction - an analysis of protective and modifiable factors. [Accessed 8/12/20].

[367] Alzheimer's Society (2014) Dementia UK update. [Accessed 8/12/20].

shows the current prevalence estimates of late-onset dementia for males in the UK, broken down by age band. Of those who currently have late-onset dementia in the UK, 55% have mild dementia, 32% have moderate dementia and 13% have severe dementia.

Figure 26 shows the current prevalence estimates of late-onset dementia for males in the UK, broken down by age band. Of those who currently have late-onset dementia in the UK, 55% have mild dementia, 32% have moderate dementia and 13% have severe dementia.[368]

Figure 26 – Estimated Population Prevalence (%) of Late-Onset Dementia in the UK[369]

Age in Years	Male (%)
60-64	0.9
65-69	1.5
70-74	3.1
75-79	5.3
80-84	10.3
85-89	15.1
90-94	22.6
95+	28.8

These prevalence rates represent a noticeable increase from previous estimates, and even if these estimates remain static, the ageing population – both in the community and in prisons – means that the number of people with dementia will increase year-on-year. This kind of mental illness is very different to those suffered by people in the working-age population and, as such, is treated by clinical specialists in geriatric psychiatry. The Mental Health Foundation observed that the prevalence of dementia is not known and also that in many cases the condition may not be detected.[370]

There are forms of dementia that are possibly triggered by long-term excessive alcohol consumption.[371] Some forms of dementia (e.g. alcohol-related dementia, Wernicke-Korsakoff syndrome) are very clearly alcohol induced.[372]

Having said the above, it is important to note that:

> *[t]he majority of the mental illness experienced by older people is not dementia and there is significant crossover between dementia and functional illnesses such as depression and psychosis.*[373]

There is a link to the earlier section; it is estimated that 20% of people with learning disabilities develop dementia and that they do so at a younger age than the general population.[374]

Estimated Prevalence of Common Mental Health Problems

[368] *Ibid.*

[369] *Idem,* Extracted from Table A.

[370] Moll, A. (2013) Losing track of time. Dementia and the ageing prison population. [Accessed 8/12/20].

[371] Gupta, S., & Warner, J. (2008) Alcohol-related dementia: a 21st-century silent epidemic? [Accessed 8/12/20].

[372] Alzheimer's Society (N.D.) What is Korsakoff's syndrome? [Accessed 8/12/20].

[373] Joint Commissioning for Mental Health Panel (2013) Guidance for commissioners of older people's mental health services. [Accessed 8/12/20].

[374] Alzheimer's Society. (2015). Learning disabilities and dementia factsheet. [Accessed 8/12/20].

The following tables are taken from the work by Singleton *et al.*[375] These estimates are for adults of all ages; one person can have more than one condition. Across every condition the prevalence is greater amongst residents than the general population, and greater amongst remand residents than sentenced.

Figure 27 – Prevalence of Mental Health Conditions (males)

	Estimated National Prevalence		
	Community	Remand	Sentenced
Sleep disorders	21%	67%	54%
Worry	17%	58%	42%
Fatigue	21%	46%	35%
Depression	8%	56%	33%
Irritability	19%	43%	35%
Depressive ideas	7%	38%	20%
Concentration/forgetfulness	6%	34%	23%
Anxiety	8%	33%	21%
Obsessions	7%	30%	22%
Somatic symptoms	5%	24%	16%
Compulsions	5%	24%	15%
Phobias	3%	20%	13%
Worry about physical health	4%	22%	16%
Panic	2%	18%	8%
PTSD		5%	3%

The Likely Demand for Mental Health Services

National studies estimate that between 30 and 85% of people with mental health problems go undiagnosed.[376]

The table below contains estimates of the number of people in the general population presenting with mental health problems each year in different settings.

Strategic decisions about the scope and place of mental health services by commissioners and providers will influence demand, as will access to a range of other support such as listeners, counselling services, exercise and so on.

Figure 28 – Incidence and Identification of Mental Health Disorders[377]

	Percentage of Population	Percentage of those with Mental Health Problems
Mental health problems annual incidence (community)	25%	100%
Attend GP (not necessarily for MH reasons)	23%	92%
Identified by GP	13%	52%
Referred to Outpatients/CMHT	2-3%	8-12%
Admitted	1%	4%

From this, it can be estimated that, of the likely annual incidence of mental health disorders, only around 52% will be identified (have a diagnosis). In addition, not all those identified will require, or indeed want, treatment, with as little as 8 to 12% of those with mental health problems in the community going on to receive specialist treatment (beyond primary care).

[375] Singleton, N. *et al.* (1998) Psychiatric morbidity among residents. [Accessed 8/12/20].

[376] Unity Behavioural Health (2018) Why mental illness often goes undiagnosed and untreated. [Accessed 8/12/20].

[377] Sainsbury Centre for Mental Health (2003*)* Primary solutions: an independent policy review on the development of primary care mental health services. [Accessed 8/12/20].

The Singleton *et al.* study found that, in the 12 months before entering prison, about 20% of male prisoners (both remand and sentenced) had received help or treatment for a mental or emotional problem.

Based on the above estimate of 90% of prisoners with any mental health disorder (including substance misuse), it could be assumed that 52% of these may be diagnosed, giving an anticipated identification level of 47% of prisoners identified as having a mental health condition. As noted, demand for treatment is likely to be less than this.

The *Count Me In* census involved an assessment of access to mental health services by black and minority ethnic groups in prison.[378] It is interesting to note that the survey found no systematic discrimination in minority populations accessing mental health services in prisons. This contrasts to the access of mental health services by minority groups in the community, where such groups are frequently under-represented.

> *For too many, especially black, Asian and minority ethnic people, their first experience of mental health care comes when they are detained under the Mental Health Act, often with police involvement.*[379]

Comorbidity

Over 70% of residents suffer from two or more mental disorders, including substance misuse.[380] Published sources suggest that, in the community, up to 50% of those in treatment for drug use have concurrent mental health problems; the figure is closer to 100% for those in alcohol treatment.[381]

Transfer Under the Mental Health Act

NHS England guidance suggests that no-one should wait more than 14 days for a transfer under the Mental Health Act.[382] Across the prison estate in England and Wales, patients are waiting for far longer than 14 days. In 2016-17, 366 of the 1083 transfers (33.7%) were completed within 14 days, 717 (66.3%) took longer than 14 days, while 76 residents (7.1%) waited 140 days or more.[383] This is an issue which is largely outside the control of prison healthcare teams.

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[378] CQC (2010) Count me in 2010: results of the 2010 national census of inpatients and patients on supervised community treatment in mental health and learning disability services in England and Wales. [Accessed 8/12/20].

[379] DH (2016) The five year forward view for mental health. [Accessed 8/12/20].

[380] Social Exclusion Unit (2002) Reducing re-offending by ex-residents. [Accessed 8/12/20].

[381] See, for example, Weaver, T. *et al.* (2002) A study of the prevalence and management of co-morbidity amongst adult substance misuse and mental health treatment populations: executive summary. [Accessed 8/12/20]. Farrell, M. *et al.* (1998) Substance misuse and psychiatric comorbidity: an overview of the OPCS national psychiatric morbidity survey. [Accessed 8/12/20].

[382] PPO (2016) Learning from PPO investigations prisoner mental health. [Accessed 8/12/20].

