Tamlyn Cairns Partnership

Female Prison HNA

PART B

Methodology & Supporting Notes for Health & Social Care Needs Assessment

December 2020

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

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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.*

Policy Context

Policy documents acknowledge the strong evidence base that prisoners have significant health 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]

In the context of a prison system where just 5% of the population are female,[8] the Corston report[9] remains a useful reference of women-specific issues. Below are the comments that are most pertinent to health and social care provision:

- *The biological difference between men and women has different social and personal consequences;*
- *Relationship problems feature strongly in women's pathways into crime;*
- *Coercion by men can form a route into criminal activity for some women;*
- *Drug addiction plays a huge part in all offending and is disproportionately the case with women;*
- *Mental health problems are far more prevalent among women in prison than in the male prison population or in the general population;*
- *Outside prison men are more likely to commit suicide than women but the position is reversed inside prison;*
- *Self-harm in prison is a huge problem and more prevalent in the women's estate;*
- *Women prisoners are far more likely than men to be primary carers of young children and this factor makes the prison experience significantly different for women than men;*
- *Because of the small number of women's prisons and their geographical location, women tend to be located further from their homes than male prisoners, to the detriment of maintaining family ties, receiving visits and resettlement back into the community;*
- *30% of women in prison lose their accommodation while in prison; and*
- *Women and men are different. Equal treatment of men and women does not result in equal outcomes.*

Around 80% of prisoners in the UK are estimated to be suffering with some form of mental health problem, including substance misuse.[10] Following publication of The Bradley Report, there has been a significant focus on vulnerable adults caught up in the criminal justice system.[11] 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.[12] [13]

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[5] Public Health England (2019) Health and justice annual review. [Accessed 18/11/20].

[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] House of Commons (2019) Prison population figures. [Accessed 11/12/20].

[9] Baroness Corston (2007) The Corston Report. [Accessed 11/12/20].

[10] 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].

[11] *Ibid*.

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

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

A consistent key aim of current government focus and policy is to reduce health inequalities.[14]

The NHS Long Term Plan[15] and NHS England Strategic Direction[16] 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.

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.*[17]

This sits within a wider duty to address health inequalities that is detailed in NHS England guidance.[18] 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 health care 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.*[19]

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'*.[20]

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'[21] and a complementary report: 'Further mental health assessment and care planning for people in prisons and young offender institutions'.[22]

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[14] 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].

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

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

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

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

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

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

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

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

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.*[23]

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

- *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.*
- *Deliver 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.*
- *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.*

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

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.

In March 2018, Public Health England published a set of gender-specific standards for the women's prison estate which are intended to be shared objectives between HMPPS, NHS England and PHE to improve the pathways and quality of care for women in prison.[24] These standards are aspirational in places, but in practice are being overseen by partnership boards in female establishments across UK prisons. The standards cover the following areas:

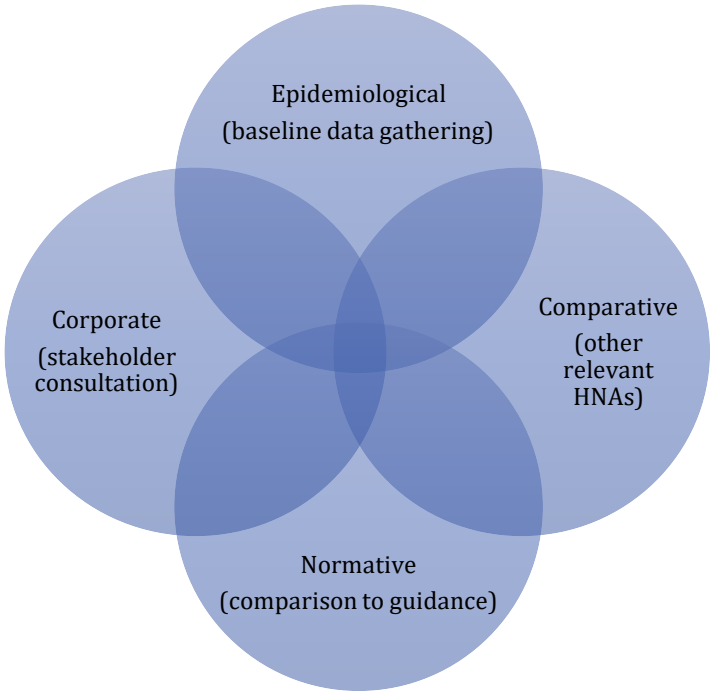
- General health and wellbeing
- Mental health, self-harm and suicide
- Substance misuse
- Violence and abuse
- Sexual and reproductive health
- Pregnancy and families
- Older women
- Nutrition and diet
- Physical activity
- Weight management

Methodology

The methodology acknowledges the guidance described in Health Needs Assessment Toolkit for Prescribed Places of Detention[25] and Health and Social Care Needs Assessments of the Older Prison Population.[26] 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.[27]

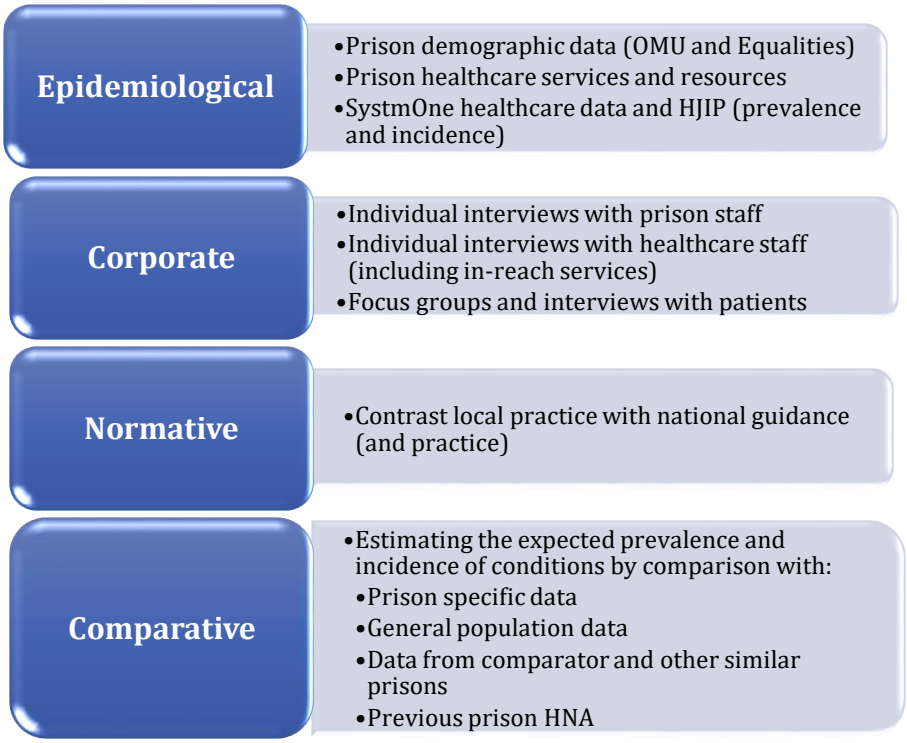
[24] Public Health England (2018) Gender specific standards to improve health and wellbeing for women in prison in England. [Accessed 11/12/20].
[25] PHE (2014) Health and Justice health needs assessment toolkit for prescribed places of detention. Parts 1 and 2. [Accessed 2/12/20].
[26] PHE (2017) Health and social care needs assessments of the older prison population. [Accessed 2/12/20].
[27] Marshall, T. *et al.* (2000) Toolkit for health care needs assessment in prisons. [Accessed 2/12/20].

Figure 1 – Methodological Overview



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

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 women 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 or 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 the HM Prison and Probation Service (HMPPS).

Comparative

Accompanying the *Toolkit* referred to above, Marshall *et al.* conducted a health needs assessment for the entire prison estate.[28] 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

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

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, the prison is highlighted with bold text; this data is referenced through the report. 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 120 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, we predict that the prevalence of diabetes in a female prison population will be 5.5%.[29] Thus, for example, given an operational capacity (op cap) of 500, this predicts 28 women 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 will healthcare have to manage in a year. Here, taking the same prevalence estimate of 6.3%, 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 6.3% = 126 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.*[30]

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.

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

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

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. However, there will be women 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.[31] 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.[32]

In modelling demand for services, 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.[33] For the purpose of this HSCNA, 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.

[31] Unity Behavioural Health (2018) Why mental illness often goes undiagnosed and untreated. [Accessed 8/12/20].
[32] Boardman, J. *et al.* (2004) Needs for mental health treatment among general practice attenders. [Accessed 2/12/20].
[33] DH (2011) A practice-based commissioning business case for IAPT. [Accessed 10/12/20].

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'[34] and a thematic review by HMIP and CQC: 'Social care in prisons in England and Wales'.[35]

For the general population, the National Service Framework (NSF) for Older People[36] 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.*[37]

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[38] and HMIP[39], 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).[40]

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

Older people now comprise more than 1/6 of the prison population in England and Wales.[42]

By 2035 the number of people aged 85 and over is projected to be almost 2½ times larger than in 2010.[43]

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,[44] 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.[45]

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 March 2016, there were 12,577 residents aged 50 and over in England and Wales. By March 2020, this had risen to 13,765.[46]

The Department of Health recognises that older people have a *'wide range of health and social care needs'.*[47] The term *'frail'* is becoming more commonly used in prisons; RCGP offers guidance for care of this group.[48]

As prisons continue to receive older residents 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.[49] The Prison Reform Trust states that:

As the prison population ages, more residents will die of natural causes while in prison.[50]

PPO focusses on this issue in their report Older Prisoners[51] 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.52 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.[53] Despite this issue being raised on many occasions over many years, the most recent reports continue

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

[42] *Ibid.*

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

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

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

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

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

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

[49] 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].

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

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

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

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

to raise the same concerns.[54]

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,[55] 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.[56] 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.[57]

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[58] compared with 15% of the general population.[59] Estimates vary, a recent study reports that 24% of residents have an alcohol problem.[60] There are no directly comparable community equivalent studies. In the community, 22% of men report drinking more than 21 units per week.[61] Thirty per cent of residents have a drug problem at reception.[62] 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.[63]

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.[64]

> *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%.*[65]

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

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

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

[56] 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].

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

[58] Data from recent TamlynCairns HNAs.

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

[60] 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].

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

[62] 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].

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

[64] MOJ (2012) Accommodation, homelessness and reoffending of residents: Results from the Surveying Prisoner Crime Reduction (SPCR) survey. [Accessed 2/12/20].

[65] Seria-Walker, E. (2018) The inequalities of homelessness – how can we stop homeless people dying young? [Accessed 2/12/20].

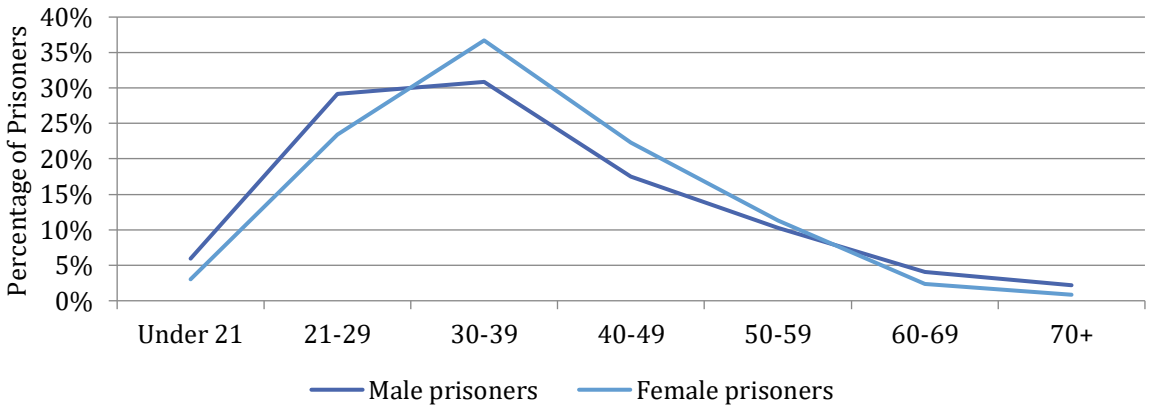
the demographic traits, one study describes older sex offenders as being 'of higher socioeconomic status, having stable backgrounds'.[66]

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.

With the current media focus on elderly male prisoners, it would be easy to assume that the ageing prison population is all linked to the prosecution of historic sex offenders. The graph below illustrates that the age profiles of male and female prison populations are fairly similar, though a higher proportion of female prisoners are aged 30-59.

Figure 3 – Age profile (March 2019)[67]



[66] 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].

[67] Ministry of Justice (2020) Offender management statistics quarterly: April to June. [Accessed 11/12/20].

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.*[68]

This indicates that prisoners from a 'non-white' ethnic group are over represented in prison, considering that 86% of the national population is white.[69] 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.[70]

The older population has been the least ethnically diverse age group; the projections are that over time, as the older population grows, it will also become more ethnically diverse.[71]

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) which is more prevalent in the South Asian population and, whilst numbers are very low, sickle cell disease is far more prevalent in Black Africans and Black Afro-Caribbeans.

Across the prison estate nationally, 10% of the female prisoner population consists of foreign nationals.[72] 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.

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.*[73]

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.[74] Disability is a protected factor, so an aspect of the work for the prison's equalities team.

