



## Reform Efforts in Public Services

### Prisons and Health Reforms in England and Wales

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Prison health in England and Wales has seen rapid reform and modernization. Previously it was characterized by over-medicalization, difficulties in staff recruitment, and a lack of professional development for staff. The Department of Health assumed responsibility from Her Majesty's Prison Service for health policymaking in 2000, and full budgetary and health care administration control were transferred by April 2006. As a result of this reorganization, funding has improved and services now relate more to assessed health need.

There is early but limited evidence that some standards of care and patient outcomes have improved. The reforms address a human rights issue: that prisoners have a right to expect their health needs to be met by services that are broadly equivalent to services available to the community at large. We consider learning points for other countries which may be contemplating prison health reform, particularly those with a universal health care system. (*Am J Public Health*. 2006;96:1730–1733. doi:10.2105/AJPH.2004.056127)

**IN 1996, HER MAJESTY'S**  
Chief Inspector of Prisons, an

independent authority, published a highly critical review entitled *Patient or Prisoner? A New Strategy for Health Care in Prisons*.<sup>1</sup> This publication drew to public and political attention the problems of the health care services in prisons across England and Wales.

Staff were often inadequately qualified, lacked suitable training, and had low morale. Professional isolation and poor communication among doctors and nurses in Her Majesty's Prison Service were common, resulting in enormous variations in the standard of care across the prison estate. The Chief Inspector of Prisons showed that prisoners' health needs were not being properly assessed or met compared with citizens in the community and that the public health opportunities prison can offer were not being exploited. A radical overhaul was required, and a government policy document, *The Future Organisation of Prison Health Care*,<sup>2</sup> addressed the critiques. This was a Department of Health rather than a Home Office or Her Majesty's Prison Service publication, signaling that the government was intent on shifting control of prison health services to the Department of Health. The document's implementation was the impetus behind the changes that are the subject of this article.

#### REFORMING PRISON HEALTH

Before reform, Her Majesty's Prison Service provided prison health care separately from the main state-funded provider for health services, the National Health Service (NHS). Primary care, which accounted for most of the health care services in prisons, was delivered in each prison primarily by prison-employed doctors, nurses, and officers with limited health care qualifications. NHS hospitals provided secondary and specialist care, but with access and security difficulties.

Today there has been radical change regarding primary care, and all of the health services within Her Majesty's Prison Service are purchased and provided for prisoners in the same way services are provided for other citizens, by the NHS.

#### Information on Prisons and the Health of Prisoners in England and Wales

The prison population rose by 2% from 2004 to 2005 to 76 190. Of these, 71 676 were men and 4514 were women. There were 8490 young adults aged 18 to 20 years, and 2310 were aged 15 to 17 years. The rate of imprisonment was the

highest at 145/100 000.<sup>3</sup> There are 139 prisons, the largest of which houses 1500 prisoners, and the smallest, 145.<sup>4</sup> Overcrowding is a growing and continual problem. The prison population has health problems including mental illness, substance abuse, or both (90%); tobacco use (80%); HIV-positive status (0.3% of men and 1.2% of women); and past injection drug use (24%, of which 20% have hepatitis B and 30% have hepatitis C).<sup>5</sup>

To understand the prison reforms, one must understand health services in England and Wales. The NHS is funded through taxation and provides most of the health services for citizens. Services are provided free at the point of delivery, apart from some relatively small charges—for prescription drugs, for example. The NHS provides health services at the local level through 300 primary care trusts, each of which serves a population of about 250,000. Some 85 of these primary care trusts serve one or more prisons.

#### Key Aspects of the Reforms

*Equivalence.* In 2000 the responsibility for policy development and standards moved from Her Majesty's Prison Service to the Department of Health. The underlying objective was to



provide services on the basis of assessed need and at least broadly equivalent to those for citizens in the community.

*Partnership approach.* At the time of the reorganization, the Department of Health instructed the NHS to recognize prisoners as part of the local community for health needs assessment and planning. Locally, a partnership developed between each prison governor (warden) and staff from the primary care trust, from which joint planning of services took place. Nationally, the director of prison health was relocated from Her Majesty's Prison Service to the Department of Health but remained a member of the Prison Service Management Board. This position reports to government ministers in both the Department of Health and the Home Office.

*Transfer of funding nationally to the Department of Health.* In 2003 the budget for prison health services transferred from Her Majesty's Prison Service to the Department of Health. The partnership approach was maintained, although the role of the NHS grew steadily larger.

*A new phase of integration.* The partnership entered a new phase; as of April 2006, the NHS commissioned all health services for prisoners in publicly funded prisons in England and Wales in much the same way that it provides services for all British citizens.

## HAVE THE CHANGES PROVED BENEFICIAL?

*There have been important service improvements.* One measure,

admittedly a subjective internal governmental measure, introduced the “traffic light” monitoring scheme of prison health care services, where red means unsatisfactory service, amber indicates significant concerns, and green represents satisfactory service for prisoners. In 2000, 5 prisons were classified as red, 45 as amber, and 83 as green<sup>6</sup>; by the end of 2002 (when 4 more prisons had opened) there were 0 red, 28 amber, and 110 green.

*The isolation of prison health care and the ad hoc nature of provision are becoming a thing of the past.* Strategically, there are plans costed out by the Department of Health to contend with prisoners' major health care needs—primary health, mental health, and dental care—and there is a workforce strategy to attempt to ensure appropriate staff are recruited, trained, and retained. Locally, there are public documents—local health delivery plans—for each prison based on local health needs assessments and carried out in partnership with the local community's NHS staff. All doctors who work in prison regularly are qualified as general practitioners; the vast majority of doctors who work at the prison do so on a part-time basis, and work in the community the rest of the time. Because prison has become just another part of an NHS provision within the community, the risk of professional isolation for those who work there has diminished, attracting many NHS nurses to prison employment.