[383] House of Commons Health and Social Care Committee (2018) Prison health twelfth report of session 2017–19. [Accessed 8/12/20].

Safeguarding, Self-Harm and Self-Inflicted Death

Safeguarding

HMPPS PSI 16/2015 Adult Safeguarding in Prison defines safeguarding in a prison context:

> *Adult safeguarding in prisons means keeping prisoners safe and protecting them from abuse and neglect.*
>
> *Abuse is any act, or failure to act, which results in a significant breach of a prisoner's human rights, civil liberties, bodily integrity, dignity or general wellbeing, whether intended or inadvertent; including sexual relationships or financial transactions to which a person has not or cannot validly consent, or which are deliberately exploitative….*
>
> *Neglect is a failure to identify and meet the needs of a prisoner, for example by ignoring medical, emotional or physical care needs, failing to provide access to appropriate health, care and support or educational services or withholding of the necessities of life, such as medication, adequate nutrition and heating.*

Self–Harm

Discussions in the House of Commons highlighted that:

> *Record high numbers of self-inflicted deaths and incidents of self-harm in prisons are a damning indictment of the current state of the mental health of those in prison and the prison environment overall. More excuses are not good enough. The Ministry of Justice, HM Prison and Probation Service and NHS England have a duty of care to those in prison, yet do not know where they are starting from, how well they are doing or whether their current plans will be enough to succeed.*[384]
>
> *People in prison are more likely to suffer from mental health problems than those in the community. Yet residents are less able to manage their mental health conditions because most aspects of their day-to-day life are controlled by the prison. These difficulties are being exacerbated by a deteriorating prison estate, long-standing lack of prison staff and the increased prevalence of drugs in prison.*[385]

Self-harm covers a wide range of behaviours and may be defined as an intentional act of self-poisoning or self-injury, irrespective of the type of motivation or degree of suicidal intent:

> *Self-harm is behaviour, not an illness, and its management is highly dependent on any underlying problems which could range from an episode of psychosis with intense suicidal urges to an impulsive reaction to a stressful emotional event.*[386]

Self-harm is described as being commonly caused by cutting, burning, hitting or mutilating body parts and attempted hanging or strangulation.

Mangnall and Yurkovich identified that those individuals who self-harm feel that they have no support, and that there is no-one who has the understanding and affection that is required to tackle their underlying emotions.[387] The prison environment can only compound these feelings.

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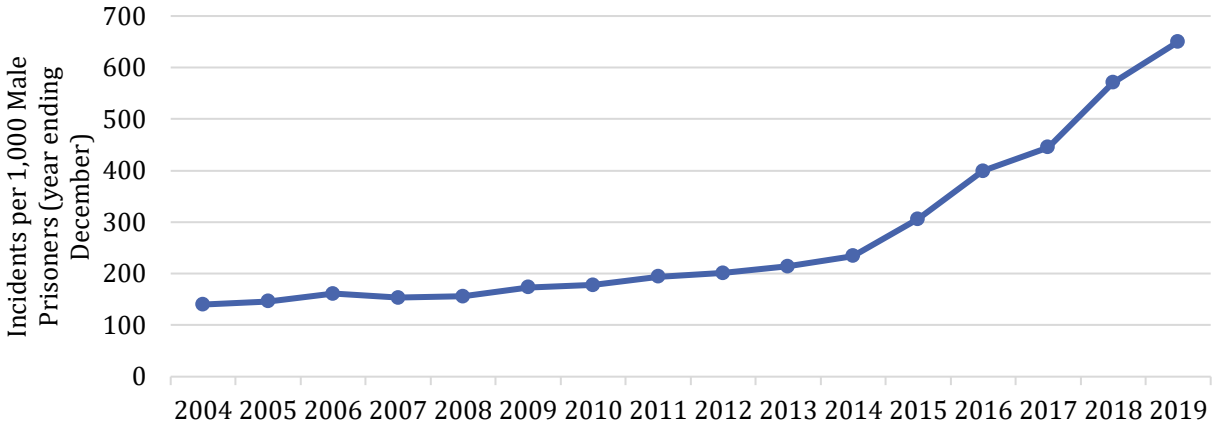
[384] House of Commons (2017) Committee of public accounts mental health in prisons eighth report of session 2017–19. [Accessed 8/12/20].
[385] *Ibid.*
[386] Skegg, K. (2005*)* Self-harm. [Accessed 8/12/20].
[387] Mangnall, J. & Yurkovich, E. (2008*)* A literature review of deliberate self-harm. [Accessed 8/12/20].

Self-harm is common in prison due to the combined increased risks from mental ill-health and being incarcerated.[388] The MOJ provides the following data which describes a marked increase in the last year.

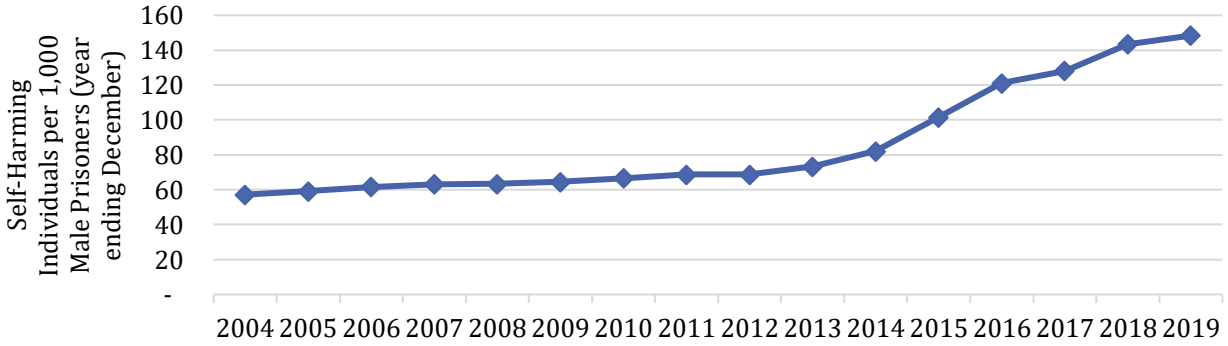
The chart below illustrates the increasing number of recorded incidents of self-harm per 1,000 residents over the past five years:

Figure 29 – National Rates of Self-Harm Incidents per 1,000 Male Prisoners



One individual may self-harm multiple times. The graph below describes the same pattern of increase in the number of self-harming individuals.

Figure 30 – National Rates of Self-Harm Individuals per 1,000 Male Prisoners



The MOJ released a report in 2018 indicating that, while males represented 95% of residents, they accounted for just under 90% of individuals who self-harmed in the 12-month period to December 2017:

> *The rate of self-harm individuals per 1,000 residents was substantially higher for females (300 per 1,000 female residents) than for males (128 per 1,000 male residents). For males, both the number of individuals and the rate of self-harm increased each year from 2012.*[389]

Self-Inflicted Deaths

A self-inflicted death (SID) is defined by the MOJ as any death of a person who has apparently taken his or her own life, irrespective of intent. This not only includes suicides, but also accidental deaths as a result of the person's own actions. This classification is used because it is not always known whether a person intended to commit suicide.

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[388] Royal College of Psychiatrists (2010) Self-harm, suicide and risk: helping people who self-harm. [Accessed 8/12/20].

[389] Her Majesty's Prison and Probation Service (2018) Offender Equalities Annual Report 2017/18. [Accessed 8/12/20].