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[68] Ministry of Justice (2019) Her Majesty's prison and probation service offender equalities annual report 2018/19. [Accessed 2/12/20].
[69] Gov.uk (2020) Population of England and Wales. [Accessed 2/12/20].
[70] MOJ, ONS and HO (2013) An overview of sexual offending in England and Wales. [Accessed 2/12/20].
[71] See for example: Lievesley, N. (2010) The future ageing of the ethnic minority population of England and Wales. [Accessed 2/12/20].
[72] Ministry of Justice (2019) Offender management statistics quarterly: January to March. [Accessed 11/12/20].
[73] WHO (2015) Disabilities. [Accessed 2/12/20].
[74] NOMS (2011) SSI 32/2011 ensuring equality. [Accessed 2/12/20].

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.[75] As the older prisoner population continues to rise nationally, we can expect to see the number of residents with disabilities increase. A notably higher proportion of female prisoners reported having a disability than male prisoners (35% compared to 28%).[76]

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.[77]

These are:

- Foot problems
- Arthritis
- Heart problems
- Vision

Other common problems include hearing impairment, chronic obstructive pulmonary disease (COPD) and falls and hip fractures.[78]

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.[79] 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.*[80]

The Prison Reform Trust suggests that many women lose their housing whilst in prison and 60% leave prison with no housing.[81] More recently, it is estimated that 16% of female prisoners are released into homelessness.[82]

First Time Prisoners

In 2017, a greater proportion of females were first time offenders (34% of females and 21% of males). Male offenders also tended to have a longer offender history, with 26% having had 15 or more previous cautions or convictions compared to 18% of females.[83]

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[75] HMIP (2018) Annual report 2017-18. [Accessed 3/12/20].

[76] MOJ (2018) Statistics on women and the Criminal Justice System 2017. [Accessed 11/12/20].

[77] Christensen, K. *et al.* (2009) Ageing populations: the challenges ahead. [Accessed 3/12/20].

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

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

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

[81] PRT (2016) Home truths: housing for women in the criminal justice system. [Accessed 11/12/20].

[82] Revolving Doors (2018) Freedom of information request. [Accessed 11/12/20].

[83] MOJ (2018) Statistics on women and the criminal justice system 2017. [Accessed 11/12/20].

Whether or not someone has previously spent time in prison will have an impact on their health. The ageing effect on older women who are long-term prisoners is described as giving them the profile of someone in the community who would be 10 years their senior.

Gender

A growing body of research confirms the significant health inequalities amongst people from gender minority groups:

> *Health inequalities were experienced differently between LGBTI groups and spanned both physical and mental health. LGB people reported significantly worse physical health compared to the general population with gay men showing an increased incidence of long-term conditions that restricted their activities of daily living. Conditions included musculoskeletal problems, arthritis, spinal problems and chronic fatigue syndrome, whereas gay and bisexual men showed a high incidence of long-term gastrointestinal problems, liver and kidney problems. Lesbian women had a higher rate of polycystic ovaries compared to women in general (80 vs. 32%) and both lesbian, gay and bisexual people showed weight discrepancies compared to the general population Of LGB groups, the general health of bisexual people was poorer compared to lesbian and gay counterparts due to their minority status in both communities.*
>
> *LGB people are at a higher risk of developing certain types of cancer at a younger age. Gay and bisexual men are twice as likely to report a diagnosis of anal cancer with those who are HIV-positive being at the highest risk. Rates of anal cancer in gay and bisexual men are similar to the prevalence of cervical cancer in general female populations prior to the introduction of cervical screening programmes. This evidence supports the need for anal screening programmes geared towards gay and bisexual men. In contrast there was no conclusive evidence of higher rates of breast cancer in lesbian and bisexual women. However, LGB people who survived cancer reported the need for psychological and emotional support to address their specific needs. There is a gap in high quality international research on both the cancer burden, general health profile and care needs of trans and intersex people.*
>
> *In relation to mental health, significant inequalities exist with LGBT people being twice to three times more likely to report enduring psychological or emotional problems compared to the general population. Suicide attempts, suicidal ideation, depression and anxiety disorders were 1.5 times higher for LGB people compared to heterosexual peers with alcohol related substance dependence over the previous 12 months being 1.5 times more common in LGB people. Disparities related to mental distress were most pronounced for LGB people under the age of 35, and people over the age of 55. Intersex people also showed a raised incidence of suicide attempts at 19%, with 60% having considered suicide compared to 3% in mainstream populations. Bisexual and trans people showed even greater disparities in mental health compared to lesbian and gay counterparts, increasing the need for specialist mental health services and counselling support.*
>
> *Whilst accessing treatment and care, LGBTI people were more likely to report unfavourable experiences. General concerns were around communication with health professionals and overall dissatisfaction with treatment and care provided. Trans people frequently experienced negative interactions with health professionals at gender identity clinics, mental health services and general health services. Where trans people attended gender identity clinics, long waiting times for treatment was shown to negatively impact on their emotional wellbeing.*
>
> *Like LGBT people, some intersex people experience isolation due to stigma, discrimination or rejection from others. For some intersex people, experiences of adversity were linked to the medicalization of their bodies and being subjected to 'normalising' surgery at a young age or where their bodies were surgically aligned to male or female sex characteristics. Dissatisfaction about historic treatment was linked to health professionals not openly discussing information or failing to gain informed consent prior to surgical intervention on intersex minors.*[84]

[84] Zeeman, L. *et al.* (2018) A review of lesbian, gay, bisexual, trans and intersex (LGBTI) health and healthcare inequalities. [Accessed 11/12/20].

Physical Health Needs of Female Prisoners

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.[85] Thirty-six per cent of people in prison are estimated to have a physical or mental disability compared with 19% of the general population:[86]

> *11% have a physical disability, 18% have a mental disability and 7% have both.*[87]

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.*[88]

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).[89] 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.[90]

> *[A]ll the NICE guidelines, all the pathways, are designed for people allegedly with only one condition, but most people have multiple conditions.*[91]

Residents with long-term and chronic diseases are typically repeat users of prison healthcare services. Women prisoners have been found to report higher rates of various physical and psychological problems than women in the general population. These include asthma, epilepsy, high blood pressure, stomach complaints, menstrual and menopausal problems, sight and hearing difficulties and kidney and bladder problems.[92] A study by MOJ surveyed newly-sentenced prisoners and found that female prisoners were more likely to self-report having a long-term health condition or disability than male prisoners (31% of women in the sample surveyed compared with 26% of men).[93]

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,[94] 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 graph outlines the strong correlation of LTCs by age:

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

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

[87] *Ibid.*

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

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

[90] *Ibid.*

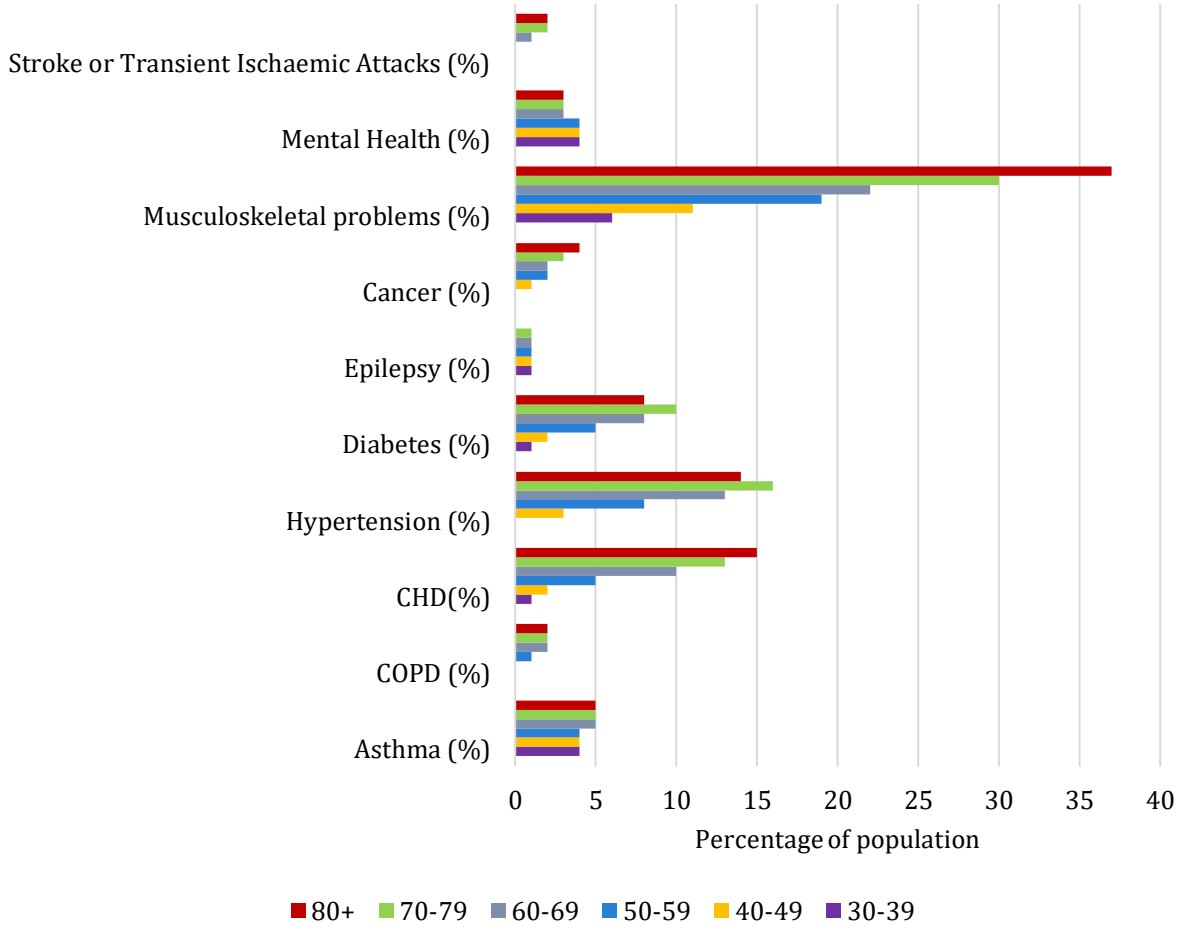
[91] House of Commons Health Committee (2014) Managing the care of people with long–term conditions. [Accessed 3/12/20].

[92] HM Chief Inspector of Prisons (1997). Women in prison: a thematic review. [Accessed 11/12/20].

[93] Ministry of Justice (2008) The problems and needs of newly sentenced prisoners: results from a national study. [Accessed 11/12/20].

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

Figure 4 – Proportion of People in the General Population with LTC by Age (2009) Graph[95]



Asthma

Unlike other chronic conditions, asthma is most 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.[96] The prevalence data in the current Toolkit is derived from the Birmingham HNA.[97] The sources cited data from 1996, so the data is 20 years old and is based on presentations to general practice in the community, and thus should be noted with caution.

Figure 5, based on the Birmingham prevalence data, shows the estimated prevalence of asthma among the female prison population, broken down by age category. Unfortunately, the oldest grouping is 45+.

[95] Department of Health and Social Care (2012). Long term conditions compendium of information: third edition. [Accessed 3/12/20].
[96] 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].
[97] 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].

Figure 5 – Estimated Prevalence of Asthma by Age (female prisoners)

Age Band	Wheezing in the Last Year	Diagnosed Asthma	Treated Asthma
15-24	23%	17%	8%
25-34	19%	14%	6%
35-44	17%	12%	5%
45+	19%	11%	6%
Total	20%	14%	6%

Chronic Obstructive Pulmonary Disease (COPD)

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

Smoking tobacco is seen as the major risk factor,[98] 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 new *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 2.8% in females over the age of 16 years in England.[99] The community data also shows that COPD is highly age correlated.

Figure 6 – Estimated Prevalence of COPD in Females by Age (2011 community data)[100]

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

Coronary Heart Disease (CHD)

A variety of factors, including high rates of smoking, combine to mean that in contrast to the general population, prisoners are at heightened risk of cardiovascular disease.[101]

The prevalence of CHD is lower in women than in men, though the chart describes how this condition is highly age-correlated. The female prison population is ageing, though at a less dramatic rate than that of males in prison.

Figure 7 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

[98] WHO Factsheet (2017) Chronic obstructive pulmonary disease (COPD). [Accessed 3/12/20].
[99] APHO COPD prevalence estimates Dec 2011. [Accessed 9/12/20].
[100] *Ibid.*
[101] Aries, E. (2013) Cardiovascular risk factors among residents: an integrative review. [Accessed 3/12/20].

2006, but Public Health England estimates from 2011 are categorised similarly.[102] Allowing for 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 7 – Prevalence of CHD by Age[103]

Age Band	Prevalence (%)
16-24	0.1%
25-34	0.1%
35-44	0.3%
45-54	1.3%
55-64	3.5%
65-74	10.0%
75+	19.3%
All ages	4.0%

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).[104] The England prevalence for diagnosed hypertension is 13.8%.[105] 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.