*Resources and funding for capital building projects and key health issues have improved.* In the past

there has been inadequate provision for the many prisoners with mental health problems. By providing considerable extra funding, the Department of Health has ensured a clear, accessible gateway to the specialist mental health services prisoners require. Some 300 NHS mental health nurses have been recruited to form mental health in-reach teams, coming into prison to provide primary mental health services to prisoners in much the same way as they might visit a patient in the community, at home. The level of need is typically high; surveys indicate that 9 out of every 10 prisoners have at least 1 of the following disorders: neurosis, psychosis, personality disorder, alcohol abuse, or drug dependence.<sup>7</sup> In other areas, such as dentistry, it is a challenge to recruit enough staff to meet the need.

That health needs are identified by assessments is an improvement over the previous system. For the effective management of drug dependence in the prison setting, there has been a review of the clinical management of substance users, and the Department of Health intends to publish new treatment guidelines that will have harm reduction and prevention benefits.<sup>8</sup> In combination with a substantial increase in Department of Health and Home Office funding, these guidelines will markedly improve treatment of injection drug use in prisons by providing universal access to opioid substitute treatment programs that will reduce the spread of blood-borne viruses.

*The medical model of health provision has been reformed; it is now the norm for relevant major public health initiatives to include prisoners.* *Choosing Health*, a government publication, is the government's latest initiative to improve the nation's health, and, for the first time, such a publication has a section specifically on prison health and throughout the document includes prisoners as a target group in areas such as smoking cessation or combating blood-borne viruses.<sup>9</sup> This inclusion does not mean that prison is good for one's health, but it does indicate that the government recognizes that imprisonment offers an opportunity to improve the people's health and it forms a legitimate and important part of the effort to reduce reoffending by addressing the mental health and drug problems that often lead to recidivism. For example, it is now normal to consider the positive role that prison can play in reducing the harm of drug use. Prisons provide the majority of detoxifications for drug users (more than 50 000 each year), and prisoners with a drug problem released back into the community are supervised and put in touch with support services. Prisons are the principal provider of hepatitis B immunizations. There are primary prevention initiatives to combat hepatitis C and sexually transmitted diseases among juvenile and young offenders. Prison also offers an opportunity for prisoners to quit smoking (quit rates are sometimes better in prison than in the community) and reduce



transmission of sexually transmitted diseases and tuberculosis.

The government's promotion of health in its broadest sense continues with the launch of the "healthy prisons strategy."<sup>5</sup> The strategy uses a settings approach and aims to build the physical, mental, and social health of prisoners; prevent the deterioration of prisoners' health during or because of custody; and help prisoners adopt healthy behaviors that can be taken back into the community.

### What About Epidemiological Evidence?

There is not much evidence to go on yet. It is difficult to monitor and measure success, especially because many prisoners are in prison for 6 months or less.<sup>10</sup> For example, in easily measured key areas such as suicide (where the rate of completed suicides has ranged over the past 5 years between 102 and 134 per 100 000), there is no evidence of significant enduring improvements despite extra funding. Further research into health outcomes is needed. Partly with this in mind, the government in 2005 funded the Prison Health Research Network, led jointly by the Universities of Manchester, Southampton, and Sheffield and the Institute of Psychiatry. The Prison Health Research Network is intended to provide a more systematic and reliable identification of needs in the prison environment and evidence of what methods work best to meet those needs. The network will develop and deliver research projects in key areas,

such as suicide, by working cooperatively with prison-based health staff.<sup>11</sup>

### Are There Lessons Here for Others?

There is a growing trend in Europe and elsewhere for this kind of reform, with Norway, France, and New South Wales in Australia having traversed similar routes before England and Wales. The impetus in each case has been to provide better quality services.<sup>12</sup>

In countries without government-run health care, the separation of provision of health services from the prison service will have to be handled differently. However, it should still be possible to work on the idea of providing a service that is not isolated and is equivalent to the health services available outside prison.

These types of reforms not only conform to the human rights belief that imprisonment should at the least not be harmful to health but they also adequately address health needs. The reforms present an opportunity to confront health issues that are important to society as a whole. In this way, prison health becomes part of public health. There is the added bonus that, by adequately treating the mental health and drug addiction problems of prisoners, we are more likely to integrate prisoners back into society and thereby reduce recidivism linked to untreated or inadequately treated drug or mental health problems. This point should have broad appeal across the political spectrum.

International cooperation in prison health reform can enable countries to share evidence of what works and develop improved practices. The World Health Organization (Europe) Health in Prisons Project, which has 28 member-states, has officially called for its members to uncover a closer link between public health and prisons.<sup>13</sup> The American Public Health Association has sent an observer to past meetings, and representatives visited England in 2004 as guests of the Department of Health and Her Majesty's Prison Service.

### CONCLUSION

This type of reform is not a panacea. The other problems facing those organizing prison health services in England and Wales still remain: ignorance and prejudice in public perceptions of prisoners, the continuing struggle for adequate resources, and the underlying problem of overcrowding. The reforms have provided useful levers for permanent change, however, such as extra capital for new facilities or the improved efficiency and staff morale from the integration with the NHS. The latest phase of integrating prison services with community services should mainstream prison health into NHS systems, making the reforms sustainable.

Looking back, there is a tendency to see a reform of this kind as driven by a complex master plan. In reality, however, although the principles and policies for reform have been deliberately and systematically laid down, the

process of change has also been creative, messy at times, and driven by what seems to work best in practice. It has certainly brought prison health issues outside the prison walls in a dramatic way in a short period. ■

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### Contributors

Paul Hayton originated the article and was the main author. John Boyington advised on the content and structure.

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No protocol approval was need for this study.

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