The table below shows the trend of self-inflicted deaths in custody using statistics from the MOJ. The rate is higher than a decade ago, but has reduced since 2017. The reporting period for these figures is 12 months ending in March of each year, and therefore the numbers differ slightly from those published by the Prisons and Probation Ombudsman.[390]

Figure 31 – Self-Inflicted Deaths in Custody in England and Wales (males)[391]

Year ending March	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
Self-inflicted deaths	58	52	66	51	87	77	95	106	73	83	76
Self-inflicted deaths per 1,000 male prisoners	0.7	0.6	0.8	0.6	1.1	0.9	1.2	1.3	0.9	1.0	1.0

According to the MOJ, prisoners are 8.6 times more likely to take their own lives than members of the general population.[392]

Within prisons, The PPO says the most vulnerable groups include:[393]

- Those who have recently been incarcerated
- Life or indeterminate sentence prisoners
- Those with an offence against a family member or someone they were close to
- Prisoners with mental health issues
- Prisoners with substance misuse and withdrawal
- Those with a history of self-harm

The first few days in custody can be highly stressful for prisoners, and this time marks an increased risk of suicide and self-harm. In 2014, almost 30% of self-inflicted deaths and 10% of all self-harm incidents in custody occurred within the first week of being in prison.[394]

> *Whilst deaths in prison have fallen slightly including self-inflicted deaths, since reaching a peak in 2016, incidences of self-harm continued to rise during 2017 and 2018 and, according to the latest safety indicators, remain at a record high.*[395]

PPO drew attention to a 25% rise in self-inflicted deaths, stating that previous recommendations have not been implemented.[396]

Self-Inflicted Deaths Amongst Young Offenders

The Harris Review[397] was a comprehensive piece of work, culminating in a report with a series

[390] PPO (2017) Annual Report 2016-17. [Accessed 8/12/20].

[391] MOJ (2019) Safer custody quarterly update March 2019. [Accessed 8/12/20].

[392] MOJ (2017) Safety in custody statistics bulletin, England and Wales, deaths in prison custody to December 2016, assaults and self-harm to September 2016. [Accessed 8/12/20].

[393] PPO (2014) Learning the lessons from PPO investigations. Risk factors in self- inflicted deaths in prisons. [Accessed 8/12/20].

[394] HM Inspectorate of Prisons (2016) Life in prison peer support: a findings paper. [Accessed 8/12/20].

[395] House of Commons Health and Social Care Committee (2018) Prison health twelfth report of session 2017–19. [Accessed 8/12/20].

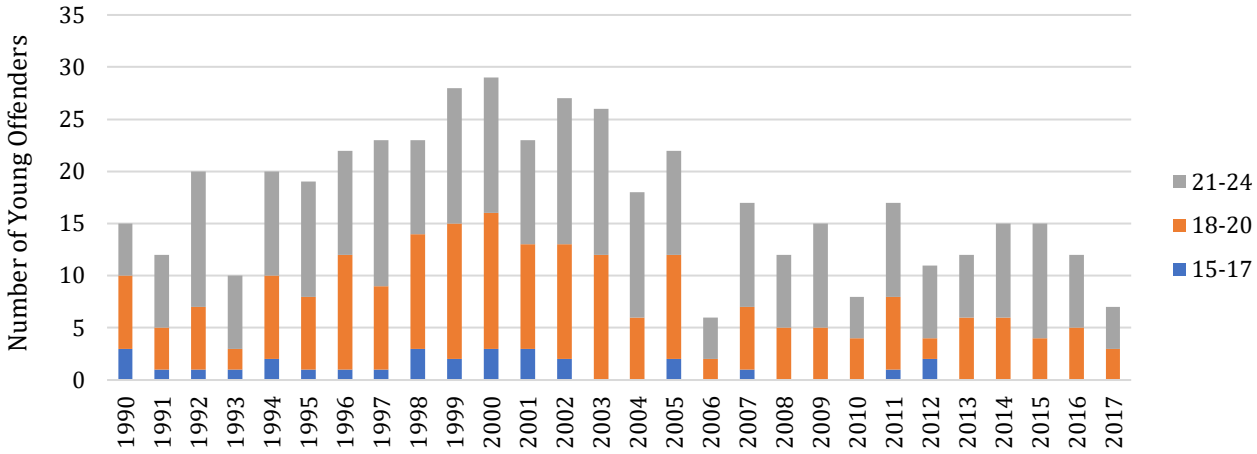
[396] PPO (2019) Annual report 2018-19. [Accessed 8/12/20].

[397] The Harris Review(2015) Changing prisons, saving lives report of the independent review into self-inflicted deaths in custody of 18-24 year olds. [Accessed 9/12/20].

of recommendations, specifically exploring self-inflicted deaths amongst the 18-24 year-old population.

Whilst the below chart may appear to show reducing numbers of self-inflicted deaths, this should be considered against the significantly reduced numbers of young offenders in custody in more recent years. Unfortunately, the MOJ no longer provides self-inflicted deaths data broken down by age group.

Figure 32 – Self-Inflicted Deaths Amongst Young Offenders[398]



Self-Harm, Suicide and Older People

ONS community data indicates that suicide in the UK is correlated with age, with rates highest amongst males aged 30-59 between 2001 and 2013.[399] This data also shows an upward trend in rates per 100,000 population between the age groups of 60-74 (14.5) and 75+ (15.4).

The World Health Organisation states that *'around a quarter of deaths from self-harm are among those aged 60 or above.'*[400]

Samaritans data on suicide is broken into smaller age groups; the upward trend among older age groups is particularly apparent, and demonstrates an increasing prevalence of suicide with older age.[401]

A *British Medical Journal* article examining suicide in older people suggests that it is:

> *a complex and multifactorial phenomenon*:
> *There is a need for vigorous screening and aggressive treatment of depression and suicidal feelings in elderly people, especially in sub-groups with additional risk factors such as those with comorbid physical illness and those who are socially isolated.*[402]

[398] MOJ (2018) Deaths in prison custody 1978 to 2017. Note this is no longer produced as part of the Safety in Custody statistics and thus deaths data for young offenders is no longer available after 2017. [Accessed 9/12/20].

[399] ONS (2015) Suicide rates in the United Kingdom, 2013 registrations. [Accessed 9/12/20].

[400] World Health Organisation (2013) Mental health of older adults. [Accessed 9/12/20].

[401] Samaritans (2015) Suicide statistics report 2015: including data for 2011-2013. Suicide as defined by the Office for National Statistics. [Accessed 9/12/20].

[402] O'Connell, H. *et al.* (2004). Recent developments: suicide in older people. [Accessed 9/12/20].