Figure 8 – Prevalence of Hypertension by Age Prevalence (females)[106]

	Treated	Untreated
16-24	0	2%
25-34	0	3%
35-44	1%	6%
45-54	4%	14%
55-64	11%	17%
65-74	19%	20%
75+	31%	14%
All ages	8%	10%

Diabetes

The prevalence of diabetes is increasing year on year, PHE project that this trend will continue.[107] Diabetes prevalence strongly correlates with increasing age. The *Birmingham HNA* states that diabetes could be between two and eight times as prevalent in prisons

[102] 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].
[103] British Heart Foundation (2012) Coronary heart disease statistics 2012 edition Table 5.3. [Accessed 3/12/20].
[104] British Heart Foundation (2017) Cardiovascular disease statistics 2017 edition. [Accessed 3/12/20]. Table 2.9, Data for England 2011.
[105] PHE (2016) Hypertension prevalence estimates for local populations. [Accessed 10/12/20].
[106] British Heart Foundation (2012) Coronary heart disease statistics 2012 edition Table 5.3. [Accessed 3/12/20].
[107] PHE (2016) Diabetes prevalence model. [Accessed 3/12/20].

compared to the community.[108] The rates of diabetes are reported to be 1.5 times as great in the most deprived quintile compared to the least.[109] 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.[110] Noting the above changes, the report draws on recent PHE data below:

Figure 9 – Diabetes Expected Prevalence (females)[111]

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).[112] 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

There has been a 70% increase in deaths in people with epilepsy and those with the condition die on average eight years earlier than the rest of the population.[113]

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

Figure 10 – Epilepsy Prevalence by Age (females)[114]

Age Band	Prevalence (%)
16-24	0.45%
25-44	0.38%
45-64	0.36%
65-74	0.43%
75-84	0.40%
85+	0.35%

[108] Marshall, T. *et al.* (2000) Health care in prisons: a health care needs assessment. [Accessed 2/12/20].
[109] Diabetes UK (2016) Facts and stats. [Accessed 3/12/20].
[110] PHE (2017) Health and social care needs assessments of the older prison population. [Accessed 3/12/20].
[111] PHE (2016) Diabetes prevalence model. [Accessed 11/12/20].
[112] Diabetes UK (2016) Facts and stats. [Accessed 3/12/20].
[113] PHE (2018) Deaths associated with neurological conditions. [Accessed 11/12/20].
[114] Marshall, T. *et al.* (2000) Health care in prisons: a health care needs assessment. [Accessed 2/12/20].

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 prisoners.[115] 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.[116] 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.

There is a potential for prisoners to be misdiagnosed with epilepsy, as evidenced in an audit of healthcare in prisoners 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 prisoners reported that their seizures developed within 12 months of beginning significant substance misuse, and a number of the prisoners also identified substance abuse as a cause for further seizures.[117]

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[118] and may require regular monitoring. In some cases, they will require care from secondary healthcare services. See NICE quality standard.[119]

It is estimated that 14,000 people in the UK are living with the disease (1 in 4600 people).[120]

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

Figure 11 – Rates of Significant Haemoglobin Conditions by Ethnic Category, 2016 to 2017[121]

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

[115] Fazel, S. *et al.* (2002) Prevalence of epilepsy in residents: systematic review. [Accessed 3/12/20].
[116] Joint Epilepsy Council (2011) Epilepsy prevalence, incidence and other statistics. [Accessed 3/12/20].
[117] Tittensor *et al.* (2008) Audit of healthcare provision for UK residents with suspected epilepsy. [Accessed 3/12/20].
[118] NHS (2019) Sickle cell disease. [Accessed 10/12/20].
[119] NICE (2014) Sickle cell disease. [Accessed 10/12/20].
[120] Dormandy, E. *et al.* (2017) How many people have sickle cell disease in the UK? [Accessed 10/12/20].
[121] PHE (2017) NHS sickle cell and thalassaemia screening programme. [Accessed 10/12/20].

Ethnicity Category	Significant Conditions	
	Rate/1000	1 in x
Other	0.20	5,108

Cancer

The following paragraphs are based on an all-age population. The community incidence of cancer (the number of people diagnosed with cancer each year) is 5.4 per 1,000 for females.[122] It should be noted that this is highly age correlated, with the peak age for diagnosis being 85 years old.[123]

Incidence rates of cancer in younger age groups are significantly higher in females than males, and in the older age groups are significantly lower in females than males.[124]

Lifestyle choices impact on the risk of contracting cancer. Cancer Research UK attributes smoking as the cause of 15% of cancer deaths.[125] It also attributes smoking as the cause of 28% of cancer deaths.[126] Smoking remains the largest single cause of preventable death in England, yet smoking prevalence in the general population is at an all-time low at 14.9%.[127]

> *The socioeconomic profile of [the prison] population means that it is at a higher risk of cancers associated with smoking, alcohol and socioeconomic deprivation.*[128]

When a prisoner is diagnosed with cancer, the impact is far more likely to be felt in terms of prisoner escorts and bed watches, 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 women 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.

End of Life Care

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.

In the 12 months to March 2019, there were 317 deaths in prison custody; 164 of these were from natural causes (a rate of 2.0 per 1,000 prisoners). This is a 6% decrease from 184 natural causes deaths the previous year.[129]

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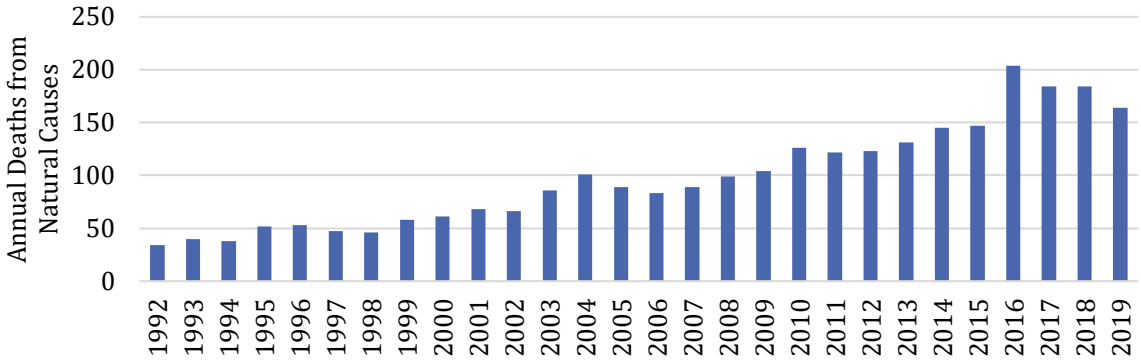
[122] ONS (2017) . Cancer registration statistics, England: first release, 2015. [Accessed 11/12/20].
[123] Cancer Research UK (2016) Cancer incidence by age. [Accessed 11/12/20].
[124] Cancer Research UK (2016) Cancer incidence by age. [Accessed 11/12/20].
[125] Cancer Research UK (2015) Tobacco statistics. [Accessed 3/12/20].
[126] Cancer Research UK (2015) How does smoking cause cancer? [Accessed 11/12/20].
[127] PHE (2018) Health matters: reducing health inequalities in mental illness. [Accessed 11/12/20].
[128] Davies, E.A. (2010) Cancer in the London prison population, 1986-2005. [Accessed 3/12/20].
[129] MOJ (2019) Safety in custody statistics. [Accessed 11/12/20].

Figure 12 – Prison Deaths from Natural Causes (male and female)[130]



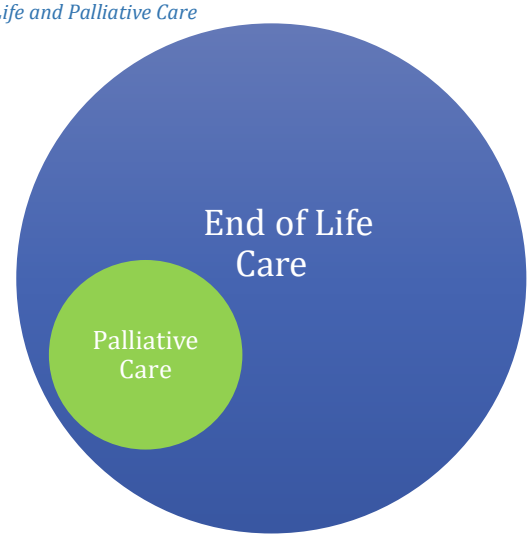
The Prisons and Probation Ombudsman (PPO) Annual Report 2018/19 describes 180 deaths from natural causes, of which 53% were of men aged over 60.[131]

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.*[132]

End of life care is defined by the NHS as 'support for people who are in the last months or years of their life.'[133] 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.[134] Figure 13 demonstrates the relationship between end of life and palliative care.

Figure 13 – End of Life and Palliative Care



PSI 64-2011 includes a section on palliative care and states:

> *Family involvement for terminally ill prisoners*
> *For those prisoners who may not be released before they die, it is important that prisoners are able to maintain close contact with their family or a nominated person. With the prisoner's agreement, the*

[130] MOJ (2019) Safety in custody statistics. [Accessed 11/12/20].
[131] PPO (2019) Prison and Probation Ombudsman annual report 2018-19. [Accessed 7/12/20].
[132] DH (2008) End of life care strategy: promoting high quality care for all adults at the end of life. [Accessed 3/12/20].
[133] NHS (2015) End of life care. [Accessed 3/12/20].
[134] *Ibid.*

family should be kept informed and updated on the prisoner's condition, particularly if there is deterioration in their condition.

Consideration of early compassionate release
It is important to discuss this with the prisoner, as an application may take some time, or the prisoner may not wish to apply.[135]

HMPS and NHS England are working together to ensure that, as far as possible, prisoners are able to exercise informed choice about where they die. PSI 21-2012 outlines the policy regarding compassionate release on temporary licence (ROTL). Some prisoners will be entitled to compassionate release and others will not.

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.

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 restrains 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.[136]

[135] 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].
[136] PPO (2015) Annual report 2014-15. [Accessed 10/12/20].

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.*[137]

> *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.*[138]

There is a solid evidence base demonstrating that prisoners have poorer dental health than the general population. Prisoners exhibit more decay and fewer filled teeth,[139] in addition to experiencing a higher prevalence of oral disease and unmet dental needs, than the general population.[140]

> *Prisoners have poorer general and oral health than the non-prison population. Remand prisoners 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 prisoners. Convicted prisoners expressed more perceived need than their fellow remand prisoners, even though convicted prisoners' normative need tended to be lower.*[141]

A needs assessment of the oral health of residents in Wales found high levels of need.[142] 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.[143]

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.[144] 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.[145] 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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[137] National Association of Prison Dentistry (2015) Service specification prison dentistry. [Accessed 9/12/20].

[138] 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].

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

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

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

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

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

[144] *Ibid.*

[145] *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.[146] 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.*[147]

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.[148] 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.

Smoking, Alcohol and Drug Use

Prevalence rates for smoking amongst residents are four times greater than in the community.[149] Approximately 80% of all residents smoke[150] compared with 15.5% of the general population.[151]

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.*[152]

Nineteen per cent of all residents (predominantly male) and 29% of female residents report having alcohol problems.[153] 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.[154]

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[146] 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].

[147] 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].

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

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

[150] Data from recent TamlynCairns HNAs.

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

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

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

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

Drinking hazardously is indicated as a cause of oral disease, including cancers of the mouth, larynx, pharynx and oesophagus.[155] Alcohol, and lifestyles closely associated with alcohol misuse, can also have detrimental effects on dentition: dental erosion, dental caries and periodontal disease.[156]

Forty-two per cent of women and 28% of men report having a drug problem on arrival to prison. Worryingly, 13% of men and 8% of women report developing a problem with illicit drugs while in prison.[157]

Thirty per cent of prisoners have a drug problem at reception.[158] 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.[159]

> *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.*[160]

Residents with any history of previous drug use show greater numbers of decayed teeth when compared to those with no history of drug use.[161]

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.[162]

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*[163]

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

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[155] 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].
[156] Amaral, C.S. *et al.* (2009). The relationship of alcohol dependence and alcohol consumption with periodontitis: a systematic review. [Accessed 7/12/20].
[157] House of Commons (2018) Prison health. [Accessed 7/12/20].
[158] 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].
[159] CSEW (2018) Drug misuse: findings from the 2017/18 crime survey for England and Wales. [Accessed 7/12/20].
[160] Shekarchizadeh, H. *et al.* (2013) Oral health of drug abusers: a review of health effects and care. [Accessed 7/12/20].
[161] SOHIPP (N.D.) The oral health and psychosocial needs of Scottish residents and young offenders. [Accessed 7/12/20].
[162] BDA (2012) Oral health in prisons and secure settings in England. [Accessed 7/12/20].
[163] Edgar (2017) Homelessness and oral health: a neglected issue. [Accessed 7/12/20].

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.[164] 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.'*[165]

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.[166]

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*[167]

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[168]

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.*

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

[165] 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].

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

[167] 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].

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

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.*[169]

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).[170]

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

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

Reproductive Health

Reproductive health encompasses the reproductive system, fertility, contraception, health during pregnancy and in the perinatal period.[171] Sexual health is covered in a separate section.

As noted in the Screenings and Vaccinations section, a number of the PHE population screening programmes relate to reproductive, perinatal and sexual health.

Menopause

Menopause refers to the cessation of menstrual periods due to the depletion of ovarian follicles and is associated with reduced production of oestrogen and other hormonal changes. The perimenopause (leading up to the last period) can last for several years. A woman is described as post-menopausal when she has not menstruated for twelve months or more.[172] Most women experience menopause between 45 and 55 years of age.[173]

Most perimenopausal women experience some symptoms; for one in four the symptoms may be more severe. Symptoms of the menopause include irregular or no periods, insomnia, hot flushes, vaginal dryness, urinary problems including incontinence, decreased libido, mood swings, poor memory and concentration, depression and anxiety.[174] These symptoms may begin when menstruation ceases, or up to six years earlier, and typically continue for up to four years after (50% of women report symptoms for up to seven years following menopause, while 10% report symptoms for up to 12 years).[175] Post-menopausal women, especially those who experience an early menopause, are at higher risk of osteoporosis compared to men or pre-menopausal women.