Evidence suggests that suicide rates are generally elevated following episodes of non-fatal self-harm, and that non-fatal and fatal self-harm are *'more closely related in older than in younger adults.'*[403]

Numerous clinical guidelines have set out advice relating to healthcare responses to high self-harm and suicide rates among older people, including advice from the Royal College of Psychiatrists and NICE.[404]

NICE observes that when older people self-harm, the treatments they need will be broadly similar to those needed by younger adults, but that older people are substantially more at risk of further self-harm and suicide.[405] Clinical Guideline 16 recommends that the assessment and treatment of older adults who have self-harmed should include the following provisions:

> *1.10.1.1 All people older than 65 years of age who have self-harmed should be assessed by mental healthcare practitioners experienced in the assessment of older people who self-harm. Assessment should follow the same principles as for younger adults who self-harm, but should also pay particular attention to the potential presence of depression, cognitive impairment and physical ill-health.*
> *1.10.1.2 All acts of self-harm in people older than 65 years of age should be regarded as evidence of suicidal intent until proven otherwise because the number of people in this age range who go on to complete suicide is much higher than in younger adults.*
> *1.10.1.3 Given the high risks amongst older adults who have self-harmed, consideration should be given to admission for mental health risk and needs assessment, and time given to monitor changes in mental state and levels of risk.*[406]

This advice is reiterated in a summary article in the *British Journal of Psychiatry*, which suggests that:

> *Optimum management of any depression (including the use of maintenance antidepressant medication when appropriate), close follow-up, collaboration and liaison between agencies, and engagement with key social factors is crucial in the care of older people who have self-harmed. [...] The role of the specialist in assessment and longer-term management of older people following self-harm, in particular for people with depression, further highlights the importance of mental health services that specifically cater for the needs of older people.*[407]

Management

Safeguarding of residents, including the prevention of both suicide and self-harm, is the responsibility of HM Prison Service. However, there are circumstances where either mental ill health precipitates the risk of harm, or healthcare is managing the damage caused by an episode.

The prison service system for safeguarding residents is 'Assessment, Care in Custody and Teamwork' (ACCT). It aims to improve the quality of care by introducing multi-disciplinary team-working to deliver individual/flexible care-planning. It is supported by improved staff training in both case management and in assessing and understanding at-risk residents. If a prisoner is identified as being at risk of suicide or self-harm, or has attempted self-harm, an ACCT case file is opened. In all establishments, healthcare is an important partner in the

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[403] Dennis, M.A. & Owens, D.W. (2012) Self-harm in older people: a clear need for specialist assessment and care. [Accessed 9/12/20].

[404] Royal College of Psychiatrists (2010) Self-harm, suicide and helping people who self-harm. [Accessed 9/12/20]. NICE (2013) Better services for people who self-harm: quality standards for healthcare professionals. [Accessed 9/12/20].

[405] NICE (2011) Self harm: the short-term physical and psychological management and secondary prevention of self-harm in primary and secondary care. [Accessed 9/12/20].

[406] *Idem,* pp. 31-32.

[407] Dennis, M.A. & Owens, D.W. (2012) Self-harm in older people: a clear need for specialist assessment and care. [Accessed 9/12/20].

prison system. The role of healthcare is not uniform, but all prisons operate some form of multi-agency safeguarding meeting to monitor and review ACCTs. In most prisons, a representative of the mental health team attends all ACCT reviews for patients of their team; in many prisons they attend every ACCT review. In many prisons, the number of ACCTs is increasing and mental health teams observe that this is very demanding upon their time. The PPO observes:

> *We remain concerned that ACCT was designed for a prison system that had far fewer residents and many more staff.*[408]

Residents have suggested that ACCT may have become a box-ticking exercise and advocated that it could be improved via the increased involvement of residents, family members and mental health professionals.[409]

If someone is the subject of 'constant observation', the PSO states they should be seen by a doctor at least every 24 hours. It is difficult to see how prisons that do not have seven-day doctor cover can meet this requirement.

The Howard League and Centre for Mental Health published a series of briefings. In addition to re-iterating the PPO concerns about staffing levels, they drew attention to negative impacts of the incentives and earned privileges system and use of segregation.[410]

[408] PPO (2017) Annual Report 2016-17. [Accessed 8/12/20].

[409] Independent Advisory Panel on Deaths in Custody (IAP) (2017) Keeping safe - preventing suicide and self-harm in custody. Residents' views collated by the IAP December 2017. [Accessed 8/12/20].

[410] Howard League (2016) Preventing prison suicide. [Accessed 9/12/20]. Howard League (2016) Preventing prison suicide: staff perspectives. [Accessed 9/12/20]. Howard League (2016) Preventing prison suicide: perspectives from the inside. [Accessed 9/12/20].

Health Promotion

An aspect of health promotion is assisting people in taking responsibility for their own health. Prisoners are a cohort of society who typically assume little personal responsibility for their own health. Consequently, as we see through this report, smoking rates are higher than in the general population, alcohol and drug problems are more prevalent, and there is a greater prevalence of health conditions allied to lifestyle factors.

Prison Service Order (PSO) 3200 requires that governors ensure efforts are made to:[411]

- *Build the physical, mental and social health of prisoners (and, where appropriate, staff) as part of a whole prison approach.*
- *Help prevent the deterioration of prisoners' health during or because of custody, especially by building on the concept of decency in our prisons.*
- *Help prisoners adopt healthy behaviours that can be taken back into the community upon release.*

The PSO goes on to identify five major areas:

- *Mental health promotion and wellbeing*
- *Smoking*
- *Healthy eating and nutrition*
- *Healthy lifestyles, including sex and relationships and active living*
- *Drugs and other substance misuse.*

Health promotion is an activity that is one aspect of delivery within a wellbeing service. Wellbeing covers a wide range of domains, including both physical and mental health (see, for example, the 'wellbeing wheel' used by ONS).[412]

To define wellbeing, the Local Government Association states:

> *Wellbeing is a subjective evaluation of how we feel about and experience our lives. Wellbeing, positive mental health and mental wellbeing are often used interchangeably, although 'wellbeing' is also used in a broader sense to include physical health. In the sense being used here, wellbeing includes how we feel, how we think, relationships and meaning and purpose.*[413]

As the role of prison healthcare evolves, we are seeing many providers embrace a wellbeing model.

All prisons run smoking cessation services, GUM screening and clinics, vaccination programmes, etc. These are all components of a wider health promotion strategy.

The NHS Health Promotion Calendar

The national health promotion calendar considers a series of health issues in turn and offers a specific focus on each by date, for example:

[411] HMPS (2003) Prison service order 3200: health promotion. [Accessed 9/12/20].
[412] ONS (2015) Measuring national wellbeing: at what age is personal well-being the highest? [Accessed 9/12/20].
[413] Local Government Association (2015) Our future wellbeing. [Accessed 9/12/20].

Figure 33 – Health Promotion Calendar[414]

Date	Event
8 - 14 January	National Obesity Awareness Week
4 February	World Cancer Day
15-19 February	OCD week of action
1-31 March	Prostate Cancer Awareness Month
7 March	No Smoking Day
12-18 March	Brain Awareness Week
15 March	World Sleep Day
26 March	Epilepsy Awareness Purple Day
1-30 April	Bowel Cancer Awareness Month
7 April	World Health Day
10-16 April	Parkinson's Awareness Week
23-29 April	European Immunisation week
24-30 April	MS Awareness Week
27 April	On your Feet Britain
1-31 May	Action on Stroke Month
2 May	World Asthma Day
14-20 May	Mental Health Awareness Week
15-21 May	Deaf Awareness Week
31 May	World No Tobacco Day
11-17 June	Men's Health Week
28 July	World Hepatitis Day
10 September	World Suicide Prevention Day
11-17 September	Sexual Health Week
2-8 October	National Dyslexia Week
7-13 October	OCD Awareness Week
9-16 October	National Arthritis Week
10 October	World Mental Health Day
20 October	World Osteoporosis Day
1-30 November	Movember Men's Health Awareness Month
1 November	National Stress Awareness Day (NSAD)
6-12 November	National Pathology Week
14 November	World Diabetes Day
13-19 November	Alcohol Awareness Week
19-25 November	National HIV Testing Week
1 December	World Aids Day

Prison healthcare teams are able to access national resources to run local campaigns to follow events throughout the health promotion calendar.

Peer Support/Health Trainers

A meta-analysis published by NICE concluded that:

> *There is consistent evidence from a large number of studies that being a peer worker is associated with positive health. Peer support services can also provide an acceptable source of help within the prison environment and can have a positive effect on recipients. This was confirmed by expert evidence. Research into cost-effectiveness is sparse but a limited HIV-specific economic model, although based on a number of assumptions and evidence of variable quality, showed that peer interventions were cost-effective compared with professionally led interventions.*[415]

[414] NHS Employers (2021) Health promotion calendar. [Accessed 10/12/20].

[415] South, J. *et al.* (2014) A systematic review of the effectiveness and cost-effectiveness of peer-based interventions to maintain and improve offender health in prison settings. [Accessed 9/12/20].

An HMIP report indicates that peer support is often promoted as a form of support that may be considered preferential to more formal support from staff members.[416] The shared experiences of residents means that peer workers may be able to better empathise with their problems. There is also evidence that becoming a peer worker can have a positive effect on the prisoner, for example by increasing self-esteem and organisational skills.[417]

Health trainers are residents who are trained to fulfil any of a range of health promotion or support functions and can be utilised for a wide range of health promotion-type work. The problem faced by local prisons is that their turnover means men do not stay long enough to train and then be made useful in the establishment, thus the model is more suited to prisons with lower turnover rates. We have seen residents running smoking cessation groups, taking height and weight checks, etc. Nearly 20 years ago it was a real challenge for prisons to accept the 'listeners' scheme: now it is nearly universal. Health trainers is a nationally recognised scheme, which is an extension of the process of partnership with residents.

Obesity

Body mass index (BMI) testing gives a clear indication of the levels of obesity. Across the general population, the average BMI rate for men has been steadily increasing over recent years. In England, 28.7% of adults are obese and a further 35.6% are overweight, making a total of 64.3% who are either overweight or obese.[418] The prevalence of obesity increases with age and is highest among the 55-64 age group in men.[419] Of obese adults, around one in eight are morbidly obese (3.6% of all adults). Men are more likely than women to be overweight or obese (67.2% of men compared with 61.5% of women).[420] High BMI has been shown to correlate with frailty, which is typically conceptualised as a wasting disorder, with weight loss as a key component. A US study found that those with a high waist circumference were significantly frailer than those with an average waist circumference, and that the accumulation of abdominal fat may be a *'core mechanism leading to age-associated frailty'*.[421]

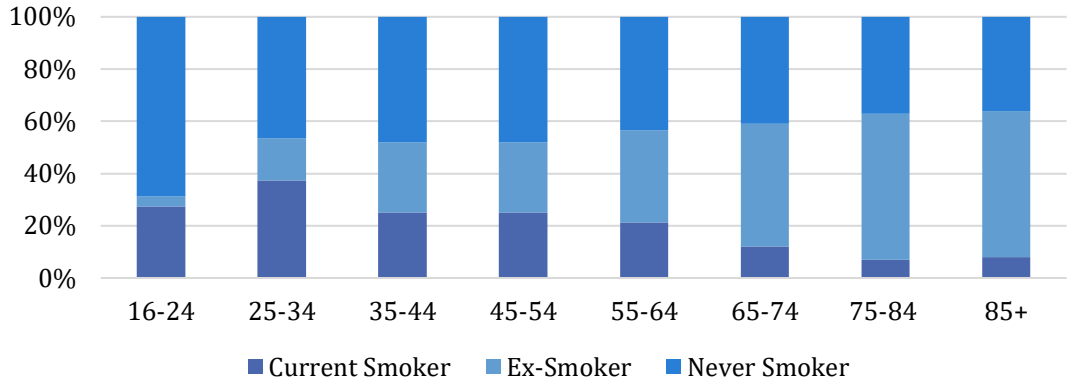
Smoking

In the UK, 14.7% of people aged 18 years and above smoked cigarettes in 2018, which equates to around 7.2 million people in the population and represents a statistically significant decline of more than 5 percentage points since 2011.[422] In the UK, 17.7% of men were current smokers which was significantly higher in comparison with 14.1% of women.[423]

The Health and Social Care Information Centre published data relating to the smoking status of men in the general population in England. This is shown in Figure 34, categorised by age band.

[416] HM Inspectorate of Prisons (2016) Life in prison: peer support a findings paper. [Accessed 9/12/20].
[417] *Ibid.*
[418] Baker, C. (2019) Obesity statistics. [Accessed 9/12/20].
[419] *Ibid.*
[420] *Ibid.*
[421] Hubbard, R.E. (2010) Frailty, body mass index and abdominal obesity in older people. [Accessed 10/12/20].
[422] ONS (2019) Adult smoking habits in the UK: 2018. [Accessed 9/12/20].
[423] *Ibid.*

Figure 34 – Cigarette Smoking Status by Age (men)[424]



This shows that men in the age group of 25-34 years are the most likely to be current smokers; as men age they become less likely to be current smokers, with the exception of a 1% increase in the over 85 age band. Similarly, as they age, men are more likely to be ex-smokers.

In September 2015, Public Health England stated that:

> *Reducing smoking should be given the highest priority across the CJS and comprehensive nicotine dependence treatment (cessation and/or harm reduction) should be delivered to all smokers in the CJS.*[425]

HMPPS has been rolling out a programme of smoke free prisons, as a result of which all prisons are now smoke free. This is likely to precipitate a jump in obesity; the NHS states that, on average, people put on 11 pounds after quitting smoking.[426]

Transgender Pathway

Data is not regularly collected, but according to MOJ, there were 163 transgender residents in the population in 2019. 129 prisoners reported their legal gender as male, 32 as female and 2 did not state their legal gender.[427] Forty-four of the 124 public and private prisons in England and Wales house one or more transgender prisoner.[428] An MOJ commissioned review recommended that:

> *People who are living in a gender different to that of their assigned sex at birth should, as a general presumption, be treated by offender management services according to the gender in which they identify.*
>
> *Regardless of where residents are held, they should be respected in the gender in which they identify, being provided with those items that enable their gender expression.*
>
> *The prison service should develop a single "facilities list" of items available to be purchased that can be used in either male or female establishments, and standardise rules on what constitutes acceptable clothing.*[429]

[424] Statista (2019) Distribution of cigarette smoking status in England in 2018, by gender. [Accessed 9/12/20].

[425] PHE and King's College London (2015) Reducing smoking in prisons: management of tobacco use and nicotine withdrawal. [Accessed 9/12/20].

[426] NHS (2019) Stop smoking without putting on weight. [Accessed 9/12/20].

[427] Ministry of Justice (2019) Her Majesty's prison and probation service offender equalities annual report 2018/19. [Accessed 2/12/20].

[428] *Ibid.*

[429] MOJ (2016) Review on the care and management of transgender offenders. [Accessed 9/12/20].

The review goes on to note both the challenges of managing this population, and the risks they experience, including possible mental health issues and risk of self-harm.