Some women may experience early menopause, or premature ovarian insufficiency (defined as menopausal symptoms before the age of 40); the most common causes of early menopause are genetic factors, autoimmune conditions, some infections, or surgical removal of the ovaries. Women who experience an early menopause are more likely to suffer higher levels of morbidity and mortality during menopause than those aged 45 and over; they are also more at risk of developing osteoporosis and cardiovascular disease if left untreated.

Hormone replacement therapy (HRT) in the form of combined oestrogen and progesterone or oestrogen alone, may be used to alleviate some of the symptoms of menopause, and can also provide protection against osteoporosis. However, this can have side effects including breast pain, headaches and vaginal bleeding, as well as increased risk of blood clots and breast cancer. Treatment should be offered on a case-by-case basis and the risks and benefits discussed with the patient.[176]

Contraception

With regard to contraception, PHE states:

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[171] World Health Organisation (N.D.) Sexual and reproductive health research. [Accessed 11/12/20].

[172] National Collaborating Centre for Women's and Children's Health (2015) Menopause: full guideline. [Accessed 11/12/20].

[173] NICE (2017) Menopause: NICE quality standard. [Accessed 11/12/20].

[174] Royal College of Obstetricians and Gynaecologists (2018) Treatment for symptoms of the menopause. [Accessed 11/12/20].

[175] NICE (2015) Menopause: diagnosis and management NICE guideline [NG23]. [Accessed 11/12/20].

[176] Rees,M. (2011) Management of menopause: integrated health-care pathway for the menopausal woman. [Accessed 11/12/20].

> *Women should be offered a full range of choices in all settings so that they can choose a method of contraception that suits them best.*[177]

Up to 45% of pregnancies in England are unplanned at the time of conception. Risks associated with unplanned pregnancy include obstetric complications and antenatal and postnatal depression, as well as risks for the child, including low birthweight and developmental abnormalities.[178]

Younger women, those with lower educational attainment, and those who misuse substances are more at risk of unplanned pregnancy; early motherhood is associated with detrimental outcomes for both mother and baby.[179] Teenagers remain the group at highest risk of unplanned pregnancy, despite reducing rates (18.8 conceptions per 1,000 women aged 15-17 in England in 2016, the lowest ever recorded rate). Unplanned pregnancy can also be an issue for older women: women aged over 35 are the least likely to use adequate contraception, despite being sexually active.[180]

> *Women who are already disadvantaged are less likely to access contraception and preconception care altogether. Women who are not reached by existing contraceptive services are ideally placed to receive opportunistic contraceptive advice, such as after taking emergency hormonal contraception (EHC), after having an abortion or a baby, or when they are in contact with health services for other issues or conditions.*[181]

Postnatal women should also be offered contraception and contraceptive advice, since repeat pregnancy less than one year following delivery is associated with adverse outcomes for mother and child.[182]

Pregnancy and Perinatal

> *Imprisoned women who are pregnant constitute a high-risk obstetric group, that is, both mother and foetus are more likely to have problems during pregnancy and, subsequently, to have poorer outcomes.*[183]

This is likely to be for a number of reasons, including the increased likelihood of risk factors for pregnancy and perinatal complications such as obesity, smoking and substance use among women from disadvantaged backgrounds.[184] Pregnant women in prison are less likely to have received adequate antenatal care than non-imprisoned pregnant women.[185]

During pregnancy, women should be offered appropriate vaccinations and screenings (covered in the Screening and Vaccinations section), encouraged to take appropriate nutritional supplements (folic acid and vitamin D), and encouraged to adopt positive health behaviours such as stopping smoking, alcohol consumption and drug use. [186]

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[177] Public Health England (2018) Health matters: reproductive health and pregnancy planning. [Accessed 11/12/20].
[178] *Ibid.*
[179] Public Health England (2018) Health matters: giving every child the best start in life. [Accessed 11/12/20].
[180] Public Health England (2018) Health matters: reproductive health and pregnancy planning. [Accessed 11/12/20].
[181] *Ibid.*
[182] Public Health England (2018) Understanding the contraceptive needs of postnatal women. [Accessed 11/12/20].
[183] Van den Bergh, B. *et al.* (2013) Women's health and the prison setting. [Accessed 11/12/20].
[184] Public Health England (2018) Health matters: giving every child the best start in life. [Accessed 11/12/20].
[185] Knight, M. & Plugge, E. (2005) Risk factors for adverse perinatal outcomes in imprisoned pregnant women: a systematic review. [Accessed 11/12/20].
[186] Public Health England (2018) Health matters: giving every child the best start in life. [Accessed 11/12/20].

Up to 20% of women experience mental health problems during pregnancy and the first year after birth.[187] NICE guidelines state that pregnant women should be routinely asked about their mental health at every prenatal and postnatal healthcare contact, and, if necessary, assessed and offered treatment for any mental health problems.[188]

Female Genital Mutilation

Female genital mutilation (FGM) describes a range of practices, typically performed on girls before the age of 15, involving damage to, or partial or total removal of, the external female genitalia.[189] It has no health benefits and a number of risks, both at the time of the procedure and in later life. Risks in later life include urinary tract infections, sexual problems, problems with menstruation, childbirth complications, and psychological trauma.[190] It is not known what proportion of women in the UK may have experienced FGM, but it may be more likely among foreign national women, particularly those from the 30 countries across Africa, the Middle East and Asia where FGM is concentrated. [191]

Mother and Baby Units

Women who give birth in prison can keep their baby for the first 18 months in a mother and baby unit (MBU), of which there are six in England. A prisoner with a child under 18 months old can apply to bring their child to prison with them.[192] The national operational capacity of MBUs is 64 mothers and 70 babies. [193]

> *Pregnant women make up a small proportion of [the prison] population, which at the last self-declared snapshot at 15:00hrs on 28 October 2019 stood at 47. This represented less than 2 percent of the women's prison population. The majority of pregnant women reaching their expected delivery date during their custodial sentence will give birth in outside hospital, however the unpredictability of labour means that some will give birth in transit or in a prison setting. Births in prison settings are rare; the latest snapshot for the year 2018 stood at less than 5 women. In these instances, prisons are supported by their onsite healthcare teams or the local hospital or maternity centre.*[194]

Children of Female Prisoners

> *An estimated 17,000 children are affected by maternal imprisonment each year, and we know that these children are at risk of significantly worse outcomes than children not affected by parental imprisonment. These include, amongst others, an increased risk of future offending. We know that female prisoners are more likely to be a primary carer and imprisoned mothers are more likely to be living with their children prior to custody – around 60% of women compared with about 45% of men in prison who have children. Our experience shows that those experiencing separation from a child due to imprisonment or following time on an MBU can find the experience very difficult, and this can impact on them in different ways during the rest of their sentence.*[195]

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[187] Public Health England (2018) Health matters: reproductive health and pregnancy planning. [Accessed 11/12/20].
[188] NICE (2016) Quality Standard [QS115]: antenatal and postnatal mental health. [Accessed 11/12/20].
[189] World Health Organisation (N.D.) Female genital mutilation. [Accessed 11/12/20].
[190] World Health Organisation (2018) Working to end myths and misconceptions about female genital mutilation. [Accessed 11/12/20].
[191] World Health Organisation (N.D.) Female genital mutilation. [Accessed 11/12/20].
[192] HM Government (N.D.) Prison Life: Pregnancy and childcare in prison. [Accessed 11/12/20].
[193] MOJ (2020) Review of operational policy on pregnancy, mother and baby units and maternal separation. [Accessed 11/12/20].
[194] *Ibid.*
[195] *Ibid.*

Imprisoned mothers are more likely to be a primary carer and are more likely to be living with their children prior to custody – around 60% of women compared with about 45% of men in prison who have children.[196]

In addition, because of the smaller number of female prisoners and thus female prisons, women in prison are more likely to be geographically isolated from their families than male prisoners, making it more difficult to maintain family relationships. The average distance from home for female prisoners is 64 miles.[197]

[196] *Ibid.*

[197] Women in Prison (N.D.) Key facts. [Accessed 11/12/20].

Communicable Diseases

Routine Immunisations

The Health Protection Agency[198] 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.*[199]
>
> *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.[200]

Screening and Vaccinations

NICE (2016) recommend that prison healthcare should:

> *offer people equivalent health checks to those offered in the community*.[201]

All new receptions are eligible for both a first and secondary health screens; in some prisons this may include NHS Health Checks.[202]

The PHE population screening programme makes reference to 12 recognised screening programmes in the UK.[203] Seven of these relate to antenatal and new born babies. The following screening programmes are relevant for the young offender and adult female prison population:

- National Breast Screening Programme for all women aged 50 to 70 years
- Cervical Screening Programme. All women aged 25-64
- Diabetic Eye Screening (DES) programme (everyone aged over 12 years with type 1 and type 2 diabetes)
- Bowel Cancer Screening Programme (BCSP) for men and women aged 60-74 years

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[198] Health Protection Agency (2009) Schedule for vaccination of residents and young offenders in North West region. [Accessed 7/12/20].
[199] Public Health England (2011) PHE press release. [Accessed 7/12/20].
[200] PHE (2018) The complete routine immunisation schedule from autumn 2018. [Accessed 7/12/20].
[201] NICE (2016) Physical health of people in prison. [Accessed 11/12/20].
[202] *Ibid.*
[203] PHE (N.D.) Population screening programmes. [Accessed 11/12/20].

There is a rage of antenatal screening programmes for pregnant women including:

- Foetal Anomaly Screening Programme (FASP) which screens for foetal abnormalities including Down's, Edward's and Patau's Syndromes.
- Infectious Diseases in Pregnancy Screening Programme.
- Sickle Cell and thalassaemia (SCT) Screening Programme.

There are also two additional, related programmes in England that are relevant to the prison population. These are:

- The National Chlamydia Screening programme (for under 25s)
- 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)

The Health Protection Agency states:[204]

> *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.*[205]
>
> *Hepatitis A and B vaccinations are recommended for all prisoners.*
>
> *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 prisoners 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).

Blood Borne Viruses

PHE state that BBV infection rates are four times higher amongst prisoners compared to the general population.[206] 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.[207] PHE are promoting opt out testing for prisoners using dry blood spot testing; this approach is increasing rates of testing.[208]

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[204] Health Protection Agency (2009) Schedule for vaccination of prisoners and young offenders in North West region. [Accessed 11/12/20].
[205] PHE (2011) 300% increase in Hep B prison vaccine helps to drive down infection rates in injecting drug users. [Accessed 11/12/20].
[206] PHE & WHO (2018) Public Health England health and justice annual review 2017/18. [Accessed 10/12/20].
[207] Public Health England (2015) Hepatitis cases responsible for 93% of prison disease reports. [Accessed 10/12/20].
[208] PHE (2018) Hepatitis C in the UK. [Accessed 10/12/20].

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.[209] 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.[210] This is likely due to risky behaviour, for example, associated with substance misuse. Over 90% of new hepatitis C cases are believed to be acquired through injecting drug use.[211]

Figure 14 – BBV Prevalence[212]

Blood Borne Viruses	Estimated Prevalence (%)
Hep B	8%
Hep C	9%
HIV	0.30%

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.[213] 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.[214]

More recently, NICE published guidelines on testing for BBVs in prisons.[215] 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.[216]

NICE recommend routine HBV vaccinations for staff and inmates of custodial institutions.[217] 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.[218]

Sexual Health

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

NHS England states that:

[209] Public Health England (2017) Infection inside international. [Accessed 7/12/20].

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

[211] 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].

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

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

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

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

[216] 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].

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

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

> *anyone under 25 who is sexually active should be screened for chlamydia annually, and on change of sexual partner.*[219]

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.[220] From 2017 to 2018 there was a 6% increase in the number of chlamydia cases. This was, at least in part, attributed to better testing.[221]

> *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.*[222]

The PHE published rate of diagnosed sexually transmitted infections (STI) amongst residents is reported to be low.[223]

Chlamydia is most relevant and pertinent in establishments (both male and female) with YO populations.[224]

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.[225]

Prisoners include a disproportionate number of those with social and clinical risk factors for tuberculosis and pose a challenge for control.[226] 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.[227]

In 2018, 4,655 people were diagnosed with TB in England, and people born outside the UK accounted for 72% of cases.[228]

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.[229]

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[219] PHE (2018) Sexually transmitted infections and screening for chlamydia in England, 2017. [Accessed 7/12/20].
[220] PHE (2019) Health matters: preventing STIs. [Accessed 10/12/20].
[221] *Ibid.*
[222] *Ibid.*
[223] PHE (2016) Public Health England Health and Justice annual review 2015/16. [Accessed 7/12/20].
[224] PHE (2016) Public Health England Health and Justice annual review 2015/16. [Accessed 7/12/20].
[225] PHE (2019) Tuberculosis cases in England hit lowest ever levels. [Accessed 7/12/20].
[226] Anderson, C. (2010) Tuberculosis in UK prisoners: a challenge for control. [Accessed 7/12/20].
[227] PHE (2019) Tuberculosis cases in England hit lowest ever levels. [Accessed 7/12/20].
[228] Public Health England (2019) Tuberculosis in England 2019 report. [Accessed 7/12/20].
[229] Public Health England (2020) Flu in prisons and secure settings. [Accessed 7/12/20].

A PHE audit discusses influenza vaccination programmes in prison settings.[230] Guidance requires that all those aged 65 or older, and those who fall into clinical risks groups, should be offered the vaccine.[231]

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

[231] 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].