The literature describes how prisons are designed and managed for binary gender considerations; historically, a prisoner was housed according to their legal gender identity. The most recent prison service instruction, (PSI)[430] for the care and management of transgender residents, makes it clear that a prisoner's view of whether they should be in a male or female environment should be taken into account and decisions should not be informed solely by their legal gender. As guidance evolves, and the numbers of residents increase, the MOJ states all staff should have access to training on this issue.[431]

Transgender residents convicted of sex offences present specific challenges and MOJ recommends that:

> *there should be specialised support in a small number of sex offender prisons (i.e. not the whole sex offender estate), ideally with reasonable access to appropriate NHS facilities in the community.*[432]

The PPO has recently published a lessons learned commentary on the management of transgender residents, which explores, in some detail, how prisons should manage transgender residents.[433]

The MOJ states:

> *An establishment must permit residents who consider themselves transsexual and wish to begin gender reassignment to live permanently in their acquired gender.*
>
> *Permitting residents to live permanently in their acquired gender will include allowing residents to dress in clothes appropriate to their acquired gender and adopting gender-appropriate names and modes of address (e.g. Ms, Mr, Mrs). An establishment must allow transsexual people access to the items they use to maintain their gender appearance, at all times and regardless of their level on the Incentives and Earned Privileges Scheme or any disciplinary punishment being served.*
>
> *Establishments must produce a management care plan outlining how the individual will be managed safely and decently within the prison environment.*[434]

HMPPS has recently issued a new PSI on *The Care and Management of Transgender Offenders*.[435]

NHS England has ruled that prisoners have a right to appropriate gender re-alignment. The PSI states:

> *6.26 If medical treatment for gender dysphoria is commenced before reception into prison, and the prisoner applies for it to be continued, it should be continued until the prisoner's gender specialist has been consulted on the appropriate way to manage the prisoner's treatment unless the doctor working in the prison has reasonable clinical grounds for not doing so.*

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[430] NOMS (2016) The care and management of transgender offenders. [Accessed 9/12/20].

[431] MOJ (2016) Review on the care and management of transgender offenders. [Accessed 9/12/20].

[432] *Ibid.*

[433] PPO (2017) Learning lesson bulletin transgender residents. [Accessed 9/12/20].

[434] MOJ (2016) Prisoner transgender statistics, March/April 2016. [Accessed 9/12/20].

[435] NOMS (2016) The care and management of transgender offenders. [Accessed 9/12/20].

6.28 The prison health care team must inform the relevant NHS commissioning authority of any request from a prisoner (whether remanded or sentenced) to begin medical treatment for gender dysphoria and request a contact point for liaison purposes.

Annex G8

Every effort should be made to ensure that prisoners with gender dysphoria are retained in one establishment during the period they are on remand, subject to security requirements and population pressures, to provide stability of counselling and other support services and to maintain some aspect of confidentiality concerning their medical status.

Social Care

Definition

It is important to note that, while elderly prisoners tend to dominate discussions on social care, the needs of individuals of all ages are included. Age-related conditions make up a large proportion of social care cases, but by no means all. For example, there are duties of care for young adults who have previously been in the care of their local authority (care leavers) which are described below.

A publication by the Revolving Doors Agency examined the social care needs of short-sentenced prisoners and summarised their key social care needs as follows:

- Accommodation
- Employment, training and education
- Finance, benefits and debt
- Drugs and alcohol
- Family, relationships and social networks
- Emotional wellbeing
- Mental health
- Disabilities requiring social care
- Learning disabilities and difficulties[436]

The report highlighted that, whilst there are systematic screening processes used to assess health needs when an offender enters a prison, no explicit and equivalent process is systematically undertaken to understand many of the above-identified social care needs, which can underpin the presenting health needs. This remains the case today.

Noting the overlap between health and social care, some of the above needs are dealt with in this HSCNA from a 'health' perspective and feature in previous sections (e.g. substance misuse, mental health, learning disability and physical disability).

Prison Responsibilities

The PPO comments on the impact of changes in the prison population:

> *The challenge is clear: prisons designed for fit, young men must adjust to the largely unexpected and unplanned roles of care home and even hospice.*[437]

HMIP recommends that prisoners should spend at least 10 hours per day out of cell.[438] Finding 'purposeful activity' for men over retirement age or the frail elderly is a challenge for prisons, leading to cases of social isolation.

The social care responsibilities for the prison are detailed in PSI 03-2016 'Adult Social Care', which explains the different partners' roles and responsibilities in the delivery of care, both within prison and in preparation for release.[439] The PSI details the relationship that should

[436] Anderson, S. & Cairns, C. (2011) The social care needs of short-sentence residents. [Accessed 9/12/20].
[437] PPO (2016) Annual report 2015-16. [Accessed 9/12/20].
[438] HMIP(2007) Time out of cell: a short thematic review. [Accessed 9/12/20].
[439] NOMS (2015) PSI 03-2016: adult social care. [Accessed 9/12/20].

exist between a prison and its local authority, as informed by the Care Act (2014). These should be confirmed, at a local level via a Memorandum of Understanding (MOU).[440]

In addition, PSI 16-2015 'Adult Safeguarding in Prisons', draws together all the pre-existing safeguarding processes for prisoners, highlighting that those with disabilities are at greater risk of abuse.[441]

Background

While needs are not limited to older prisoners, the increasing age of the prisoner population, and their declining health, mean that it is likely there will be more explicit and immediate needs for social care services than many establishments are currently equipped to provide. Whilst the prison population remains relatively young, stakeholders described more elderly men. This issue is not new; well over a decade ago it was recognised and addressed in a national thematic review of older prisoners by HMIP:

> *Prisons are primarily designed for, and inhabited by, young and able-bodied people; and in general the needs of the old and infirm are not met.*[442]

As noted in the earlier section on age, older prisoners are the fastest growing cohort within the population.

In the past, social care in prisons had not been clearly addressed by the prison service, leading to sporadic and *ad hoc* developments. It is, however, important to stress that many aspects of social care have been delivered by the prison service and its partners for many years. The Care Act (2014) changed this and clarified responsibilities.

Throughout these changes, the responsibility for the physical environment, including physical adaptions to cells, remains, as ever, with the prisons. The rule of thumb is that anything which is immovable is prison responsibility (e.g. a hand rail bolted to a wall), while anything movable is a third-party responsibility (e.g. a walking stick, wheelchair or a hoist). In the past, provision of items such as mobility aids has been *ad hoc* and differed in different establishments. PSI 03-2016 states:

> *Local authorities in England are required by regulations supported by guidance to provide at their cost equipment (e.g. hoists) and personal aids (e.g. to assist mobility); this is up to the value of £1,000.*

Whilst this is now dated, the only national comparator data describing need is from October 2014; HMPPS and MOJ conducted a national survey to assess the likely level of social care needs across the prison estate. It concluded that 0.9% of the national prison population had personal care needs. However, wide demographic variations underpin this figure:

> *The proportions of residents with personal care needs increased with age, with 12.6% of 65-74 year-olds and 22.7% of those aged 75+ having personal care needs.*[443]

In February 2016, the Association of Directors of Adult Social Services (ADASS) issued a brief update on the implementation of the 2014 legislation across the prison estate (England and

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[440] HMIP and CQC (2018) Social care in prisons in England and Wales A thematic report. [Accessed 9/12/20].
[441] NOMS (2015) PSI 16-2015: adult safeguarding in prison. [Accessed 9/12/20].
[442] HMIP (2004) 'No problems old and quiet': older residents in England and Wales. [Accessed 2/12/20].
[443] *Ibid.*

Wales) for the first half of 2015/16, which concluded that more useful questions were raised than were answered.[444] A King's Fund study concluded:

> *Public spending on adult social care is set to fall to less than 1 per cent of GDP. The potential for most local authorities to achieve more within existing resources is very limited and they will struggle to meet basic statutory duties.*[445]

The most recent report from HMIP and CQC states that:

> *The review has identified several developments that are good practice in the social care of residents. However, there continue to be wide variations between social care services in prisons, so that as yet they are neither equitable nor consistent. Gaps remain in provision of services in English prisons…*
>
> *We are also concerned that developments in social care in prisons are only related to current need. We are not convinced that there is adequate consideration of what will be required in the very near future, such as the obvious needs that will flow from the projected growth in the older prisoner population.*[446]

Likely Need

In England and Wales this has been very difficult to clarify, the last national report was the limited ADASS study described above. Our database and local reports describe massive variance in the rate of identified needs even within similar demographic profiles. The Scottish Prison Service published a snapshot in 2017 noting the population similarities within the UK, whilst the policy framework is different north of the border, this is important because it is a more recent estate-wide systematic review.

A greater proportion of residents are classified as disabled (definition includes both mental and physical) compared to the broader population.[447]

Eligibility Criteria

With prisoners being received from the community and transferred between prisons (thus moving between local authority area), continuity of care is a challenge. HMIP and CQC state that:

> *The social care support needs of prisoners should be met from the moment a need is identified. Prisoners should not be subject to administrative delays or unnecessarily lengthy processes*[448]

HMIP and CQC went on to note:

> *Screening of prisoners' social care needs was not sophisticated or robust enough to pick up every need. We were not satisfied that all prisoners with social care needs were identified, either at reception or during their time in custody.*[449]

In order to be entitled to care, prisoners must meet the eligibility criteria as defined in 'The Care and Support (Eligibility Criteria) Regulations 2014'.[450] Because this is not widely understood, the relevant paragraphs are reproduced in full below:

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[444] ADASS (2015) Care Act stocktake 5 - autumn 2015 prisons and approved premises. [Accessed 9/12/20].
[445] Humphries, R. *et al.* (2016) Social care for older people home truths. [Accessed 9/12/20].
[446] HMIP and CQC (2018) Social care in prisons in England and Wales: a thematic report. [Accessed 9/12/20].
[447] HMIP (2009) Disabled residents: a short thematic review on the care and support of residents with a disability. [Accessed 9/12/20].
[448] HMIP and CQC (2018) Social care in prisons in England and Wales a thematic report. [Accessed 9/12/20].
[449] *Ibid.*
[450] Social Care England (2014) The care and support (eligibility criteria) regulations. [Accessed 10/12/20].

Needs which meet the eligibility criteria: adults who need care and support

(1) An adult's needs meet the eligibility criteria if -
- *(a) the adult's needs arise from or are related to a physical or mental impairment or illness;*
- *(b) as a result of the adult's needs the adult is **unable** to achieve two or more of the outcomes specified in paragraph (2); and*
- *(c) as a consequence there is, or is likely to be, a significant impact on the adult's well-being.*

(2) The specified outcomes are -
- *(a) managing and maintaining nutrition;*
- *(b) maintaining personal hygiene;*
- *(c) managing toilet needs;*
- *(d) being appropriately clothed;*
- *(e) being able to make use of the adult's home safely;*
- *(f) maintaining a habitable home environment;*
- *(g) developing and maintaining family or other personal relationships;*
- *(h) accessing and engaging in work, training, education or volunteering;*
- *(i) making use of necessary facilities or services in the local community including public transport, and recreational facilities or services; and*
- *(j) carrying out any caring responsibilities the adult has for a child.*

(3) For the purposes of this regulation an adult is to be regarded as being unable to achieve an outcome if the adult -
- *(a) is unable to achieve it without assistance;*
- *(b) is able to achieve it without assistance but doing so causes the adult significant pain, distress or anxiety;*
- *(c) is able to achieve it without assistance but doing so endangers or is likely to endanger the health or safety of the adult, or of others; or*
- *(d) is able to achieve it without assistance but takes significantly longer than would normally be expected.*

A problem appears to be that in a prison environment, many of the daily living needs are met by the prison. In some local authority areas, this appears to mask actual need.

Figure 35 considers this in relation to the outcomes specified in paragraph (2) above:

Figure 35 – Eligibility Criteria and the Prison Environment

Criteria (must be unable to achieve outcomes)	Situation in Prison	Comment
(a) managing and maintaining nutrition	Prison caters for all prisoners in this respect.	All those assessed will be deemed ineligible in respect of food preparation. They may not be able to collect food, though 'enablers' can do this. A man may not be able to actually feed himself, which is a social care need.
(b) maintaining personal hygiene	Prisons are set up to monitor and encourage personal hygiene.	Prisoners who need assistance to manage intimate care will have a social care need.
(c) managing toilet needs	As in the community.	
(d) being appropriately clothed	Prison service provides clothing.	Limited applicability
(e) being able to make use of the adult's home safely	Prison service largely manages safety.	
(f) maintaining a habitable home environment	Prison contributes to many of the requirements for ensuring a habitable environment.	

Criteria (must be unable to achieve outcomes)	Situation in Prison	Comment
(g) developing and maintaining family or other personal relationships	Relationships within prison are unique to the institutional environment.	Limited applicability (in many cases)
(h) accessing and engaging in work, training, education or volunteering	Prisons manage activities, but by virtue of the regime these are limited.	Limited applicability
(i) making use of necessary facilities or services in the local community including public transport, and recreational facilities or services	Prisons manage these. They are all on site.	
(j) carrying out any caring responsibilities the adult has for a child	Not applicable	

Care Leavers (Under 25s)

HMIP notes that specific provision is in place for care leavers which need '*to be identified and met.*'[451]

At present, it appears that the social care needs of care leavers are not being addressed. Being a care leaver is not a protected characteristic, so identification does not fall within the remit of the equalities team, nor does it logically sit anywhere else. The equalities team should focus on age as a protected factor and, make reference to the needs of those under 21, as well as to older prisoners.

Care leavers are disproportionately over-represented within the prison population, especially young residents. Twenty-seven per cent of prisoners have been in care as children (and yet only 2% of children in the general population are taken into care).[452]

The particular needs of young adults who are care leavers are acknowledged by the UK Government in the 2013 Care Leavers Strategy:

> *The Ministry of Justice (MoJ) and Home Office (HO) recognise that young adults who have been in care can be particularly vulnerable as they transition into adulthood, particularly if they are in the criminal justice system.*[453]
>
> *It will be essential that continuing leaving care support is available to relevant or former relevant children if they are convicted and sentenced to a community sentence, or imprisonment. In fact, this group of care leavers will be especially vulnerable and will require carefully planned and well-focused support from their responsible authority.*[454]

[451] HMIP and Ofsted (2014) Resettlement provision for adult offenders: accommodation and education, training and employment. [Accessed 9/12/20].

[452] Full Fact (2012) Were a quarter of prisoners in care as children? [Accessed 9/12/20].

[453] HM Government (2013) Care leaver strategy. [Accessed 9/12/20].

[454] DfE (2010) The Children Act 1989 guidance and regulations Volume 3. [Accessed 9/12/20].