Substance Misuse Needs of Female Prisoners

Overview

Substance misuse interventions in prison settings have evolved. The Drug Strategy 2010[232] both embraced the concept of recovery and broadened the definition of substances to include alcohol. In respect of illicit drug use only, HMIP in 'Changing patterns of substance misuse in adult prisons and service responses' continued to carry the agenda forward, including a focus on psychoactive substances (PS) (previously referred to as NPS).[233]

The Drug Strategy 2017[234] continues to develop the concept of recovery and now includes a focus on PS. The MOJ,[235] places a strong emphasis on *'getting offenders off drugs*' and restricting supply within prisons.

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.[236] 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.[237] 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.[238]

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.*[239]

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, therefore, was on engaging people in treatment. The recovery agenda has shifted the focus to the numbers of individuals who complete treatment and become drug free.

Prevalence of Substance Misuse amongst Prisoners

The numbers in treatment (in England and Wales) and a detailed breakdown of their characteristics, informed by NDTMS data, are published annually by PHE.[240]

- 70% of offenders report drug misuse prior to prison

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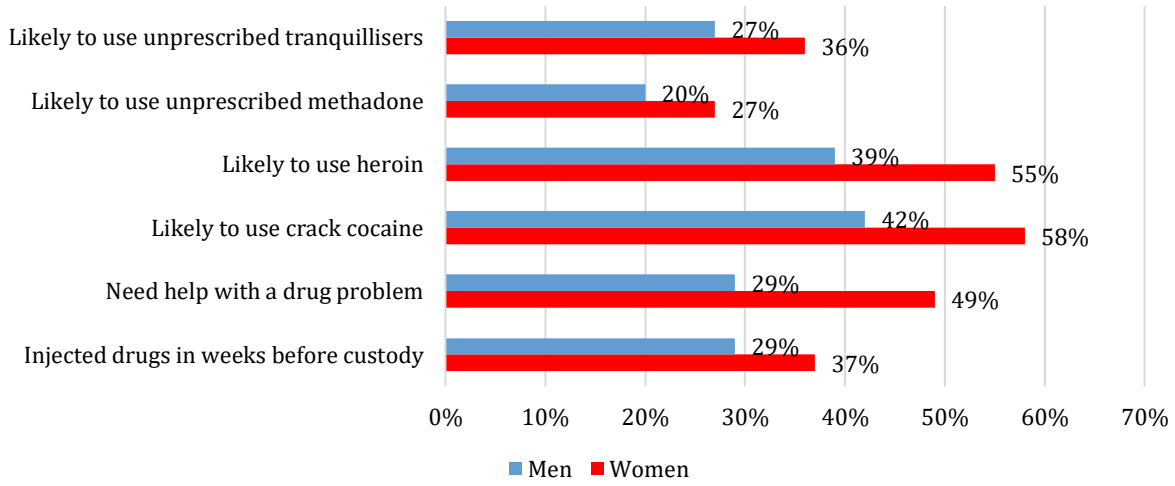
[232] HM Government (2010) Drug strategy 2010. Reducing demand restricting supply, building recovery: supporting people to live a drug free life. [Accessed 10/12/20].
[233] HMIP (2015) Changing patterns of substance misuse in adult prisons and service responses. [Accessed 11/12/20].
[234] HM Government (2017) 2017 drug strategy. [Accessed 11/12/20].
[235] MOJ (2016) Prison safety and reform. [Accessed 11/12/20].
[236] House of Commons Health and Social Care Committee (2018) Prison health twelfth report of session 2017–19. [Accessed 8/12/20].
[237] 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].
[238] Prison Reform Trust (2019) Bromley briefings prison factfile. [Accessed 3/12/20].
[239] HMIP (2015) Changing patterns of substance misuse in adult prisons and service response. [Accessed 7/12/20].
[240] PHE (2018) Secure setting statistics from the National Drug Treatment Monitoring System. [Accessed 10/12/20].

- 51% report drug dependency
- 35% admit injecting behaviour
- 36% report heavy drinking
- 16% are alcohol dependent

A higher proportion of female prisoners reported to have an alcohol or drug problem upon arrival into prison than males. Forty-two per cent of women and 28% of men report having a drug problem on arrival to prison. In addition, 13% of men and 8% of women report developing a problem with illicit drugs while in prison.[241]
Of those prisoners who had/have an alcohol problem, 64% of females and 59% of males reported that they received help with their alcohol problem while in prison,[242] while 75% of females and 59% males reported receiving help in prison for a problem with illicit drugs.[243]

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.[244]

Figure 15 – 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:

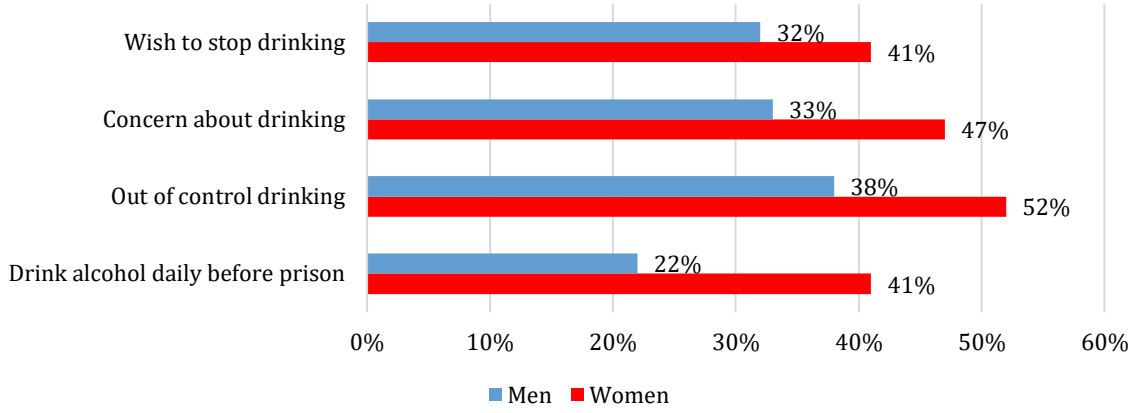
[241] House of Commons (2018) Prison health. [Accessed 11/12/20].

[242] MOJ (2018) Statistics on women and the criminal justice system 2017. [Accessed 11/12/20].

[243] *Ibid.*

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

Figure 16 – Findings from National Prisoner Survey (SPCR)



Drug use was seen as a preserve of the young, but this is no longer the case.[245]

The 2015 HMIP thematic report[246] 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.[247]

> *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 prison on, inappropriately prescribed drugs. In recent years, the use of NPS – in particular, synthetic cannabis, known as 'Spice' or 'Mamba' – has grown significantly.*[248]

A rapid systematic review[249] of studies of prisoners found that between 39% and 83% of females who were screened scored positive for an alcohol disorder and 42% scored for alcohol dependency.

Figure 17 – HMIP Self Report Data[250]

	Female	Male
Use of unprescribed tranquillizers	36%	27%
Use of unprescribed methadone	27%	20%
Problem with drugs on arrival	41%	27%
Heroin users who started in prison	10%	38%
Received help	83%	59% (male locals)
Found support received helpful	88%	79%

Confirming the pattern described above, earlier studies also described different rates of prevalence of alcohol problems between male and female prisoners as outlined below. This

[245] Wadd, S. *et al.* (2014) The forgotten people: drug problems in later life. [Accessed 7/12/20].

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

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

248 HMIP (2015) Thematic Report. Changing patterns of substance misuse in adult prisons and service responses. [Accessed 7/12/20].

249 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].

[250] HMIP (2015) Changing patterns of substance misuse in adult prisons and service responses. [Accessed 11/12/20].

shows that males are more likely to have alcohol problems whereas females are more likely to have drug problems in prison:[251]

However, other studies dispute this:

> *There were no differences between the proportion of male and female prisoners who reported needing help for an alcohol problem, nor in the amount of help they reported needing.*[252]

> *Significantly more females had an alcohol problem when they arrived in prison (24%) than males (18%); similarly for a drug problem (39% compared to 28%).*[253]

Figure 18 – Fazel Estimates[254]

	Male Prisoners	Female Prisoners
Alcohol Abuse or Dependence	18-30% (midpoint 24%)	10-24% (midpoint 16%)
Drug Abuse or Dependence	10-48% (midpoint 29%)	30-60% (midpoint 45%)

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 19 – Rates of Drug and/or Alcohol Problems used in Prevalence Estimates

	Male Residents	Female Residents
Alcohol abuse or dependence	16[255]-43%[256] (midpoint 29.5%)	20[257] - 54%[258] (midpoint 37%)
Drug abuse or dependence	28[259] to 51%[260] (midpoint 39.5%)	52%[261] 58%[262] (midpoint 55%)

In a remand setting, the majority of presentations will be people arriving in the prison system who are seeking clinical support for dependence or who are seeking psychosocial support for a dependency developed in the community. In a long-term prison, presentations for clinical interventions will be from transfers in who are currently prescribed OST or people with 'a prison habit'; plus psychosocial referrals will be largely for support regarding a previous habit or assistance in how to remain substance free after release.

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[251] 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].
[252] Light, M. *et al.* (2013) Gender differences in substance misuse and mental health amongst prisoners. [Accessed 11/12/20].
[253] MOJ (2018) Statistics on women and the criminal justice system 2017. [Accessed 11/12/20].
[254] HMIP (2015) Changing patterns of substance misuse in adult prisons and service responses. [Accessed 11/12/20].
[255] Singleton *et al.* (1999) Substance misuse among residents in England and Wales. [Accessed 7/12/20].
[256] Newbury-Birch, D. *et al.* (N.D.) Alcohol screening and brief intervention in the prison system. [Accessed 7/12/20].
[257] Singleton *et al.* (1999) Substance misuse among residents in England and Wales. [Accessed 7/12/20].
[258] Parkes *et al.* (2011) Prison health needs assessment for alcohol problems. [Accessed 7/12/20].
[259] HMIP (2015) HM Inspectorate of Prisons annual report 2014-2015. [Accessed 7/12/20].
[260] Home Affairs Committee (2012) Drugs in prisons: drug use in prisons. [Accessed 7/12/20].
[261] Women in Prison website Key facts. [Accessed 7/12/20].
[262] Light, M. *et al.* (2013) Gender differences in substance misuse and mental health amongst residents. [Accessed 7/12/20].

Therefore, for this section of the report we are taking incidence to be the static population plus 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.

Psychoactive Substances (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.*[263]

There have been changes in the law regarding possession in the community,[264] though all PS-type drugs have been prohibited in prison for some considerable time.[265] 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[266] that:

> *Much of the violence seemed to be linked to drugs and debt.*[267]

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.*[268]

Concerns about PS use are not restricted to the UK, it is an EU-wide problem.[269]

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.[270] 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 misleading to describe PS and particularly 'Spice' as synthetic cannabinoids, as the effects and side effects bear little resemblance to those of even the most potent forms of cannabis. Project Neptune[271] has suggested PS and club drugs can be divided into four categories:

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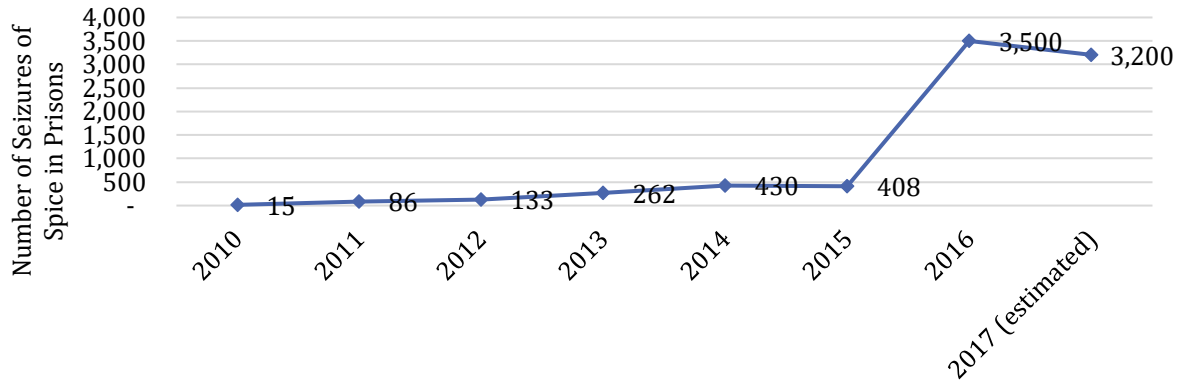
[263] Home Office (2014) New psychoactive substances review. [Accessed 3/12/20].
[264] Home Office (2016) Psychoactive Substances Act 2016. [Accessed 3/12/20].
[265] Including specific powers under the Criminal Justice and Courts Act (2015). [Accessed 3/12/20].
[266] HMIP (2017) Annual report 2016-17. [Accessed 3/12/20].
[267] HMIP (2018) Annual report 2017-18. [Accessed 3/12/20].
[268] HMIP (2015) Changing patterns of drug use in adult prisons and service responses. [Accessed 3/12/20].
[269] EMCDDA (2018) New psychoactive substances in prison. [Accessed 3/12/20].
[270] MOJ (2017) Supplementary tables and MDT data tool. [Accessed 3/12/20].
[271] Project Neptune (N.D.) Neptune clinical guidance. [Accessed 7/12/20].

Figure 20 – 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:

Figure 21 – HMPS Seizures of Spice (2010-2014)



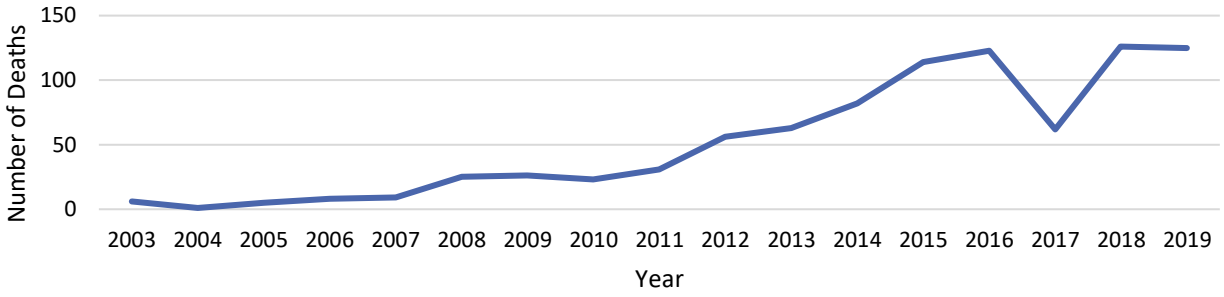
Spice is now a substantial problem in prison, with the number of seizures having gone up from 408 in 2015[272] to 4,261 in 2016.[273]

Of all substances including psychoactive substances, HMPPS reports that 17.7% of drug tests were positive in the 12 months to March 2019.[274] 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.[275]

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.[276] In the community, ONS reports that deaths attributed to PS use across the whole community remain infrequent but are increasing over time.[277]

[272] House of Commons (2017) Mental health in prisons. [Accessed 7/12/20].
[273] Forward Trust (2016) Prison seizures of 'legal highs' increased by 30 times in five years. [Accessed 7/12/20].
[274] HMPPS (2020) HMPPS annual digest. [Accessed 7/12/20].
[275] *Ibid.*
[276] Prison Reform Trust (2019) Prison: the facts. [Accessed 7/12/20].
[277] ONS (2020) Deaths related to drug poisoning in England and Wales: 2019 registrations. [Accessed 10/12/20].

Figure 22 – PS Deaths in England and Wales (2005-2016)



Predicting future demand, common across all establishments, we believe that healthcare will continue to see some impact from the use of PS. Recent 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, prisoners have learned and either use less, or less dangerously, because the frequency of incidence has peaked.

Figure 23 – PS Drug Challenges

Challenges for Healthcare Staff	Challenges for Prison Staff/Regime
Unpredictable effects, coupled with covert nature of drug use often means 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[278] and a useful discussion document about PS use in prisons, informed by a series of training events.[279]

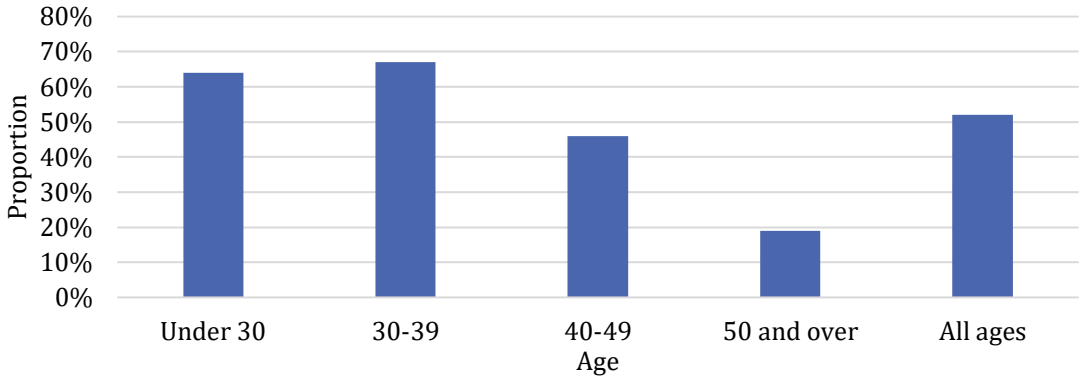
An MA dissertation, partly informed by research in a North West prison, provides a synopsis of the published research, and explores reasons for NPS use and approaches to combatting it.[280]

[278] PHE (2015) NPS toolkit. [Accessed 7/12/20].
[279] PHE (2017) Thematic analysis of training for prison staff on new psychoactive substances. [Accessed 7/12/20].
[280] Norton, A. (N.D.) Spicing up the subject. [Accessed 7/12/20].

Substance Misuse and Young Offenders

Drug misuse is more prevalent among younger prisoners than older prisoners, as is illustrated in the latest HMIP thematic report.[281]

Figure 24 – Prevalence of Drug Misuse by Age[282]



Substance Misuse and the Elderly

ONS data suggests that 67% of British people who consume alcohol do so at 'hazardous' levels and, of these, 20% are female.[283] Alcohol Concern states that older people tend to drink more frequently than younger people, but that younger people tend to drink more heavily on a single occasion. They also observe that adults from the highest income quintile are twice as likely to drink heavily as adults in the lowest income quintile – 22% to 10%.[284]

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%

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:

> *[a]s 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.*[285]

The Mental Health Foundation states that alcohol abuse is more likely to go unrecognised in older people.[286]

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

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[281] HMIP (2015) Changing patterns of substance misuse in adult prisons and service responses. [Accessed 7/12/20].
[282] *Ibid.*
[283] ONS (2001) Psychiatric morbidity among adults living in private households. [Accessed 11/12/20].
[284] Alcohol Concern (2015) Alcohol statistics. [Accessed 7/12/20].
[285] Wadd, S. *et al.* (2011) Working with older drinkers. [Accessed 11/12/20].
[286] Mental Health Foundation (2015) Mental health in later life. [Accessed 7/12/20].

> *[o]lder prisoners reported lower levels of drug use compared to younger prisoners, with fewer than three in ten older prisoners reporting using any drug before custody compared to the majority of younger prisoners.*[287]

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

> *[s]ubstance use problems affect almost 1%...Substance abuse problems among the elderly are often overlooked or misdiagnosed.*[288]

[287] MOJ (2014) The needs and characteristics of older residents: results from the Surveying Prisoner Crime Reduction (SPCR) survey: analytical summary. [Accessed 7/12/20].
[288] World Health Organisation (2013) Mental health of older adults. [Accessed 7/12/20].

Mental Health Needs of Female Prisoners

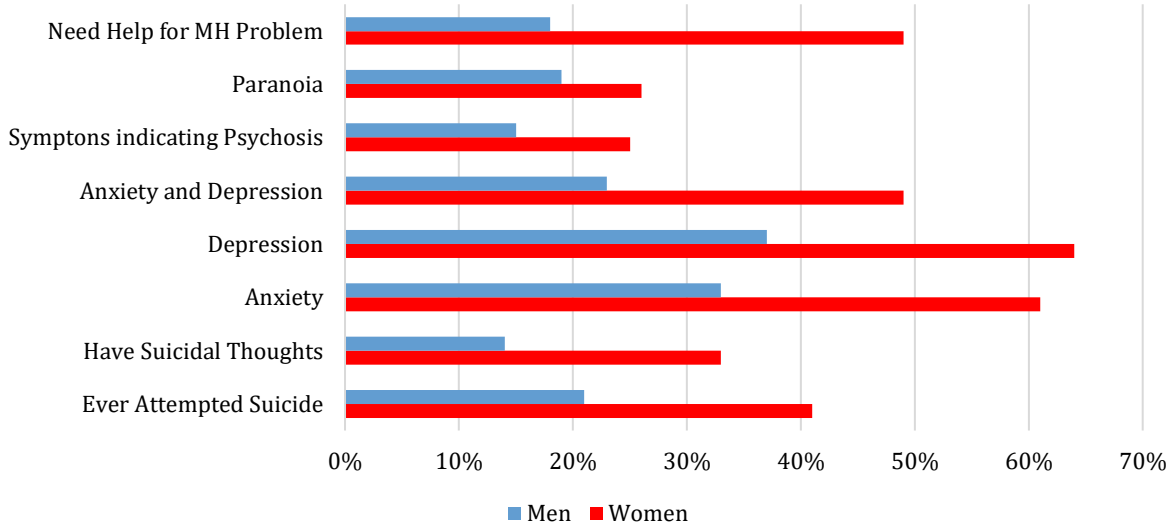
National Evidence Base on Prevalence

The prevalence of both common and severe and enduring mental health issues is far higher amongst prisoners than is the case in the general population.[289] Within prisons the prevalence is far higher amongst women than men.[290]

NHS England estimates that 37% of its adult healthcare spend in prisons is on mental health and substance abuse.[291]

The following illustrates the sheer difference between male and female prisoners, specifically in relation to mental health needs. The critical point to note in the below illustration is the difference between the red and blue bars:[292]

Figure 26 – Findings from National Prisoner Survey (SPCR)



Despite almost three times the number of female prisoners than male prisoners stating they felt they needed help for their mental help problem, the same data set suggests that they are barely more likely to receive help with their mental health (10% women vs 11% men). Nearly one in five of prisoners diagnosed with a mental health problem receive no care from a mental health professional in prison, and 40% of prisons inspected in 2016–17 were reported to have inadequate or no training for prison officers on when to refer a person for mental health support.[293]

Twenty-six per cent of women and 16% of men in prison said they had received treatment for a mental health problem in the year before custody.[294]

The level of psychotic disorders amongst the general public is 4%. In prison, 25% of women and 15% of men report symptoms that indicate psychosis.[295] The level of personality

[289] PHE (2018) Health matters: reducing health inequalities in mental illness. [Accessed 11/12/20].
[290] Singleton N *et al*. (2003) Substance misuse among prisoners in England and Wales. [Accessed 11/12/20].
[291] House of Commons (2017) Mental health in prisons. [Accessed 11/12/20].
[292] MoJ (2013) Gender differences in mental health & substance misuse issues (SPCR). [Accessed 11/12/20].
[293] Prison Reform Trust (2019) Mental health care in prisons. [Accessed 11/12/20].
[294] *Ibid.*
[295] *Ibid.*

disorders amongst female prisoners is 14 times as high as amongst the females in the general public and the level of neurotic disorders three times as high. Fifteen per cent of female sentenced prisoners and almost 10% of female young offenders report having been admitted to a mental inpatient facility at some point.[296]

The NHS Five Year Forward View for Mental Health (2016) states:[297]

> *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.[298]

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).[299]

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.[300]

New NICE guidelines were issued in March 2017 covering the assessment and management of people (over 18) with mental health problems in prison.[301]

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.*[302]

In March 2018, NHS England issued a new Service Specification.[303]

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.[304] 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,

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

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

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

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

[300] *Ibid.*

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

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

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

[304] 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].

nourishing food at sensible times and a decent night's sleep.[305]

> *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.*[306]

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.[307]

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.[308] Male prisoners are described as being more than ten times as likely to have a personality disorder than a member of the general community.[309]

A previous systematic review on the mental health of residents in the UK found a wide range of prevalence rates for mental health disorders.[310] 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.*[311]

The most robust prevalence study, covering both England and Wales, was conducted in 1998.[312] 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[313]

A more recent meta-analysis by NICE found that prescribing rates of psychotropic medications to men in prisons are four times greater than for an equivalent age-adjusted community sample:

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[305] *Ibid.*

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

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

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

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

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

[311] 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].

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

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

> *[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.*[314]

In 2016, this pattern was confirmed to still be the case.[315]

Learning Difficulties & 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.[316] 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.*[317]

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.*[318]

It is estimated that between two and 10% of offenders have a learning disability.[319] Supporting this order of prevalence, a study of nearly 3,000 prisoners using the LDSQ tool found 7% screened positive.[320] In addition, *'a significant percentage of the prison population'*[321] 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:

> *They 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.*[322]

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

[315] 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].

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

[317] 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].

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

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

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

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

[322] 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. There is a suggestion that ADHD may be underdiagnosed in girls.[323]

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.[324]

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 prisoners and six times more than prisoners 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.*[325]

Autism Spectrum Disorders

Whilst often bundled alongside learning disabilities,[326] autism 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.*[327]

> *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.*[328]

> *It is estimated that a disproportionately high number of prisoners 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*

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[323] Quinn, P. & Madhoo, M. (2014) A review of attention-deficit/hyperactivity disorder in women and girls: uncovering this hidden diagnosis. [Accessed 11/12/20].

[324] NICE (2008) Attention deficit hyperactivity disorder: diagnosis and management of ADHD in children, young people and adults. [Accessed 11/12/20].

[325] 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].

[326] 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].

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

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

learning disabilities observatory indicates that around 20-30 percent of people with a learning disability also have an autistic spectrum condition.[329]

DH guidance to support the Adult Autism Strategy[330] includes a chapter specifically on working in the criminal justice system.[331] This states that:

NHS England is responsible for arranging the provision of health services for such prisoners 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.[332]

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; and a rate of 0.2% for women nationally. Though a recent study suggests an under identification in girls.[333]

The study noted:

Rates may be different in specific adult populations, such as among people who are homeless or living in prison.[334]

Speech, Language and Communication Needs

The Royal College of Speech and Language Therapists produced a dossier of evidence in 2012 that suggests a 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. 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 6% as 'very severely delayed'.