Who is entitled to support and who should deliver care is a complex issue. There is a range of definitions that bring young care leavers within the remit of local authority responsibility.

A 'Qualifying Young Person', is defined as a young person who is:

- *aged at least 16 but is under 21;* and
- *at any time after reaching the age of 16 while he was still a child [under 18] was, but is no longer, looked after, accommodated or fostered.*[455]

> *A young person who was not looked after for 13 weeks may be a qualifying child. If that young person returns home, perhaps as a result of a decision made at their first statutory review as a looked after child, then that young person should not be regarded as "qualifying" under Section 24 of the 1989 Act; rather, support to the young person and his family should be provided under section 17 of the 1989 Act.*[456]

A qualifying young person has the least amount of entitlement to services as a care leaver, however it is acknowledged in government policy that:

> *[s]ome qualifying children will be as vulnerable and have very similar needs to eligible, relevant or former relevant children.*[457]

This is particularly true of the complexity of needs that young people in custody can present.

A 'former relevant child' is a young person aged 18 years or over who was in care for at least 13 weeks and did not subsequently return to their parents. Following the Children and Social Work Act (2017),[458] the home local authority duties in relation to former relevant children have been extended so that they now cover a young adult up to their 25th birthday.

For looked after children, and therefore by extension care leavers, responsibility rests with the home local authority, not the authority in which the prison is situated. All councils with social services responsibilities are asked to take the following action:

- *Ensure that they fulfil their statutory responsibilities for contact with any children, for whom they have parental responsibility, who are placed in custody;*
- *Where they were previously responsible for accommodating a child who is now in custody, or where a child who is now in custody, who was previously looked after by another local authority under section 20, now plans to live in their area on release, establish arrangements to promote and safeguard his or her welfare on release.*[459]

The home local authority must:

- *Take reasonable steps to keep in touch with the relevant child*
- *Prepare an assessment of the relevant child's needs* and *prepare a pathway plan*
- *Keep the pathway plan under regular review*
- *Appoint a personal advisor*
- *If his welfare requires it, provide financial assistance by contributing to the former relevant child's expenses in living near the place where he is, or will be, employed or seeking employment*
- *If his welfare and education and training needs require it, provide financial assistance to enable him to pursue education or training*

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[455] DfE (2010) The Children Act 1989 guidance and regulations Volume 3. [Accessed 9/12/20].
[456] *Ibid.*
[457] *Ibid.*
[458] (2017) Children and Social Work Act (2017). [Accessed 10/12/20].
[459] DfES (2004) Local authority circular 26. [Accessed 10/12/20].

- *If the former relevant child pursues higher education in accordance with his pathway plan, to pay him the higher education bursary.*[460]

The relevant local authority…must consider whether the person needs help of a kind the local authority can give:

- *Under section 24A - to advise and befriend and give assistance*
- *Under section 24B - to give financial assistance.*[461]

Social care needs for care leavers within prison will be limited, unless the person has separate adult social care needs. The need is primarily in respect of a support package for release, for example housing needs. Care needs within prison will be more limited than those on release.

Enablers

> *In a number of prisons the provision of social care by competent peer support workers was very good and well supervised, but in some places we were not assured that peer support workers were appropriately trained, supervised or monitored. This placed peer supporters, and the prisoners they supported, at considerable risk.*[462]

A prison enabler can perform some of the functions that could be delivered by a 'carer' in the community. The role of an enabler is limited by a range of considerations described in PSI 17-2015. PSI 17-2015 clarifies the role of an enabler, in particular, the distinction between personal and intimate care:[463]

> ***A2*** *Prisoners must not be permitted to provide other prisoners with intimate care. They may, however, provide some personal care. It is important to be aware of and sensitive to cultural differences when agreeing the tasks that a prisoner will perform in each case.*
>
> ***A3*** *The term intimate care refers to tasks concerned with personal hygiene and bodily functions and products, particularly those that require contact with or the exposure of intimate parts of the body. These must not be allocated to prisoners to undertake. Some examples of intimate care include:*
>
> - *Assisting with eating and drinking (in the sense of placing food or drink into the mouth, as distinct from other activities to manage and maintain nutrition such as cutting up food and transporting food);*
> - *Oral care, including teeth cleaning;*
> - *Washing body areas that are usually clothed for privacy and dignity;*
> - *Dressing and undressing body areas that are usually clothed for reasons of privacy and dignity;*
> - *Toileting support, e.g. changing continence pads or sanitary towels;*
> - *Assisting an adult with cleaning himself or herself following a soiling or wetting episode.*
>
> ***A4*** *The term personal care is a broader one that applies to tasks that do not require contact with or the exposure of intimate parts of the body. Some examples of personal care include:*
>
> - *Dressing and undressing that does not involve body areas that are usually clothed for reasons of privacy and decency, for example helping to put on a pair of socks, or a jacket over a shirt;*
> - *Maintaining hygiene for bodily areas that are normally exposed;*
> - *Providing mental stimulus support for adults that have permanent or temporary mental impairment or diminished mental capacity;*
> - *Support with movement or transportation, including moving an appropriately dressed prisoner to the shower or bathroom;*
> - *Support with nutritional requirements which do not reach the level of regular assistance with eating and drinking;*

[460] DfE (2010) The Children Act 1989 guidance and regulations Volume 3. [Accessed 9/12/20].
[461] DfE (2010) The Children Act 1989 guidance and regulations Volume 3. [Accessed 9/12/20].
[462] HMIP and CQC (2018) Social care in prisons in England and Wales a thematic report. [Accessed 9/12/20].
[463] NOMS (2015) PSI 17-2015: residents assisting other residents. [Accessed 9/12/20].

- *Applying makeup;*
- *Maintaining personal appearance;*
- *Skin care (of non-intimate areas);*
- *Providing reminders for essential activities like taking medication/going to the toilet.*

As explored above, enablers should be able to assist in delivering a wide range of non-intimate care. The prison should identify suitable men; dependent on their role they will need some level of training, not least to fully understand what they can and cannot deliver. They should be cognisant of the concept to enable, rather than to do; it is not the role of an enabler to care for someone who is, with help, able to care for themselves.

Enablers will need ongoing support/management to thrive in their roles. Additionally, there will need to be ongoing contact with those they care for to check for any issues. HMPPS sees this as a key contribution of any additional social work input.

Resettlement

The Centre for Policy on Aging notes that:

> *Prison resettlement programmes need to recognise the special needs of older prisoners, for example longer term prisoners due for release and past retirement age may never previously have claimed pensions or benefits.*[464]

Various reports note that older prisoners often feel there is little to go out to, especially if their crimes were against family members, or if they have lost contact with family, whatever the reason.

> *In order to reduce the likelihood of these older prisoners re-offending, it is imperative that those services that best aid rehabilitation – health and social care support, housing and pensions advice, education and training – are made available to them, both in prison and crucially following release. It is also imperative they work together.*[465]

HMIP and CQC state:

> *Prisons and local authorities should ensure that processes are in place for the smooth transfer of prisoners with packages of social care…on release into the community. This should include effective information sharing.*[466]

[464] The Centre for Policy on Ageing (2016) Diversity in older age – older offenders. [Accessed 9/12/20].
[465] Le Mesurier, N. (2011) Support older people in prison: ideas for practice. [Accessed 9/12/20].
[466] HMIP and CQC (2018) Social care in prisons in England and Wales. [Accessed 2/12/20].