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 (Heritage, Virag, McCuaig, 2011). In comparison a separate study showed that there is a high level (91%) of communication

[329] DH (2015) Equal access, equal care; guidance for prison healthcare staff treating patients with learning disabilities. [Accessed 8/12/20].
[330] DH (2015) Adult autism strategy. [Accessed 8/12/20].
[331] DH (2015) Statutory guidance for local authorities and NHS organisations to support implementation of the adult autism strategy. [Accessed 8/12/20].
[332] National Autistic Society (2011) A guide for criminal justice professionals. [Accessed 8/12/20].
[333] Scottish Intercollegiate Guidelines Network (2016) Assessment, diagnosis and interventions for autism spectrum disorders. [Accessed 8/12/20].
[334] McManus, S. *et al.* (2016) Mental health and wellbeing in England: adult psychiatric morbidity survey 2014. [Accessed 8/12/20].

disability in young people known to the youth offending team. This is significantly greater than in the general population (10%).

Specifically over 44% of women in the criminal justice system have communication difficulties. It is important to note that the incidence of communication problems is higher among women offenders than for the general population.[335]

Traumatic Brain Injury

There are around 900,000 hospital admissions for head injuries each year. Of these, 10% are categorised as severe. Head injuries are proportionately higher amongst young adults and those over 75 years. Estimates state that from 31%[336] to 60%[337] 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.[338]

In a study in HMP/YOI Drake Hall found 64% of female reported a history indicative of brain injury.[339]

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'.[340] 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,[341] 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.[342] This was followed up with PPO guidance identifying how dementia can make delivering all aspects of healthcare more complex and demanding.[343]

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.[344] 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.[345]

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[335] 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].

[336] 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].

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

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

[339] The Disabilities Trust (2019) Making the link. Female offending and brian injury. [Accessed 11/12/20].

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

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

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

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

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

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

Figure 27 shows the current prevalence estimates of late-onset dementia for females in the UK, broken by age band. For those with dementia aged over 60 years, it is estimated that 55% have mild dementia, 32% have moderate dementia and 12% have severe dementia.[346]

Figure 27 – Estimated Population Prevalence (%) of Late-Onset Dementia in the UK[347]

Age in Years	Female (%)
60-64	0.9
65-69	1.8
70-74	3.0
75-79	6.6
80-84	11.7
85-89	20.2
90-94	33.0
95+	44.2

These prevalence rates represent a noticeable increase from previous estimates, and even if the 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.[348]

There are forms of dementia that are possibly triggered by long-term excessive alcohol consumption.[349] Some forms of dementia (e.g. alcohol-related dementia, Wernicke-Korsakoff syndrome) are very clearly alcohol induced.[350]

However, 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.*[351]

There is a link to the section above in that 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.[352]

Estimated Prevalence of Mental Health Problems

The following table is taken from the work by Singleton *et al.*[353] These estimates are for adults of all ages; one person can have more than one condition. Across every condition the

[346] *Ibid.*

[347] *Ibid.* Extracted from Table A.

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

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

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

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

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

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

prevalence is greater amongst prisoners than the general population, and greater amongst remand prisoners than sentenced.

Figure 28 – Prevalence of Common Mental Health Conditions (females)

	Female Community	Remanded Female Prisoners	Sentenced Female Prisoners
Sleep disorders	28%	81%	62%
Worry	23%	67%	58%
Fatigue	33%	64%	57%
Depression	11%	64%	51%
Irritability	25%	51%	43%
Depressive ideas	11%	57%	39%
Concentration/forgetfulness	10%	53%	38%
Anxiety	11%	42%	32%
Obsessions	12%	35%	24%
Somatic symptoms	10%	40%	30%
Compulsions	8%	25%	18%
Phobias	7%	31%	22%
Worry about physical health	5%	25%	23%
Panic	3%	26%	15%
PTSD		9%	5%

The following tables are taken from far more recent work by Jakobowitz *et al.*[354]

Figure 29 – Prevalence of Mental Health Conditions (females)

Disorder	% Meeting Diagnostic Criteria
Psychosis	9.9%
Depressive states	58.0%
Depressive episode	24.6%
Anxiety states	24.3%
Phobias	16.0%
Panic	5.9%
PTSD	12.0%
Personality disorder	32.7%
Alcohol dependence	34.3%
Drug dependency	59.6%

The Likely Demand for Mental Health Services

National studies estimate that a considerable proportion of people with mental health problems go undiagnosed.[355]

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

[354] Jakobowitz *et al.* (2017) Assessing needs for psychiatric treatment in prisoners: 1. prevalence of disorder. [Accessed 8/12/20].

[355] 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].

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 30 – Incidence and Identification of Mental Health Disorders[356]

	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 8-12% of those with mental health problems in the community going on to receive specialist treatment (beyond primary care). The Singleton *et al.* study found that in the 12 months before entering prison, 40% of female prisoners 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 – leading to 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.[357] 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.*[358]

Comorbidity

An estimated 70% of female prisoners suffer from two or more mental health disorders including substance misuse; this is around 35 times the level in the general female population.[359] 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.[360]

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[356] *Ibid.*

[357] 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].

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

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

[360] 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].

Liaison and Diversion Services (community)

Liaison and Diversion services are being established throughout the country to better identify vulnerable individuals (for example, but not exclusively, people with mental health problems/learning difficulties) at the earliest possible point in the criminal justice pathway. These services are becoming well established in many police custody suites (and courts). In 2009, The Bradley Report renewed the emphasis on the use of Liaison and Diversion, but nine years on, these schemes only covered 82% of the population. Full roll-out was achieved in March 2020.[361]

Higher proportions of adult females (69%) in contact with Liaison and Diversion Services had mental health needs than males (61%). Depressive illness was the most common need. In young people, 51% of females had mental health needs compared to 41% of males. For these young people, emotional and behavioural issues were the most common need.[362]

[361] NHS (2020) About liaison and diversion. [Accessed 11/12/20].

[362] MOJ (2018) Statistics on women and the criminal justice system 2017. [Accessed 11/12/20].

Self-Harm and Self-Inflicted Deaths in Female Prisoners

Drawing on a meta-analysis from a range of studies, Light stated:[363]

> *Rates of self-harm and attempted suicide are known to be higher amongst female than male prisoners.*
>
> *All prison staff, not just those in healthcare, need to be able to recognise the major symptoms of mental ill-health and know where to refer those requiring help. Staff training is, therefore, crucial.*[364]

Self–Harm

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.*[365]

Self-injury 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.[366] The prison environment can only compound these feelings.

Self-harm is common in prison due to the combined increased risks from mental ill-health and being incarcerated.[367] Females are 135% more likely to self-harm in prison compared to males.[368]

In 2017, there were 44,700 self-harm incidents in prisons, and 19% (8,300) occurred in the female estate. Females constitute 5% of the prison population, meaning that levels of self-harm are disproportionately high among female prisoners.[369] Rates of self-harm vary significantly between male and female establishments. In 2017 there was a rate of 445 incidents per 1,000 prisoners in male establishments (demonstrating an increase of 12% in the number of incidents since 2016) compared to 2,093 per 1,000 in female establishments (an increase of 8% since 2016).[370] However, overall, the number of incidents has decreased by 27% in female establishments (from 11,000 to 8,000 incidents) since 2007 whereas male establishments have seen a 213% increase over the same time frame (from 11,600 to 36,300 incidents).[371]

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[363] Light, M. *et al.* (2013) Gender differences in substance misuse and mental health amongst prisoners. [Accessed 11/12/20].

[364] PPO (2016) Prisoner mental health. [Accessed 11/12/20].

[365] Skegg, K. (2005*)* Self-harm. [Accessed 8/12/20].

[366] Mangnall, J. & Yurkovich, E. (2008*)* A literature review of deliberate self-harm. [Accessed 8/12/20].

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

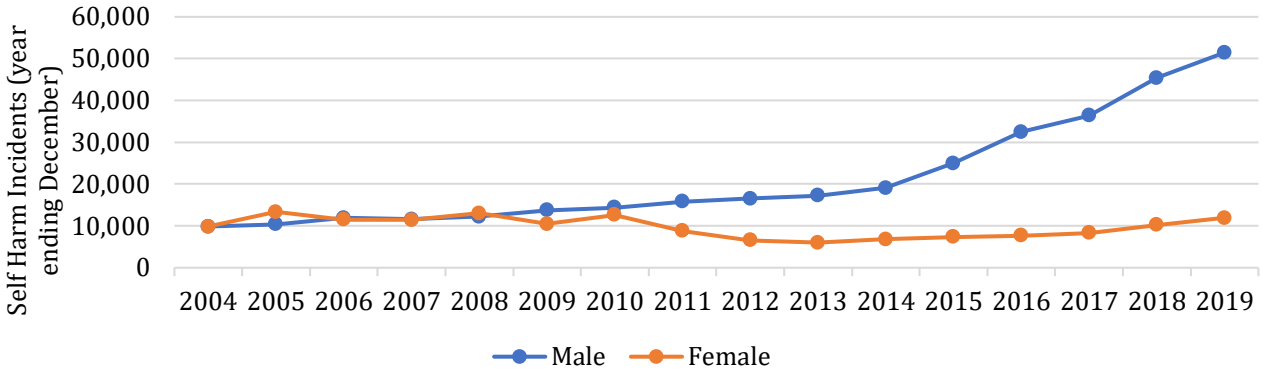
[368] MOJ (2018) Statistics on women and the criminal justice system 2017**.** [Accessed 11/12/20].

[369] Ibid

[370] Ibid

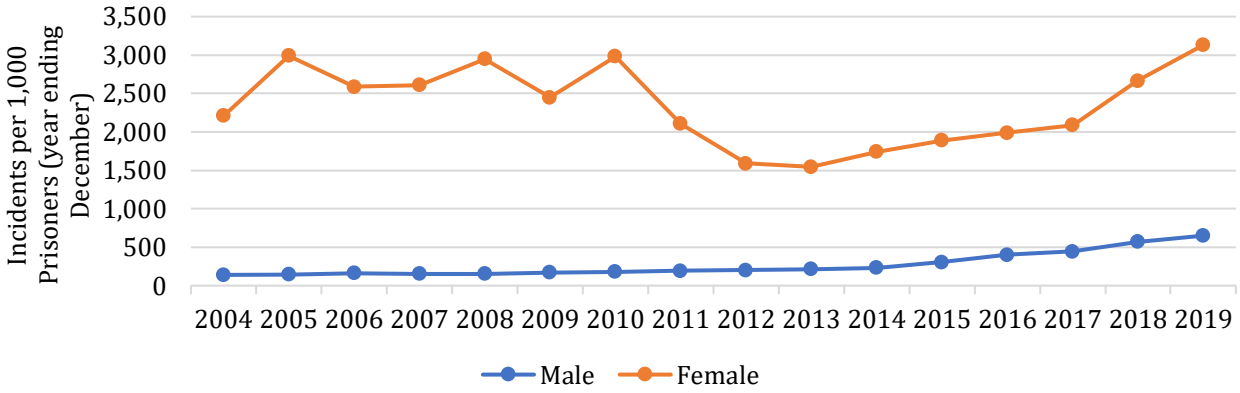
[371] Ibid

Figure 31 – Actual Self-Harm Incidents[372]



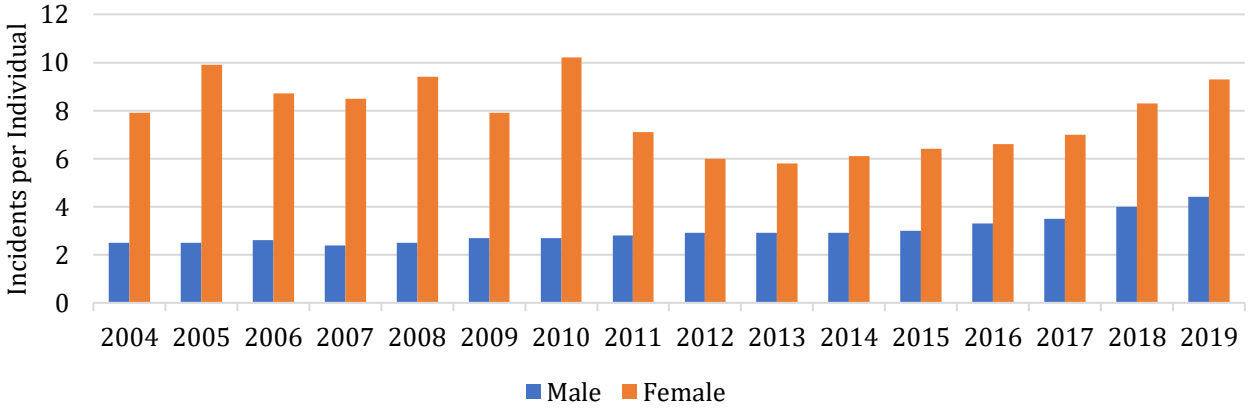
Noting that only 5% of the total prison population is female, the following illustration considers the rate of self-harm per 1,000 prisoners, so allows a more accurate comparison of males and females:

Figure 32 – Self-Harm Incidents per 1,000 Prisoners



The number of incidents per individual (frequency of self-harm) is higher in female prisoners than male prisoners:

Figure 33 – Self-Harm Incidents per Individual



Self-harm incidents requiring hospital attendance decreased in male establishments by 13%, from 3,138 in the 12 months to June 2019 to 2,732 in the 12 months to June 2020, and increased by 11% to 281 in female establishments in the latest 12 months. Self-harmers in female establishments were more than twice as prolific as those in male establishments in the latest 12 months (9.4 incidents per self-harming individual, compared to 4.3 in male establishments), although the proportion of incidents that required hospitalisation was higher in male establishments (5.6% compared to 2.4% in female establishments).[373]

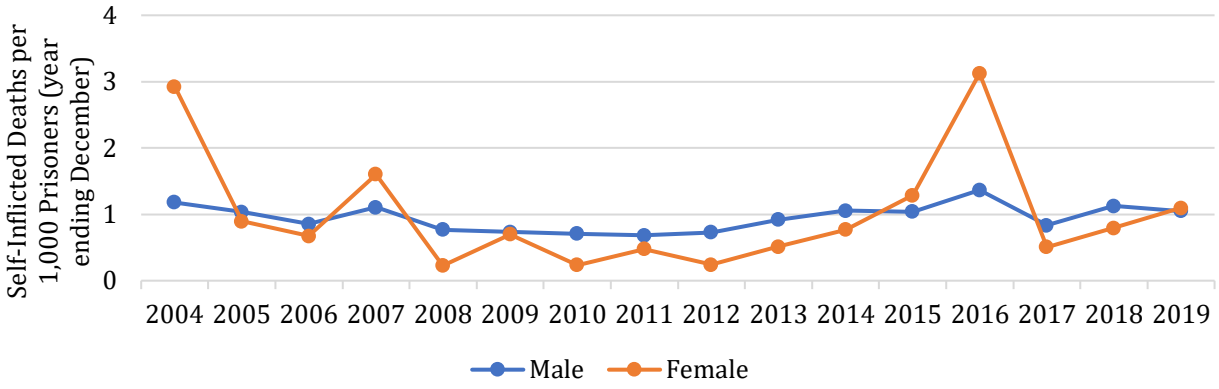
[372] MOJ (2020) Safety in custody statistics, England and Wales. [Accessed 11/12/20].

[373] MOJ (2020) Safety in custody statistics, England and Wales. [Accessed 11/12/20].

Self-Inflicted Deaths

In 2016, there were 120 self-inflicted deaths in prison.[374] A recent change has been the spike in the number of self-inflicted deaths amongst female prisoners, both in terms of number, but also as a proportion of all self-inflicted deaths across the prison estate:

Figure 34 – Self-Inflicted Deaths per 1,000 Prisoners



The likelihood of self-inflicted death in prisons is 8.6 times greater than the that in the community.[375]

Of those who died from self-inflicted means whilst in prison, 70% had previously been identified as having mental health needs. However, PPO found that only just over half of these had been flagged for concerns about mental health problems on entry to the prison.[376]

Management

Safeguarding of prisoners 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 prisoners 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 prisoners. 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 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.

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.

[374] House of Commons (2017) Mental health in prisons. [Accessed 7/12/20].
[375] Prison Reform Trust (2019) Mental health care in prisons. [Accessed 11/12/20].
[376] *Ibid.*

Health Promotion and Female Prisoners

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 3200 requires that governors ensure efforts are made to:[377]

- *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).[378]

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.*[379]

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 Service Health Promotion Calendar considers a series of health issues in turn and offers a specific focus on each by date, for example:

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

Figure 35 – Health Promotion Calendar[380]

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.*[381]

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

[381] 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].

Health Trainers are prisoners 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 women 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 prisoners 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 prisoners.

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.[382] The prevalence of obesity increases with age and is highest among the 55-64 age group in men.[383] 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).[384] 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'*.[385]

Healthy eating is difficult to promote when prisoners have little choice over what they eat, and when prisons have a budget of £2 per day to feed each prisoner.[386]

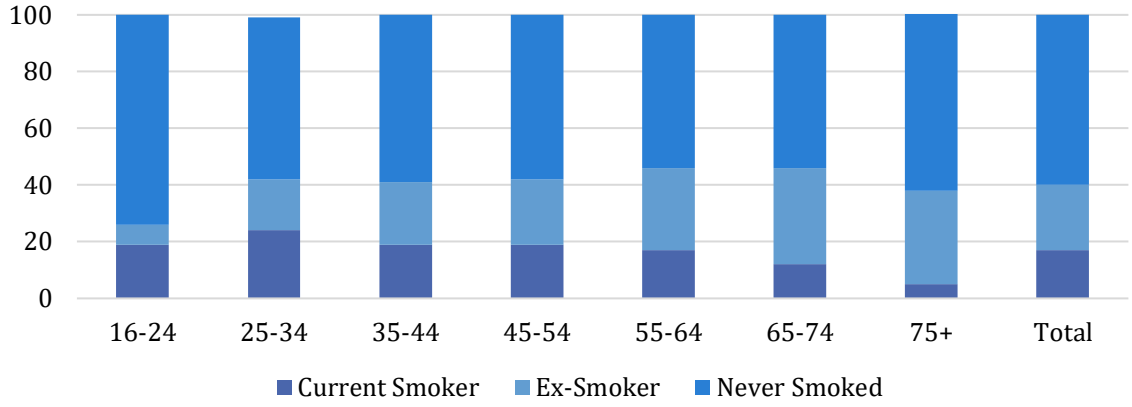
Smoking

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.[387] In the UK, 17.7% of men were current smokers which was significantly higher in comparison with 14.1% of women.[388]

Smoking is less prevalent in women than in men. The Health and Social Care Information Centre published data relating to the smoking status of women in the general population in England. This is shown below, categorised by age band.

[382] Baker, C. (2019) Obesity statistics. [Accessed 9/12/20].
[383] *Ibid.*
[384] *Ibid.*
[385] Hubbard, R.E. (2010) Frailty, body mass index and abdominal obesity in older people. [Accessed 10/12/20].
[386] House of Commons (2018) Prison health. [Accessed 10/12/20].
[387] ONS (2019) Adult smoking habits in the UK: 2018. [Accessed 9/12/20].
[388] *Ibid.*

Figure 36 – Cigarette Smoking Status by Age (women) Percentages[389]



The chart shows that women in the age group of 25-34 years are the most likely to be current smokers; as women age they become less likely to be current smokers. Similarly, as they age, women 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.*[390]

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.[391]

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.[392] Forty-four of the 124 public and private prisons in England and Wales house one or more transgender prisoner.[393] 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.*[394]

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.

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[389] Statista (2019) Distribution of cigarette smoking status in England in 2018, by gender. [Accessed 9/12/20].

[390] PHE and King's College London (2015) Reducing smoking in prisons: management of tobacco use and nicotine withdrawal. [Accessed 9/12/20].

[391] NHS (2019) Stop smoking without putting on weight. [Accessed 9/12/20].

[392] Ministry of Justice (2019) Her Majesty's prison and probation service offender equalities annual report 2018/19. [Accessed 2/12/20].

[393] *Ibid.*

[394] MOJ (2016) Review on the care and management of transgender offenders. [Accessed 9/12/20].

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)[395] 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.[396]

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.*[397]

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.[398]

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.*[399]

HMPPS has recently issued a new PSI on The Care and Management of Transgender Offenders.[400]

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.*
>
> *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

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[395] NOMS (2016) The care and management of transgender offenders. [Accessed 9/12/20].

[396] MOJ (2016) Review on the care and management of transgender offenders. [Accessed 9/12/20].

[397] *Ibid.*

[398] PPO (2017) Learning lesson bulletin transgender residents. [Accessed 9/12/20].

[399] MOJ (2016) Prisoner transgender statistics, March/April 2016. [Accessed 9/12/20].

[400] NOMS (2016) The care and management of transgender offenders. [Accessed 9/12/20].

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 Needs of Female Prisoners

The social care needs of women prisoners are often fundamentally different to the needs of their male counterparts. The most obvious social care issue relevant to women in prison is around family, but wider needs (such as finance and debt) are often also very apparent.

The Corston report[401] is the centrepiece of evidence in outlining the impact of imprisonment on women and it comments on numerous social care issues.

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 are care leavers.

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, benefit and debt*
- *Drugs and alcohol*
- *Family, relationships and social networks*
- *Emotional wellbeing*
- *Mental health*
- *Disabilities requiring social care*
- *Learning disabilities and difficulties*[402]

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.

Some of the above needs are dealt with in this HNA from a 'health' perspective and feature in previous chapters (e.g. substance misuse, mental health, learning disability and physical disability).

Women are less likely than men to have someone outside who can look after their home and family while they are away. There is a solid evidence base demonstrating that women in prison are far more likely to be the primary carer for children than male prisoners.[403]
A significantly higher proportion of females than males reported having children under the age of 18 (54% compared to 47%).[404]

From a safeguarding perspective, prisoners (parents) who misuse drugs and alcohol are likely to feature higher on the radar. Contact with partners and families while incarcerated is likely to be a greater issue for female prisoners than their male counterparts, since the limited

[401] Home Office. (2007) The Corston Report. [Accessed 11/12/20].
[402] Anderson, S. & Cairns, C. (2011) The social care needs of short-sentence residents. [Accessed 9/12/20].
[403] HMIP (2005) Women in prison: a literature review. [Accessed 11/12/20].
[404] MOJ (2018) Statistics on women and the criminal justice system 2017. [Accessed 11/12/20].

number of female prisons means that women are more likely to be imprisoned far from their homes and families.

Many women in prison are mothers, and around a third are single parents. Nationally, between 2005-2008, 382 babies were born to women prisoners – the information is no longer centrally collected.

If a prisoner is pregnant and likely to have the baby whilst in prison, or has recently given birth to a baby, they may apply for a place in a mother and baby unit. The geographic location of all these units can result in women being imprisoned at an even greater distance from their family and support networks.

Prison Responsibilities

In the most recent annual report, the PPO comments on the impact of recent 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.*[405]

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.[406] The PSI details the relationship that should exist between a prison and its local authority, as informed by the Care Act (2014).

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.[407]

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 that there will be more explicit and immediate needs for social care services than establishments are currently equipped to provide. Whilst the prison population remains relatively young, stakeholders described more elderly women. 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.*[408]

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

[405] PPO (2016) Annual report 2015-16. [Accessed 9/12/20].
[406] NOMS (2015) PSI 03-2016: adult social care. [Accessed 9/12/20].
[407] NOMS (2015) PSI 16-2015: adult safeguarding in prison. [Accessed 9/12/20].
[408] HMIP (2004) 'No problems old and quiet': older residents in England and Wales. [Accessed 2/12/20].

is immovable is prison responsibility (e.g. a hand rail bolted to a wall). 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:

> *[l]ocal 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 prisoners 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.*[409]

In February 2016, Association of Directors of Adult Social Services (ADASS) issued a brief update on the implementation of the Care Act across the prison estate for the first half of 2015/16, which concluded that more useful questions were raised than were answered.[410] Since then, they have published little in the way of further analysis. A recent King's Fund study concludes:

> *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.*[411]

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.*[412]

Eligibility Criteria

In order to be entitled to care, prisoners must meet the eligibility criteria as defined in 'The Care and Support (Eligibility Criteria) Regulations 2014'.[413] Because this is not widely understood, the relevant paragraphs are reproduced in full below

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.*

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[409] *Ibid.*

[410] ADASS (2015) Care Act stocktake 5 - autumn 2015 prisons and approved premises. [Accessed 9/12/20].

[411] Humphries, R. *et al.* (2016) Social care for older people home truths. [Accessed 9/12/20].

[412] HMIP and CQC (2018) Social care in prisons in England and Wales: a thematic report. [Accessed 9/12/20].

[413] Social Care England (2014) The care and support (eligibility criteria) regulations. [Accessed 10/12/20].

(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 37 considers this in relation to the outcomes specified in paragraph (2) above:

Figure 37 – Eligibility Criteria and the Prison Environment

Criteria (must be unable to achieve outcomes)	Situation in prison	Comment
(a) managing and maintaining nutrition	Prisons 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 woman may not be able to actually feed herself, 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.	
(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	Prisons manage these. They are all on site.	

Criteria (must be unable to achieve outcomes)	Situation in prison	Comment
community including public transport, and recreational facilities or services		
(j) carrying out any caring responsibilities the adult has for a child	Not applicable	

Care Leavers

HMIP notes that specific provision is in place for care leavers which need '*to be identified and met.*'[414]

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).[415]

The particular needs of young adults who are care leavers are acknowledged:

> *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.*[416]
>
> *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.*[417]

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.*[418]

> *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,*

[414] HMIP and Ofsted (2014) Resettlement provision for adult offenders: accommodation and education, training and employment. [Accessed 9/12/20].
[415] Full Fact (2012) Were a quarter of prisoners in care as children? [Accessed 9/12/20].
[416] HM Government (2013) Care leaver strategy. [Accessed 9/12/20].
[417] DfE (2010) The Children Act 1989 guidance and regulations Volume 3. [Accessed 9/12/20].
[418] DfE (2010) The Children Act 1989 guidance and regulations Volume 3. [Accessed 9/12/20].

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.[419]

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.[420]

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),[421] 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.[422]

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*
- *If the former relevant child pursues higher education in accordance with his pathway plan, to pay him the higher education bursary.*[423]

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.*[424]

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.

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[419] *Ibid.*

[420] *Ibid.*

[421] (2017) Children and Social Work Act (2017). [Accessed 10/12/20].

[422] DfES (2004) Local authority circular 26. [Accessed 10/12/20].

[423] DfE (2010) The Children Act 1989 guidance and regulations Volume 3. [Accessed 9/12/20].

[424] DfE (2010) The Children Act 1989 guidance and regulations Volume 3. [Accessed 9/12/20].

Enablers

Most prisons now have a clear and well-established programme of peer 'enablers' or 'buddies'. 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:[425]

> ***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;*
> - *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 women; 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.

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[425] NOMS (2015) PSI 17-2015: residents assisting other residents. [Accessed 9/12/20].